# Strengthening the Home and Community-Based Services (HCBS) Grievance Process

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## Introduction

In May 2024, the Centers for Medicare & Medicaid Services (CMS) finalized regulations meant to improve access to key Medicaid services for people with disabilities. These home and community-based services (HCBS) – such as personal assistance to eat, dress, and move about – help people with disabilities live at home, stay close to their families, and keep active in their communities. If HCBS are not timely and consistently high quality, recipients may not be able to stay in their communities. Medicaid beneficiaries need ways to flag problems when they occur, and get those issues resolved quickly. That is why one part of the new regulations, known collectively as the HCBS Access Rule, requires all states to establish a grievance process for individuals receiving Medicaid HCBS.

Medicaid has multiple systems to resolve service-related problems. Eligibility and authorization problems, like getting service hours cut too low, go through the Medicaid appeals system. Events that put someone at risk or cause serious harm, like a medication error or the improper use of restraints, must be reported through a state's incident management system. Other problems, like having a caregiver consistently show up late to work or living in a setting that restricts visits with family and friends, are typically handled through a grievance process. Unfortunately, knowing which system (or systems) to contact, and how to contact them, can be really confusing.

The HCBS Access Rule offers states a chance to revamp their often patchwork, siloed approach to addressing problems. An effective, user-friendly grievance process can help integrate these different problem resolution systems and inform quality improvement for HCBS programs. But developing systems that meet the federal requirements and also integrate well

with related critical incident reporting and formal appeals processes (described below) will require a lot of careful planning. States must implement the new grievance standards by July 2026. With the deadline fast approaching, states should already be engaged in the redesign.

This brief reviews the new federal requirements and situates them in the context of related oversight and monitoring processes. It provides advocates with suggestions and ideas for how to build and test a grievance process responsive to the needs of people using HCBS. It also points to promising approaches that some states have already implemented.

## Distinguishing Between Grievances, Critical Incidents, and Appeals

One of the major challenges states face in creating an effective grievance process is making sure the matrix of different processes work together so beneficiaries get pointed to the right channel to address their problem. As noted above, states have at least three related systems to handle problems a beneficiary who uses HCBS might face:

**The grievance system** (evaluating issues that arise outside the scope of an appeal). In the context of HCBS, grievances may include problems related to the setting where the individual receives services, with the person-centered planning process, or issues with the quality of services. Grievances may be initiated by a beneficiary or their representative, and could include issues like not having access to do chosen activities in the community, disrespectful treatment by a provider, or having a provider consistently show up late for work.

**The critical incident system**, also overhauled under the HCBS Access rule, requires providers to report incidents that put the health or welfare of beneficiaries at serious risk. Critical incidents include instances of abuse, neglect, financial exploitation, medication or treatment errors, inappropriate use of restraints, and even unexplained deaths. Under the new rule, states must develop electronic systems to track critical incidents and ensure they are appropriately reported and investigated. Critical incident reviews are retrospective, meaning this system mostly engages after a serious harm (or risk of harm) has occurred with the aim of preventing recurrence.

**The appeals system** addresses issues primarily related to an individual's eligibility for or authorization of Medicaid services. Any challenge to an "adverse action" – basically a decision that involves denials, delays, or limitations of requested services, payments for services, or cost-sharing disputes – should be handled through the appeals process.[1] Disputes about Medicaid eligibility would also go through this system. The appeals process includes fair

hearings and may involve higher courts. Grievances that are not resolved within the allotted time would also go to the appeals system.

## New Federal Requirements for FFS Grievances

The HCBS Access Rule requires all states to implement a grievance process before July 2026 for fee-for-service (FFS) HCBS programs authorized through 1915(c) HCBS waivers, 1915(i), 1915(j), 1915(k) and 1115 demonstrations.[2] The new rules do not apply to states that run HCBS through managed care, where grievance processes must already be in place through existing regulations for managed care.[3] The HCBS Access rule mostly aligns with the existing managed care grievance standards. Both processes require states to:

- Provide beneficiaries notice and information about their rights and how to file a grievance;
- Inform providers and subcontractors about the grievance system;
- Provide assistance to file grievances, including ensuring that the system is accessible to people with disabilities and with Limited English Proficiency. This includes allowing beneficiaries to file a grievance at any time, either orally or in writing;
- Inform a beneficiary when their grievance has been received;
- Give beneficiaries access to their medical records as well as information and evidence the State used related to the grievance (free of charge and with enough time before the resolution is determined);
- Allow the beneficiary to present supporting evidence and testimony face-to-face or in writing; the evaluator must consider all the information submitted by the beneficiary;
- Verify the person evaluating the grievance has the appropriate expertise, and has not been involved in a prior decision about the case;
- Resolve the grievance as quickly as the beneficiary's health condition requires, but not longer than 90 days (states may set shorter time frames);
- Notify the beneficiary of the resolution in an accessible and language-appropriate format; and
- Maintain basic records about each grievance and its resolution.[4]

The regulation standards for grievance systems in states that provide HCBS through managed care plans also differ in a few respects. For example, the older managed care grievance regulations do not explicitly require states to prevent "punitive or retaliatory action" or threats against individuals who file a grievance, while the new regulations do.[5] CMS has previously found evidence that fear of retaliation prevents HCBS recipients from filing complaints, so this

protection for FFS recipients is a welcome addition.[6] Managed care states should consider adding similar protections to their grievance processes if they have not already done so.

The new regulations also require states to keep records of each grievance and make those records available to CMS, but public reporting of these grievances and resolutions related to HCBS is not required by regulation. Advocates should encourage their state to regularly review its grievance process to evaluate its effectiveness and impact on care quality.

**Advocate Recommendations for HCBS Grievance Processes**

- Ask states to set shorter timelines for investigating and resolving grievances, including for accelerated decisions based on a beneficiary's health condition;
- Push states to periodically audit their HCBS grievance system using an independent evaluator to identify trends, deficiencies, and recommendations for improvement. Results should be publicly posted;
- Make sure states inform people of their right to appeal a grievance if they are not satisfied with the resolution or if the resolution takes too long.
- Help develop simple, accessible outreach materials to inform beneficiaries of their rights and regularly share information on how to report problems;
- Above all, push states to develop an integrated system with various entry points for receiving reports on problems and assisting beneficiaries through the appropriate resolution system (see below.)

## Changes to the Critical Incident Management System

States have long maintained critical incident reporting systems (sometimes called different names) to identify, investigate, and resolve issues that affect the health and safety of people who use HCBS. Generally, providers are required to report these events promptly and implement corrective actions, but the details vary widely across states and HCBS programs. Prior studies found inconsistencies in how frequently these incidents were reported, how effectively states identified unreported events, and how thoroughly investigations and corrective actions were conducted.[7] One survey identified 14 different incident management systems in 7 states, the majority of which had no capacity to estimate how many incidents go

unreported.[8] State systems even diverged on the definition of what counts as a critical incident.[9] The final HCBS Access Rule strengthens these state critical incident systems.

The rule establishes a structure to improve consistency and transparency with the ultimate goal of making sure that when these events happen, providers make the necessary corrections to prevent them from happening again. The changes include a new minimum federal definition for critical incidents that occur during the course of delivering services (or the failure or delay in delivering services).[10] A critical incident must include at least:

- Verbal, physical, sexual, psychological, or emotional abuse;
- Neglect;
- Exploitation, including financial exploitation;
- Misuse or unauthorized use of seclusion or restraints
- Medication errors that results in an interaction with poison control, an urgent or emergency care visit, a hospitalization, or death; or
- An unexplained or unanticipated death.[11]

This uniform standard of what qualifies as a critical incident should increase consistency and comparability across HCBS programs, and should make it easier for states and CMS to conduct effective oversight.

The new rule also requires states to develop checks to identify unreported critical incidents and make sure that all critical incidents are appropriately investigated, including if the State has to conduct the investigation on its own.[12] For example, if a beneficiary arrived at an urgent care with signs of abuse, but the county-run adult protective service (APS) is the designated entity to investigate. If the APS did not start an investigation within the state-required time limit, the state would have to begin an investigation itself.

States will have to use available data from health care claims, Medicaid fraud units, and other state agencies to identify critical incidents that went unreported. Data sharing with agencies should include Adult and Child Protective Services and could also include Protection and Advocacy organizations, Long Term Care ombuds offices, law enforcement, and provider licensing agencies. A nationwide CMS review of 38 existing systems found that 36 communicated with other state agencies, but most did not do so at regular intervals.[13] A 2023 review found that only 33 of 101 systems were able to integrate electronically with other state systems, and only 27 cross check emergency department admissions with HCBS data to alert their providers and caregivers.[14] Building better electronic connections will be necessary to fulfill the new requirement that all states utilize electronic systems for collecting, tracking and trending critical incidents by July 2029.[15] Evidence shows that reviewing health claims data can

help identify unreported incidents. For example, one CMS review of a sample of Medicare claims suggestive of potential abuse and neglect found that just under 20% had not been reported to law enforcement.[16] Identifying unreported critical incidents is not just about improving data accuracy, it also encourages providers and state programs to improve their training and correct problems that could harm people who use HCBS.

States must also establish time limits for initiating investigations, completing investigations, and completing corrective actions. In this case, corrective action may include disciplinary action and/or a corrective action plan (CAP) that calls for changes to a providers' internal policies to address deficiencies. For example, if an individual was hospitalized due to pneumonia and their clinical team identified improper bed positioning as the cause, a CAP might require a review of training policies at their HCBS provider and extra staff training. A recurrence or a pattern of similar events might lead to disciplinary action against the provider.

CMS elected not to set federal maximum time limits for resolving critical incidents, but it has previously recommended that states complete investigations within 14 days for incidents of physical abuse and neglect that result in serious illness or injury, and 30 days for all other incidents.[17] Required response times for reporting incidents, particularly for events that cause serious illness or injury, are typically less than 24 hours, or slightly longer for less severe events.[18] Advocates may weigh in with their states to recommend maximum time frames for reporting, starting, and finishing incident investigations. States must begin reporting on rates of meeting these time limits by July 2027.[19] Specifically, states must maintain rates of at least 90% for initiating and completing investigations of all critical incidents, as well as the rate of completing required corrective actions after critical incidents occur.

One important feature of the critical incident structure is that it centers on provider reporting and interagency coordination. This can lead to situations where the beneficiary's role in the process is less clear. For example, states are not required to establish specific mechanisms for individuals to report critical incidents.[20] If your state does not take up the option to allow beneficiaries to report critical incidents, it becomes even more important to have a grievance system that can triage problems and identify issues that endanger health or welfare to activate the critical incident review and reporting process. Advocates should recommend that states actively review any HCBS grievances to check for unreported critical incidents.

## Importance of an Integrated Approach

From the perspective of an individual with an urgent problem, the distinctions between grievances, critical incidents, and appeals can be very confusing. Feedback on existing

grievance systems points to piecemeal state systems with widespread confusion about where to direct complaints.[21] Say an individual has money stolen by a staff member of their group home. This would qualify as a critical incident, but an individual may report the violation through the individual grievance process. Similarly, an individual might use the process set up to report grievances to complain about a reduction in services that really should be evaluated as an appeal.

As states update their HCBS grievance process, they should recognize that people cannot be expected to identify the correct bureaucratic channel for their complaint. Any state committed to quality improvement in its HCBS programs should prioritize simplifying the process for reporting all of these issues and assisting individuals in resolving them, no matter which channel a beneficiary used to report it. In its final rule, CMS suggested that an integrated approach would likely reduce confusion for people receiving HCBS and also streamline bureaucratic reporting and coordination efforts across government agencies.[22]

What does an integrated system look like? First, a clear, accessible, plain language, and user-friendly mechanism to field complaints from HCBS participants. States could set up a main hotline number and/or online chat assistance (with a human and confidentiality protections) to field and direct calls. Alternatively, it could designate an ombuds office or similar agency that participants can contact for support. States should also examine all the ways HCBS users raise problems now – such as through their case manager, their provider, a visit to an Aging and Disability Resource Center, or, a call to their health plan in a managed care state. These contacts should be trained in how to identify and triage problems and smoothly assist individuals through the appropriate process. The system should accommodate different reporting pathways. This increases accessibility, but also allows people to avoid unwanted confrontations. For example, in someone has a problem with their case manager, they may not want to report that problem directly to their case manager!

The principle behind this integrated approach means the state builds the entire process from the perspective of the HCBS user, and make sure all the links in the chain hold up, including:

1. Making sure all users know their rights and can identify when something is wrong;
2. Providing users with simple, accessible mechanisms to report problems;
3. Telling people how to use these systems. Repeatedly.
4. Allowing individuals to present their case with supporting evidence, and making sure the investigation and evaluation is fair and timely;
5. Protecting individuals from retaliatory threats and actions;
6. Communicating throughout the process to the complainant, including at resolution; and
7. Making sure that any corrective action is actually enforced.

If any one of these links breaks down, people may lose faith in the system and stop using it. That means that if a person calls a grievance hotline and reports that their service hours have been cut, the hotline staff should be able to recognize that the issue should be handled as an appeal, and then be able to connect that individual and their report to the fair hearing process and to legal aid, if necessary. If a family member contacts a grievance hotline to let them know that their aging mother tripped on a broken sidewalk outside the assisted living facility and broke her wrist, the intake person should be able to check to see if the provider has reported a critical incident, and if not should know who to contact to begin an investigation. In short, states should try to connect and coordinate data electronically across systems and state agencies on the back end, and all the point people who may receive grievances should be well-trained to sort problems into the right channels. This will help beneficiaries receive appropriate referrals to resolve each component of their problem.

While CMS stopped short of requiring this no-wrong-door grievance approach, the final rule did clarify that part of a state's responsibility to provide "reasonable assistance" to beneficiaries includes filing the grievances "appropriately" – meaning that states must help individuals sort their concern into the appropriate system.[23] As with the service cut example above, states may treat a concern submitted through the grievance process as a fair hearing request if the concern should be appropriately treated through the appeal system.[24] In these cases, using the date of grievance filing as the date of a fair hearing request can help speed up the resolution process. States should take into account these overlaps across the fair hearing, grievance, and critical incident systems and develop responsive, beneficiary-centered systems that people are willing to use, as it stands to improve HCBS quality over time.

**Recommendations for Integrated Issue Resolution**

- Encourage states to allow beneficiaries and their representatives to report critical incidents directly, even if they use the grievance process to do so;
- Create multiple, accessible pathways for people to raise problems they experience in the course of receiving (or not receiving) services;
- Encourage states to review filed grievances to identify potential unreported critical incidents;
- Ask your state take up the option to use the date of grievance submission as the submission date for a fair hearing request when the contents of the submission are found to be appropriate for the fair hearing system.

## Finding Information about Your State's Issue Resolution Processes

In states with 1915(c) HCBS waiver programs, details about each program's grievance, appeals, and critical incident reporting systems should be in the 1915(c) waiver application. Advocates, beneficiaries, and their families can submit comments on these systems during renewal or amendment of the waiver. For more information and tips on commenting, see our brief Commenting on § 1915(c) HCBS Waivers: A Guide for Common Issues. The waiver descriptions for resolution processes can be found in the application appendices as follows:

- fair hearings (F-1),
- grievances (F-3), and
- critical incidents (G-1).[25]

Until recently, states only had to describe the HCBS grievance process if it had one in place. Going forward, any new application or amendment for 1915(c), (i), (j), or (k) programs should include a description of the state's HCBS grievance process, since all states are required to have grievance systems in place by July 2026.

With awareness of the new requirements, advocates and people using HCBS should consider informing and improving these processes through formal comments (or criticisms) on the state's application. To do so, advocates can compare the description in the appendices listed above with the actual experience of waiver participants who have used, or tried to use, one or more of these systems to address a problem they experienced. Advocates and beneficiaries should consider including specific information and recommendations for the state, such as:

- How providers can offer clear explanations of information on what grievances are for and how to file them;
- Whether information on beneficiaries' rights (including the settings requirements) are clearly posted and frequently shared, such in person-centered planning documents and meetings;
- Identifying gaps or conflicts that show poor integration of grievances with the fair hearing and critical incident systems;
- Reporting instances of conflicts-of-interest, such as having an individual who was involved with the problem as the point-of-contact for starting a grievance or having that person involved in investigating the complaint;
- Whether/how the state provides provide accommodations readily and how accessible the process is;
- How the state will enforce protections against retribution from the provider or plan;

- How the state will reduce barriers to identify or trigger a formal grievance (not requiring extensive information or magic words to justify); and
- Asking the state to describe policies around the response to the complaint, including timelines, how states notify beneficiaries at key points, such as acknowledging the grievance has been received and sharing the resolution and remedy (if necessary).

## Other Advocacy Approaches

Commenting is just one approach where advocacy can influence what a state's HCBS grievance process looks like. Advocates could also encourage states to create an advisory group on the development of its HCBS grievance system, the revamping of critical incident management, and the connection of both systems to appeals and fair hearings.

As part of the HCBS Access rule, states are currently updating their stakeholder advisory groups to include more beneficiary and advocacy participation.[26] While these groups are not specific to HCBS, they may include members with disabilities and could provide another platform to make recommendations to state officials.

## Conclusion

High quality, dependable, and timely HCBS keep people with disabilities close to their families, active in their communities, and out of institutional care. The new grievance regulations present a real opportunity to work with their states to build more integrated HCBS grievance systems. The new provisions should elevate beneficiary perspectives, offer better protection against retribution, and strengthen oversight and quality management of HCBS programs. States that embrace approaches that interlink grievance, critical incident, and appeals systems can help build confidence that states are committed to identifying and resolving problems and improving their HCBS programs.

Advocates should start asking their state now about its plan to implement the HCBS grievance system requirements by July 2026. Taking a more ambitious approach that adopts features of a no-wrong-door complaint process will take longer, so states should already be busy with planning. While there have been some rumblings that parts of the HCBS Access Rule may be under review for proposed changes or delayed implementation, there have been no public indications that the HCBS grievance process will be affected. Advocates and people with disabilities should share their vision of a better grievance system that protects people from harm, addresses problems on an individual level, and tracks and identifies patterns that can help states prioritize areas for improvement.

## ENDNOTES

[1] The appeals system and the definition of an appeal differ slightly between managed care and fee-for service Medicaid. In either system, Medicaid applicants and recipients have rights to notice and administrative hearings when their claims for medical assistance are denied or not acted on with reasonable promptness. These rights are found in the Medicaid statute and are guaranteed by the Due Process Clause of the U.S. Constitution. Relevant regulations are at 42 C.F.R. § 438 Subpart F for managed care and at 42 C.F.R. § 431 Subpart E.

[2] See 42 C.F.R. §§ 441.301(c)(7), 441.464(d)(5), 441.555(e), and 441.745(a)(1)(vi).

[3] See 42 C.F.R. § 438 Subpart F.

[4] See 42 C.F.R. § 441.301(c)(7).

[5] See 42 C.F.R. § 441.301(c)(7)(iii)(B)(3).

[6] *See*, *e.g.*, CMS, *Montana On-Site Review Summary Report*, 7-8 (June 2023), https://www.medicaid.gov/medicaid/home-community-based-services/downloads/MT-hw-summary-rpt.pdf.

[7] U.S. Gov't Accountability Office, *Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed* (Jan. 5, 2018), https://www.gao.gov/products/gao-18-179; Jay Bulot, WellSky, *Critical Incident Management Best Practices* (2019), https://info.wellsky.com/hswp006-incident-management-wp.html?utm_source=mktg&utm_campaign=&utm_content=advstates.

[8] Jay Bulot, *supra* note 7, at 4.

[9] U.S. Gov't Accountability Office, *Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed* (Jan. 5, 2018), https://www.gao.gov/products/gao-18-179; Jenna Libersky et al., Mathematica Policy Research, *Critical Incidents, Grievances, and Appeals: Data to Support Monitoring and Evaluation of Medicaid Managed Long Term Services and Supports (MLTSS) Programs* (Oct. 2019), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/1115-mltss-grievances-appeals-data.pdf.

[10] 42 C.F.R. § 441.302(c)(6).

[11] 42 C.F.R. § 441.302(c)(6)(i)(A). A state could add other categories of incidents to its definition, such as discharge and eviction or injuries related to a fall.

[12] 42 C.F.R. § 441.302(c)(6)(i)(F).

[13] CMS, *Managing Incident Management: How Can States Create a System that Best Manages Critical Incidents and Critical State Resources Simultaneously?,* 39 (Aug. 2018), https://www.advancingstates.org/sites/default/files/12%20-%20CMS_Managing_Incident_Mgmt_508.pdf.

[14] CMS, *Incident Management in 1915(c) Waiver Programs: Incident Management Recommendations,* 31, 35 (Sept. 2020), https://www.medicaid.gov/medicaid/home-community-based-services/downloads/incident-mgmt-rec.pdf.
[15] 42 C.F.R. § 441.302(a)(6)(i)(B) and (6)(iii).
[16] HHS Off. Inspector Gen. (OIG), *CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect*, 19 (June 2019), https://oig.hhs.gov/reports/all/2019/cms-could-use-medicare-data-to-identify-instances-of-potential-abuse-or-neglect/. This study included incidents that occurred in inpatient and institutional settings and was not specific to HCBS. CMS also noted that claims data has a time lag that makes it most useful to identify patterns of failed reporting (rather than helpful to specific individuals who need more rapid intervention.)
[17] HHS Off. of Inspector General, *Ensuring Beneficiary Health and Safety in Group Homes through State Implementation of Comprehensive Compliance Oversight*, 28 (Jan. 2018), https://oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf.
[18] CMS, *Using Data to Inform and Improve 1915(c) HCBS Incident Management Systems*, 19 (Oct. 2022), https://www.medicaid.gov/medicaid/home-community-based-services/downloads/ims-using-data-oct-2022.pdf.
[19] 42 C.F.R. § 441.302(a)(6)(iii).
[20] 89 Fed. Reg. 40604.
[21] David Machledt & Syd Pickern, National Health Law Program & the Community Living Policy Center, *The HCBS Settings Rule: Looking Back and Forging Ahead*, 20-21 (May 2024), https://healthlaw.org/resource/the-hcbs-settings-rule-looking-back-and-forging-ahead/.
[22] 89 Fed. Reg. 40578, 40581.
[23] 89 Fed. Reg. 40582.
[24] 89 Fed. Reg. 40582.
[25] Elizabeth Edwards, National Health Law Program, *Commenting on § 1915(c) HCBS Waivers: A Guide for Common Issues* (Sept., 2024), https://healthlaw.org/resource/commenting-on-%c2%a7-1915c-hcbs-waivers-a-guide-for-common-issues/.
[26] *See*, Wayne Turner & Dan Young, National Health Law Program, *Medicaid Advisory Committees: Best Practices for Effective Stakeholder Engagement* (Aug. 28, 2024), https://healthlaw.org/resource/medicaid-advisory-committees-best-practices-for-effective-stakeholder-engagement/; *See also*, CMCS, *Medicaid Advisory Committees & Beneficiary Advisory Councils – Implementation Considerations* (Jan. 2025), https://www.medicaid.gov/medicaid/access-care/downloads/medicaid-advis-coite-benf-advis-councl-toolkit.pdf.