NAMD
National Association of Medicaid Directors

January 9, 2017

Ms. Vikki Wachino
Director, Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

NAMD Comments RE: Medicaid Program; Request for Information: Federal Government Interventions to Ensure the Provision of Timely and Quality Home and Community Based Services [CMS-2404-NC]

Dear Director Wachino:

On behalf of the nation's Medicaid Directors, NAMD is pleased for the opportunity to submit comments to inform future federal policies around Medicaid home and community-based services (HCBS).

The National Association of Medicaid Directors (NAMD) is a bipartisan organization which represents Medicaid Directors in the 50 states, the District of Columbia, and the five territories. Medicaid programs are often the largest insurers in a state, with responsibility to provide coverage for the sickest, frailest and most complex and costly patients in the country. Many of those complex patients are recipients of Medicaid-covered long-term services and supports (LTSS), including HCBS programs.

The states, in partnership with CMS and other federal entities, have made substantial progress in rebalancing the delivery of Medicaid LTSS towards the community in recent years. However, that progress has not been without its challenges. We hope our comments here provide context around these challenges and point to effective solutions for CMS to consider. As CMS reviews stakeholder responses to this RFI, we urge the following principles to be kept at the forefront:

- **States are equal partners with CMS in administering the Medicaid program:** States, as co-financers and direct administrators of the Medicaid program, are uniquely situated to provide meaningful insight into Medicaid HCBS program operations. CMS should give states significant deference in consideration of the multitude of stakeholder perspectives that will be forthcoming in the RFI.

More fundamentally, NAMD recommends CMS reconsider its relationship with states going forward in terms of how HCBS program approval and oversight is conducted. In recent years, CMS waiver review and approval processes have placed significant burden on states, even when state and federal aims are in total alignment. The need for states to deliver HCBS primarily through federal waivers, as a means of obtaining programmatic flexibility and managing program growth, necessitates the frequent need for federal approval for program operations. Many states indicate that CMS's expectations for these programs constantly shifts and incrementally increases over time, despite long-standing successes. This creates an environment of unpredictability for state program administration, introduces delays in routine program changes, and builds differential standards from one state to another.

Going forward, we recommend CMS adopt a more flexible approach to its oversight of state HCBS programs and allow states to more fruitfully explore innovative program design. CMS should design approval pathways and oversight processes that are outcomes-oriented and avoid unnecessary administrative burden on the states.

- **The HCBS landscape is continually evolving, and this evolution must be considered in any additional federal rulemaking:** Like many areas of Medicaid, the HCBS benefit is undergoing significant change. This change is driven in part by federal rulemaking, in particular CMS's 2014 HCBS rule. This rule creates definitions for HCBS settings and gives states until 2019 to develop and implement transition plans to bring settings into compliance with the rule or otherwise remove the settings from state HCBS programs. States and HCBS providers are investing significant time and energy to achieve compliance with this rule, which requires many programs and providers to undergo transformational change. State efforts here, and uncertainty in terms of how the 2019 compliance picture will impact overall HCBS availability, introduces an element of uncertainty to overall state HCBS programs. The magnitude of this task along with uncertainty around the shifting HCBS landscape should be considered as CMS reviews RFI comments and plans additional regulatory action.

We request CMS keep these two principles in consideration as the remainder of our comments are reviewed. Our responses to the specific RFI questions can be found in the attachment to this letter.

NAMD again wishes to thank CMS for its ongoing partnership on HCBS issues and its commitment to finding mutually beneficial solutions with states. NAMD stands ready to continue this partnership in the coming years.

Sincerely,

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President, NAMD

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ATTACHMENT: NAMD Responses to HCBS RFI Questions

What are the additional reforms that CMS can take to accelerate the progress of access to HCBS and achieve an appropriate balance of HCBS and institutional services in the Medicaid LTSS system to meet the needs and preferences of beneficiaries?

States recognize that the Medicaid statute as it is currently constructed favors institutional care over care provided in the community. The statutory construct constrains actions that states and the federal government can take in order to keep individuals in community settings, or otherwise provide individuals with care in the setting of their choice. Yet despite the barrier posed by federal law, CMS, states, and stakeholders have made substantial progress in improving community LTSS capacity to provide HCBS via a variety of Medicaid waiver (and more recently, State Plan) authorities. This progress, driven in part by advocates for person-centered planning and individual engagement in LTSS systems of care, has achieved significant milestones in rebalancing Medicaid LTSS towards the community in recent years. NAMD shares CMS's goal of building on these efforts and further expanding the availability of HCBS in a deliberative, sustainable manner that is reflective of state resources and community capacity to provide care.

We wish to call attention to the successes of the Money Follows the Person (MFP) demonstration program, which expired in September 2016. MFP allowed states significant flexibility and opportunity to generate savings, which were in turn re-invested in a variety of community transition support services - such as short-term rental subsidies, provider training, quality improvement activities, and the development of additional HCBS resources in rural areas. We support CMS's efforts to incorporate successful MFP activities into state HCBS waivers, absent an MFP reauthorization by Congress.

- **On the reinterpretation of the definition of "nursing facility" to allow Medicaid's mandatory nursing facility benefit only to individuals with nursing facility assessed need whose needs cannot be met in the community:**
    - While we recognize that the intent behind redefining "nursing facility" in this manner is aimed at further driving continued rebalancing of Medicaid LTSS towards the community, there would be significant operational challenges associated with this change. The proposed definition would have significantly disparate impact across states, which have varying levels of community capacity to support HCBS. Alteration of the nursing facility definition could result in the disruption or reduction of available LTSS, depending on these capacity issues.

Additionally, it is unclear how the proposed definitional change would impact the various Medicaid LTSS eligibility pathways, such as individuals who initiate nursing facility care as a private payer and attain Medicaid eligibility via spending down their assets. It is possible for such individuals to experience care disruptions if they are required to, upon attaining Medicaid eligibility, transition to a different setting solely due to the Medicaid definition of nursing facility. Similar disruptions could also occur for individuals who are initially receiving Medicare-covered nursing facility post-acute or rehabilitative care.

Given these constraints, we encourage CMS to remain focused on beneficiary preferences and person-centered planning principles in its approach to the definition of nursing facilities, to utilize these touch points in further consideration of additional levers to support Medicaid LTSS rebalancing, and address other existing instances of institutional bias persisting in CMS regulation and processes. This can include ensuring robust processes are in place to inform beneficiaries of the full set of care options available, both within institutions and the community.

- **On 1115 strategies and budget neutrality:**
    - NAMD has found CMS's other targeted 1115 efforts, such as the substance use disorder 1115 in operation in California and Massachusetts, to be effective vehicles for creating innovative delivery system reforms to address the needs of complex beneficiaries. We hope a collaborative federal/state approach can produce similarly effective results in the HCBS space.

      There are several measures that CMS could take under 1115 demonstration waiver authority which could support innovative state efforts to enhance LTSS delivery in the community. One approach would be to build a specialized 1115 on the lines of the Pilot Comprehensive Long-Term Care State Plan Option, as referenced in the RFI.

      As another option, CMS may grant a state authority to create a streamlined LTSS delivery system which draws across the full spectrum of available institutional and community resources to establish a baseline of LTSS capacity. The state would then be granted the flexibility to draw down institutional capacity and divert those resources to the development of community capacity, structured such that the overall LTSS capacity in the state does not fall below the established baseline. The state could be given full flexibility to achieve these aims, including

caps or wait lists for institutional care similar to the caps that exist for current HCBS waiver services.

An additional area for focus in an 1115 is overall care coordination, particularly for individuals who receive Medicaid HCBS and occasionally require short-term institutional stays for certain specialized service needs. Currently, it is difficult, if not impossible, for states to ensure a case manager or care coordinator assisting the individual in the HCBS benefit follows that individual into the institution for short-term stays. Current Medicaid rules and waiver authorities do not provide states with sufficient flexibility to ensure individuals retain their care coordinators in these scenarios, as FFP is only available to reimburse a case manager upon completion of the short-term stay. This restriction poses challenges to ensuring a case manager remains with the beneficiary throughout the stay. A targeted 1115 to ensure robust care coordination, regardless of the Medicaid authority providing coverage, would be of significant benefit.

We also encourage CMS to continue exploring the full universe of authorities that may be leveraged to provide Medicaid-supported housing. One of the chief impediments to continued expansion of HCBS capacity in states is the limited supply of affordable housing for beneficiaries. These limits may drive individuals who otherwise could remain in the community into institutional care or prevent transitions out of an institution into the community. Ideally, states would appreciate CMS diligently looking for pathways to permit Medicaid funding to be used for housing assistance in instances where such assistance is key for transitioning to the community and sustaining community living. At minimum, CMS should continue the work undertaken by the Innovation Accelerator Program's HCBS housing track, promulgate relevant guidance for states, and provide technical assistance in this key area.

Regardless of how CMS chooses to apply 1115 waiver authority in HCBS, NAMD wishes to call attention to the critical need for clear, predicable and streamlined approval pathways for states. Recent experience with other CMS approvals, including State Plan Amendments, managed care rate reviews, and modifications to existing waivers, have often been time and resource-intensive for states. Delayed approvals introduce instability into state programs and create impediments to future innovation, as well as delays the provision of needed services and supports to beneficiaries. We encourage CMS to be collaborative,

not prescriptive, in its approach to approval of new state HCBS models leveraging 1115 waiver authority.

On the question of budget neutrality, we encourage CMS to retain its existing 1115 framework of the "with waiver/without waiver" comparison. This is the most appropriate mechanism for assessing the value of HCBS services, which are generally lower cost than equivalent care provided in institutional settings. Budget neutrality rules should not be a barrier to states' use of 1115 authority to support continued LTSS rebalancing.

- **On eligibility flexibility and controls:**
  - NAMD encourages CMS to explore modifications to HCBS eligibility criteria to support the provision of HCBS prior to an individual reaching an institutional level of care status, beyond the opportunities afforded via 1915(i). However, such work should be done hand-in-hand with work to support overall HCBS capacity in the states, in order to avoid situations where individuals may be entitled to HCBS but have no housing in which to receive services. An option could be to set the standard for waiver eligibility level of care requirements at an intermediate level below the nursing facility level to promote earlier provision of HCBS.

    One barrier states face to fully leveraging potential flexibilities in 1915(c) waivers is cost neutrality requirements. In particular, cost neutrality in its current form impedes the design of specialized waivers to "right-size" the provision of care in acute and psychiatric hospital settings. To address this, NAMD recommends CMS consider cost neutrality across the entirety of a state's LTSS system, rather than within an individual waiver. Alternatively, CMS could calculate cost neutrality across all of the state's HCBS authorities, or allow states to tailor specific benefit packages for sub-populations within a previously existing waiver.

    We also strongly recommend CMS review Medicaid medically needy spend-down rules associated with LTSS eligibility, as these represent a vestige of institutional bias in federal rules that could be swiftly remediated. Currently, individuals who are over the Medicaid income limit and living in institutions may use the projected costs of the nursing facility to spend down to the income limit. Since these individuals have no housing or living expenses in the institution, they are likely to meet the spend-down requirements. The same cannot be said of individuals in the community, who may not use projected

HCBS wavier expenses for spend-down. These individuals often cannot meet spend-down requirements while also sustaining basic community cost of living and housing.

The current alternative for states is to test individual income compared to the average cost of a nursing facility stay, which in many states could result in LTSS income eligibility thresholds that are significantly higher than those currently in place – creating an unsustainable situation for Medicaid LTSS systems. NAMD believes a more appropriate solution is for CMS to allow individuals who otherwise qualify for Medicaid HCBS to use the projected cost of waiver services in meeting spend-down requirements.

- **On benefit redesign:**
  - Many of the types of benefit redesign NAMD would find beneficial are discussed above in our comments on potential 1115 pathways. From that discussion, two key points must be reemphasized:
    - We wish to reiterate the critical need for additional support for housing in Medicaid.
    - CMS should consider flexibilities under 1915(c) waiver authority to support care coordination and allow states to claim federal match on reimbursements to case managers during an HCBS beneficiary's short-term hospital or nursing facility stay, rather than being required to wait until the beneficiary's discharge.

  In addition, CMS could consider modification of Medicare discharge rules to require hospitals to engage with HCBS providers, operating entities, and managed care plans in the community prior to discharge of a Medicare patient. Ideally, discussion of available community resources should occur prior to hospital admission, to ensure a care plan is in place and transition to the beneficiary's chosen setting is accounted for. This could include modifying Medicare hospital reimbursement to incentivize community discharges over discharges to facilities. Such a modification would more closely align Medicare's financial incentives with the objectives of Medicaid LTSS rebalancing.

  CMS should also work to streamline the process for beneficiary access to durable medical equipment (DME), particularly for dually eligible Medicare-Medicaid beneficiaries. The expansion of Medicare's DME competitive bidding process, combined with the requirement that one funding source must first deny a DME request before the other funding source may purchase an item, poses difficulties

for beneficiaries. They may either opt for a timely discharge at the risk of not having necessary DME, or discharges may be delayed while the DME process runs its course. A more streamlined process that allows timely acquisition of DME upon discharge would be of benefit for states and beneficiaries.

Further, CMS should also explore options for states outside a 1915(c) or 1915(i) to provide supports, such as training, respite, and support groups, to unpaid family caregivers when an HCBS beneficiary chooses these caregivers.

- **On resource needs for the provision of HCBS, and urban/rural differences:**
    - As CMS is well aware, Medicaid LTSS and HCBS are categorically different from other Medicaid covered services, and must be addressed in a manner reflective of their unique nature. HCBS often requires providers to travel to beneficiaries, depending on the nature of the covered service and the needs of the individual, which renders a broad-based analysis of providers and services less useful than it would be for other providers.

      These differences are further pronounced in comparing urban, rural, and frontier areas in the states. Overall population density can impact the types of HCBS that can be feasibly provided, which adds additional layers of nuance to any service adequacy analysis. This distinction is particularly important in interpreting and applying CMS's HCBS settings rule. States remain concerned about how to distinguish settings presumed institutional due to isolating characteristics, when that isolation may result from the setting's location in a rural or frontier area rather than any particular characteristic of the setting itself. Such considerations should be front of mind for CMS as it assesses community integration of HCBS settings in these areas.

      Additionally, the HCBS settings rule creates questions for states whose HCBS beneficiaries experience periods of homelessness. In these instances, the only available housing for the beneficiary may be a shelter or a temporary housing service. We request CMS consider these scenarios, and how HCBS eligibility is impacted, when it applies the rule's requirements in order to avoid a beneficiary losing services or housing.

What actions can CMS take, independently or in partnership with states and stakeholders, to ensure quality of HCBS and beneficiary health and safety?

- **On CMS and state roles in ensuring HCBS quality of care, and CMS remedial actions:**

- Medicaid Directors share CMS's commitment to the provision of safe and high-quality HCBS to the Medicaid LTSS population, which represents one of the frailest and most vulnerable populations in the nation's health care system. States are engaged in continued development and improvement of critical incident reporting and monitoring programs, and we recommend CMS work with states and other federal partners to support these efforts.

  We also recommend CMS consider opportunities to streamline the administrative reporting requirements across HCBS waiver authorities, as well as the technical tools employed in waiver application, review, and approval process. Similarly, we recommend CMS also consider opportunities for building and implementing a more deliberative, comprehensive HCBS quality strategy and framework. This strategy should be cross-cutting, blending the similar goals of previous HCBS initiatives like Money Follows the Person (MFP), the Balancing Incentives Program (BIP), and the HCBS settings rule into a unified framework.

  Regarding potential instances of non-compliance, the current structure of collaboration between CMS and states to develop corrective action plans upon identification of non-compliant HCBS programs remains the best avenue for effectuating program improvement. States are committed to being effective partners with CMS in the overall functioning of the Medicaid program, including the provision of person-centered, high quality HCBS. NAMD does not support CMS taking a less collaborative approach, such as disallowance of federal match or a freezing of enrollment in a problematic waiver program. Indeed, these more heavy-handed solutions could have the opposite effect and further exacerbate identified problems by diverting necessary federal resources and supports, which could further deteriorate the beneficiary experience of care. States strongly encourage CMS to remain committed to collaboration in these instances.

- **On the creation of federal HCBS conditions of participation:**
  - States have consistently set the parameters and requirements governing HCBS provider participation, and we believe it is appropriate for states to continue being the primary drivers of their HCBS program structures.

    NAMD does not support the creation of federal conditions of participation for Medicaid HCBS providers, modeled on the conditions of participation for institutions and home health agencies. That model is appropriate for those types

of providers, who are on fixed locations and have more standardized services and workers. HCBS providers, however, are much more varied in terms of the services they provide, how they provide them, and where they are located – often, these providers travel to beneficiaries in the beneficiary's home.

Moreover, conditions of participation create minimum compliance standards which may shift state focus away from more rigorous quality assurance and quality improvement approaches that are embedded in well-developed HCBS programs. CMS should work to identify and disseminate these practices, rather than create national minimum standards.

While NAMD does not support the development of federal conditions of participation for Medicaid HCBS providers, some providers do operate from fixed locations, and could thus be more suitable candidates for this oversight model. Should such a model be pursued, we recommend CMS be thoughtful in considering which types of HCBS providers would be most appropriate for conditions of participation, and that CMS engage with states and stakeholders to develop appropriate criteria.

- **What can CMS do to support standardized performance measures for HCBS, including in Medicaid waivers and state plans?**
    - NAMD is supportive of CMS working in collaboration with quality measure experts and other stakeholders to develop a menu of HCBS quality measures for states to voluntarily report on, similar to the work undertaken to develop the Medicaid Adult and Child core measure sets. These core measure sets allow states the flexibility to report on impactful measures in their programs, while simultaneously providing an avenue for comparability across states and programs – a worthy goal, but one which is often complicated by the intricacies of state-specific program design. CMS could also more concretely articulate via sub-regulatory guidance how states may leverage enhanced federal match for systems to support state efforts to collect, trend, and analyze HCBS quality outcomes.

      However, NAMD does not support the imposition of specific reporting requirements related to data points or indicators which are not reflective of state-specific programs. Every Medicaid program is unique, and Medicaid HCBS programs even more so. States structure their HCBS programs in part to reflect the available community resources HCBS providers on the ground, which federally-required reporting may not be sensitive to. Further, the provision of

HCBS is grounded in individualized care plans with uniquely tailored goals and outcomes, which also are unlikely to be reflected in CMS-imposed measures. The universe of HCBS is too vast for such a strategy to be impactful.

Instead, states must retain the flexibility to report on processes and outcomes which are meaningful and drive program improvement for their specific HCBS programs. The necessary reporting measures should continue to be specified in the individual HCBS waivers states negotiate with CMS, in order to ensure CMS has mechanisms in place to assess state program performance.

- **What other quality measurement activities should CMS require or do to support states and other stakeholders to strengthen the provision of quality HCBS across any Medicaid authorities?**
    - NAMD supports CMS's continued engagement with the National Quality Forum, NCQA, and other measure development and accreditation bodies focused on HCBS work. We recognize the ongoing need for more robust, validated, outcomes-oriented HCBS measures for states to adopt. We encourage a greater focus on community-oriented outcomes measures for HCBS, rather than process measures or overtly clinical measures which may not fully capture program goals.

      NAMD also supports the work CMS continues to undertake to reflect Medicaid LTSS beneficiary experience of care in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. As HCBS is highly individualized, these survey assessments provide states with valuable insights into the effectiveness of their programs for the beneficiaries served. Continued development of these survey instruments will be beneficial for states.

What program integrity safeguards should states have in place to ensure beneficiary safety and reduce fraud, waste, and abuse in HCBS?

States, as administrators and co-financers of the Medicaid program, take program integrity issues in the program extremely seriously. This responsibility is acutely felt in the LTSS space, which represents some of the most vulnerable and medically complex individuals in the nation. Each year, Medicaid Directors work to drive continued improvement in the prevention, identification, and remediation of program integrity issues, including abuse, neglect, and fraud. While these systems are not perfect, Medicaid Directors have made great strides in recent years in improving the sophistication of their program integrity efforts, as demonstrated in NAMD's

most recent Operations Survey[1]. State financial reviews, post-claim edits, audit activities, and other strategies are yielding dividends in the HCBS program integrity arena.

We recognize that work by the Health and Human Services Office of the Inspector General (OIG) continues to identify cases of abuse and neglect in Medicaid HCBS programs, particularly personal care services (PCS)[2]. Each of these instances is taken seriously by states, and we seek to work with CMS and OIG to ensure that all appropriate and feasible safeguards are taken. That said, it is important for CMS to fully assess just how widespread these instances may be, and to keep its expectations of states realistic. Collaboration and partnership are the key methods for addressing program integrity issues as they emerge.

- **On the benefits and consequences of standard federal requirements for personal care workers:**
    - NAMD cautions against the adoption of federal standards for personal care workers. The PCS workforce is highly varied compared to other workforces subject to federal conditions of participation, and there is substantial risk that the adoption of such an approach could drive out current members of the PCS workforce. This could create additional access to service problems for current beneficiaries and limit the number of future beneficiaries that could be supported by state HCBS programs. Limited state HCBS resources would have to be redirected to provider training programs, states may have to modify licensure and certification laws and regulations, and otherwise dedicate state resources to federal compliance activities rather than provision of services. The ability of beneficiaries to have a choice of providers would also likely be significantly impacted by this measure.

      NAMD recommends that states retain the authority to set provider standards for their HCBS programs, as states are best equipped to understand their beneficiary populations, service needs, and workforce capacity.

- **On home care worker registries, background checks, and fingerprinting:**
    - NAMD acknowledges the effectiveness of home care registries, criminal background checks, fingerprinting, and other OIG-recommended PCS program integrity safeguards. Several states already have such systems in place and have found them to be of use in reducing instances of abuse and neglect in their PCS

[1] 5th Annual State Medicaid Operations Survey, December 2016: https://namdstg.wpengine.com/wp-content/uploads/2022/02/NAMD-2016-Operations-Survey.pdf

[2] HHS OIG Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services, October 2016 https://oig.hhs.gov/reports-and-publications/portfolio/ia-mpcs2016.pdf

programs. That said, these states also indicated that the costs associated with putting these programs in place was significant, and several nuances had to be worked through before their potential was realized.

However, we also wish to call attention to the unintended consequences that could result from these measures. For example, in states whose HCBS programs rely heavily on family caregivers, background checks and worker registries may be too burdensome for otherwise lightly-trained caregivers to comply with. This could, in turn, pose difficulties for access to HCBS.

As such, NAMD supports states having the continued option to develop and adopt standards requiring worker registration, background checks, fingerprinting, or other identified effective practices. These practices should not be imposed by the federal government, but to the extent that states wish to adopt them, federal support should be made available.

- **On enrollment of PCS attendants, the use of identifiers, and inclusion of worker identity on claims:**
    - Similar to the measures discussed above, some states have found these strategies to be effective but have also found them costly to implement. NAMD is particularly concerned at the cost implications for states of a requirement that all PCS attendants be enrolled with the state, as this could entail the creation of new databases and impose additional administrative burdens on states in terms of tracking provider numbers and individual PCS claims. It is also unclear how this requirement would be operationalized in a self-directed context for all states, though some have successfully done so.

      We reiterate the need for technical assistance and financial support for states who desire to go down this path, but do not believe it is appropriate for CMS to mandate state adoption of these policies.

- **On additional PCS program integrity measures:**
    - NAMD encourages CMS to continue collaboration with states and external entities to improve Medicaid program integrity initiatives, via avenues such as the Medicaid Integrity Institute with the Department of Justice. We also encourage continued identification and dissemination of effective program integrity practices, continued federal financial support for state program integrity activities, and further progress on state access to Medicare data for program integrity and overall care coordination purposes.

We also wish to note that the 21st Century Cures Act, recently signed into law, accelerates the federal timeline for states to adopt electronic visit verification (EVV) systems. These systems, while effective in states that currently have them in place, are costly to adopt, with only a few vendors equipped to meet state needs in this area. We recommend CMS work with states to chart a path for smooth adoption of EVV systems required by federal law, and provide federal financial support for this adoption to the fullest extent possible. Federal guidance on methods to leverage enhanced systems funding for EVV and other critical HCBS systems work would be of significant benefit for states.

- **Are the program integrity safeguards that are appropriate for agency-directed PCS also appropriate for self-directed PCS?**
    - Self-directed PCS programs are designed to support person-centeredness by allowing individuals the autonomy to make informed decisions about specific workers providing their services, including the hiring and firing of workers at the individual's discretion. It is important to consider these unique features of self-directed PCS when contemplating appropriate program integrity safeguards. Measures which may be appropriate for agency-directed PCS, where agencies have oversight capabilities for their workers beyond what any individual could accomplish, likely will not be appropriate for self-directed PCS. Flexibility in program integrity strategies to ensure no undue burdens are placed on individuals in self-directed programs is key to ensuring the ongoing success of these person-centered programs.

What specific steps could CMS take to strengthen the HCBS home care workforce?

Medicaid Directors understand the difficulties of developing sufficient HCBS workforces to meet beneficiary needs. However, it is important to note here that workforce development is not solely a matter of financial remuneration. Indeed, rates and reimbursement is not the sole driver, or likely the primary driver, of HCBS workforce development. The significant variation in HCBS provider types, the overall lack of a clear career path or development trajectory for HCBS workers, and the at times difficult nature of the work are also all factors that impact the robustness of the workforce. Workforce development strategies must encompass the full universe of these factors.

In light of this, NAMD strongly opposes CMS expanding its rate-setting approval authority to address overall sufficiency of Medicaid rates, especially federal review of individual wage levels for HCBS workers. States are far better positioned to understand the dynamics of their existing HCBS workforces, the market factors impacting those workforces, and how rate

structures interact with the state's HCBS waiver programs and authorities. We do not believe a review of rates alone sufficiently capture the universe of factors impacting access to HCBS and the overall development of HCBS workforces.

Should such detailed rate reviews occur, the potential for unintended consequences is tremendous. The realities of state budgetary environments preclude the possibility of states funding Medicaid HCBS to the exclusion of other Medicaid services or other core government services, such as education and transportation. State legislatures allot Medicaid funding on an annual or biannual basis in the context of an overall balanced state budget, with little room for additional, unforeseen costs.

Indeed, the imposition of a federal rate sufficiency test or other detailed, individual wage level reviews would likely have the opposite effect than what is intended here. HCBS services provided under waivers are subject to enrollment caps and other restrictions, which are the primary means states have of controlling program costs. An increase in those costs would necessarily imply a potential reduction in overall beneficiaries served or benefits covered. We have seen such a scenario play out after the introduction of the Department of Labor's home care worker minimum wage and overtime rule, with states typically imposing caps on hours worked rather than paying overtime benefits. CMS should bear these lessons in mind as it considers action in this area.

Further, CMS is already undertaking significant rate review in non-HCBS Medicaid program areas via the access monitoring rule's rate SPA review process in FFS Medicaid, and in MLTSS via Medicaid managed care rate approvals. States are already experiencing a delay in overall timeliness of CMS review and approvals under these current regulatory structures. We question the utility of further expansion of CMS's scope of rate review work given these delays, and we do not anticipate such an expansion would produce more timely approvals for HCBS rates. At minimum, the current HCBS rate review and approval process should remain in place.

A more productive approach for CMS to take would be to work with states in a collaborative fashion to design educational courses, provider career advancement pathways, and exploring methods to support providers showing signs of burnout.