



July 3, 2023

Chiquita Brooks-LaSure  
Administrator  
The Center for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of the national associations that represent state and territorial Medicaid agencies and the state agencies that operate Medicaid home- and community-based services (HCBS), we are pleased to offer comments on the HCBS proposals that the Centers for Medicare and Medicaid Services (CMS) articulated in the [Medicaid Program: Ensuring Access to Medicaid Services Notice of Proposed Rulemaking \[CMS-2442-P\]](#) (Access Rule). While each of our associations is submitting standalone comments on these important policies, our comments below reflect strong alignment of position and a joint statement of interest among ADvancing States, the National Association of State Directors of Developmental Disabilities Services (NASDDDS), and the National Association of Medicaid Directors (NAMD).

### **Key Messages**

First and foremost, we strongly support CMS's goals for the Medicaid HCBS system, which are manifest not only in the proposed Access Rule, but also in related proposed and final rulemaking around eligibility, enrollment and HCBS settings. These include smoothing access to and enabling retention of eligibility, promoting awareness and literacy of Medicaid-funded HCBS, understanding and addressing disparities of experience and outcomes, ensuring high quality and timely receipt of services, facilitating engagement with individuals receiving services and providers of direct service, and taking steps to promote the economic security of the people who provide HCBS.

Each of these aspects, which are instrumentally interrelated, reflect important priorities for Medicaid, which is the principal public payer of these services for over 4 million older adults and people with disabilities nationwide. HCBS continues to become a more predominant proportion of Medicaid long-term services and supports (LTSS) expenditures. Reflecting "rebalancing" of the proportion of spending on HCBS versus institutional care, [HCBS represented 58.6% of Medicaid long-term services and supports \(LTSS\) spending](#) in FY 2019.

This trend reflects the fact that Medicaid-funded HCBS represent a truly rare opportunity for federal and state governments to honor individual preference, support family caregivers, address disparities of access and experience, and optimize use of public funds. Specifically:

- **Individuals want to remain at home, to have meaningful choices, and to live with dignity.** [AARP's 2021 Home and Community Preferences survey](#) found that over three-quarters (77%) of adults age 50+ want to remain in their homes as they age. This is a shared value across the lifespan, reflecting the preference of 63% of all adults. HCBS enables people to remain independent in the community.
- **Family caregivers, who are the fulcrum point of our LTSS system, need help.** [Caregiving obligations affect self-report of overall well-being](#), including physical and mental health, sleep, and chronic conditions. "Informal" caregivers will likely be less available in successive generations. HCBS augment the support provided by family caregivers and help to prevent burn-out.
- **Certain populations, including People of Color (POC), tribal nations, and LGBTQIA+ people, have faced challenges of access to and experience in using HCBS.** HCBS are a means of honoring the values and preferences of individuals through person-centered, holistic and culturally competent assessment and services.
- **States want to control the rate at which Medicaid spending increases over time.** With important caveats and on average, per capita Medicaid spending on HCBS is less costly than nursing home care or placement in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF-I/DD). Continuing the long trend of shifting spending to the community side will, even recognizing the significant growth in incidence of older adults that is expected, help to control the rate of Medicaid cost growth.

It is precisely because of the importance of these goals that even while supporting CMS' policy aims, we collectively urge our federal partners to take a thoughtful and measured approach to implementation timelines. Reflecting on state experience of the HCBS Settings Rule, which made similarly foundational changes to the HCBS system and required more implementation time than initially envisioned, **we recommend that CMS take proactive steps to broadly extend its proposed effective dates for the HCBS provisions of the Access Rule.** This will accommodate and address several important constraints:

- **Data collection and analysis.** States are at a very early stage of readiness around collection and stratification of demographic data that will help to illuminate disparities of HCBS access, experience and outcomes for populations including POC, tribal nations and LGBTQIA+ people.
- **Culture change for providers.** Many aspects of the Access Rule, including collection and reporting of quality and cost data, will require technical assistance and culture change for providers of HCBS. Just one example of this is the proposed new process for home care agencies to document pass-through of a minimum percentage of Medicaid payments to direct care workers, via cost reports. This will be a new process for those often small and less administratively sophisticated entities.

- **Need for specificity.** While CMS has generally signaled both its goals and an array of new policy proposals, states will need considerably more detail in the form of sub-regulatory guidance to understand and implement those provisions. In making this observation, we are influenced by the serious challenges that states faced in meeting the requirements of the HCBS Settings Rule.
- **Significant lift, time frame and cost of required systems work.** The HCBS provisions of the Access Rule will require states to implement at least five major systems initiatives: enabling mechanisms for fee-for-service grievance systems, new incident management systems, operationalization of the 80% pass-through for direct care workers, website transparency, and modification of systems to support tracking and reporting on quality measures and rates. Not only will states have to undertake these projects, but they must stage them within pipelines of already obligated (e.g. Electronic Visit Verification) and upcoming (e.g. continuous eligibility for children) systems projects.

Our associations understand and honor CMS's aims around making meaningful changes to the HCBS system in the near-term. As key partners in implementing those proposals, we ask CMS to continue its strong engagement with us and our state membership to ensure that the final version of the Access Rule effectively addresses the above change management, technical, and systems issues, on which our mutual interest in success hinges. We further request that CMS carefully consider:

- extending its proposed time frames, consistent with what we propose below; and
- using the date on which it issues sub-regulatory guidance, as opposed to the effective date of the final Access Rule, as the benchmark for those time periods.

We offer more specific comment on CMS's primary areas of HCBS focus below.

### **Person-Centered Service Plans**

CMS proposes to require states to ensure that an individual's person-centered service plan is reviewed and revised, as appropriate, based on reassessment of functional need at least every 12 months, when the individual's circumstances change significantly, and at the request of the individual.

Overall, we support CMS's focus on requirements related to person-centered service plans, as those processes are central to ascertaining both service needs and values and preferences of the people who receive them. To this end, we support a process through which person-centered service plans are reviewed annually, but urge CMS to consider:

- confirming our understanding that the proposed requirement is a reassessment of an individual's goals and service needs, and does not include a renewed determination of Medicaid eligibility or level of care (LOC);
- the potential burden of full reassessment on individuals who are being effectively served through an existing person-centered service plan, and whose circumstances have not changed, by permitting those individuals to forego a full reassessment;

- modifying its proposal to permit good-cause exceptions to the 90% threshold, including, but not limited to, situations in which an individual who is due for reassessment is hospitalized, unavailable or requests a delay;
- sufficient time for states to make required systems modifications to support and routinize these person-centered service plan requirements; and
- applying these requirements to 1915(i) and (k), but not 1915(j) and 1905(a) State Plan services.,

### **Fee-for-Service (FFS) Grievance Systems**

CMS proposes to require states to establish a procedure under which a beneficiary can file a grievance related to the state's or a provider's compliance with HCBS settings requirements and/or person-centered planning and service requirements.

We support CMS's proposal to require states to implement new grievance systems for 1915(c) waivers and 1915(i), (j), and (k) State Plan authorities, only, in FFS delivery systems as a means of ensuring procedural protections for individuals on par with protections for those served under managed care delivery systems. We further support leaving current fair hearing rights in FFS delivery systems unchanged, as they already provide administrative remedies as well as the opportunity to seek judicial review following exhaustion of those processes.

While we feel that the 90-day timeline for resolution of non-expedited grievances is appropriate and feasible, we are concerned that the proposed 14 calendar day timeline for expedited grievances will not permit sufficient time for thorough review and will not be operationally feasible. Further, we feel that it is important for CMS to consider instances in which a reported grievance may need to be escalated to investigation as a critical incident. States will need to develop policies and systems to facilitate coordination and information sharing between grievance and incident management systems to make this possible. Finally, we observe that states will require sub-regulatory guidance to implement this requirement, and that implementing these new systems requirements and processes will require significant time and effort. On that basis, we recommend that CMS extend its proposed implementation timeline from two years to at least four years following the issuance of sub-regulatory guidance.

### **Critical Incident Management Systems**

CMS proposes to require states to maintain and operate an incident management system that identifies, investigates, resolves, tracks, and trends critical incidents.

We support CMS's intent in proposing that states operate and maintain a centralized incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents that occur for people served by Medicaid LTSS authorities. We agree that it is a worthy goal to standardize data collection and achieve interoperability of data sets, promote cooperation and collaboration among state entities, and to enable timely and effective responses to those who are affected. We further support establishing a minimum performance standard for initiation and resolution of critical incidents. We appreciate that CMS has proposed that states continue to have the flexibility to set their own time frames in fulfilling this standard.

We further urge CMS to consider:

- potential unintended consequences of duplication of effort that will likely arise due to CMS’s comprehensive definition of the term “critical incident” and retaining CMS’ proposed definition, which does not include aspects that are currently handled by other entities (e.g. identity theft/fraud);
- removing the requirement that Medicaid agencies independently investigate and respond if an agency with primary responsibility for doing so fails to report resolution of an investigation within state-specified time frames, as this is likely to complicate existing processes, inhibit the good will that is essential to create true partnerships, and either duplicate or elongate investigations;
- allowing states flexibility with respect to achieving interoperability of claims, Medicaid Fraud Control Unit and Adult Protective Services/Child Protective Services data, to enable states to gain experience and to reduce administrative burden;
- clarifying how these requirements will be implemented for self-directed providers;
- the reality that both states that have already implemented electronic critical incident systems and those that have not will need considerable time to do so, commencing an implementation timeline of at least five years from CMS’s issuance of explanatory sub-regulatory guidance, which should address not only systems requirements, but:
  - the tools (e.g. data use agreements, contracts) that will be necessary to operationalize cross-agency and program collaboration; and
  - the intersection of these requirements with requirements for Adult Protective Services, which will require joint work with the Administration for Community Living.

### **HCBS Payment Adequacy**

CMS proposes to require that at least 80% of all Medicaid payments for homemaker, home health aide, and personal care services go to compensation for direct care workers (DCWs) (pass-through requirement). States must annually report to CMS on the percent of payments that are spent on compensation for direct care workers. States must report separately for each service and, within each service, separately report services that are self-directed. We support CMS’s intent and goals around adequate compensation to DCWs.

We see increasing DCW compensation as instrumentally related to improving recruitment, retention and economic security of this largely female, substantially POC workforce. This workforce is essential to continued delivery of Medicaid HCBS and the current workforce crisis is an inhibitor to strengthening and improving the quality of HCBS. We also see increasing compensation as just one needed element of a cohesive array of strategies (e.g. workforce pipelines, specialized training, immigration policy, social valuation of the work/definition of scope and job role, paid leave, health care and retirement savings vehicles) with which CMS and sister agencies (ACL, DOL) at the federal level could be great assistance in our shared goals around addressing the current workforce crisis.

With respect to the proposed pass-through requirement, we urge CMS to consider:

- enabling states, as relevant, to develop or expand their evidence base around the specific level at which state-specific pass-through requirements should be set;
- staging implementation to first focus on agency-based personal care services and later phase in homemaker and self-directed services, while developing and issuing technical assistance materials based on initial experience, to permit states to benefit from best practice and to reduce administrative burden; or
- either permitting states to:
  - elect their own minimum percentage pass-through amount, based on state-specific data, experience, and provider/stakeholder engagement; or
  - propose an alternate rate-setting strategy related to workforce for CMS review and approval;
- further clarifying terms including “personal care” (to address interpretive questions around Medicaid-funded services in which personal care is embedded, e.g. residential habilitation), and “compensation” (to clarify whether such components as travel time, paid time off, and defined training costs are intended to be included);
- developing and disseminating a standard cost-report template, guidelines for reporting and technical assistance opportunities for the often small and relatively unsophisticated entities that are providing these services, to enable consistent state adoption and implementation of the pass-through requirement;
- extending its timeline for implementation of the pass-through requirement from four years to at least six years, to accommodate the following necessary requisites for adoption in states that have not already implemented a pass-through provision:
  - enabling legislation;
  - system development for reporting and oversight, including cost reporting systems;
  - engagement and acculturation of providers;
  - development of processes and systems to support corrective action for noncompliant providers; and
  - performance on concurrent obligations including, but not limited to American Rescue Plan Act (ARPA) HCBS funding, HCBS Settings Rule, Electronic Visit Verification and Asset Verification Systems.

With respect to the proposed new reporting requirements around rate transparency, we urge CMS to consider:

- expanding the reporting obligations for other direct care worker (DCW) services (e.g., residential habilitation services, day habilitation services, and home-based habilitation services);
- permitting states to use an optional provider self-attestation process;
- permitting Medicaid agencies to exclude from their reporting to CMS payments to providers of agency directed services that have low Medicaid revenues or serve a small number of Medicaid beneficiaries; and

- extending the time frame for implementation of reporting to five years and modify the frequency of reporting to a biennial basis, to reduce administrative burden on states.

### **Timeliness of Access and Waiver Waiting Lists**

We acknowledge and support CMS's intent around promoting public literacy about access to HCBS waivers and ensuring that Medicaid members receive HCBS timely. It has historically been challenging for the public to access HCBS waiver waitlist data, and we agree that timely initiation of services is instrumentally related to addressing people's needs and helping to mitigate risks of adverse events (e.g. unattended clinical needs, falls) and resultant hospitalizations and placements in skilled nursing facilities.

That said, we urge CMS to consider:

- how instrumental collection and reporting on these two data points will be, for Medicaid members and the public, taken in context of the significant administrative effort and systems costs that states will have to undertake to fulfill them;
- permitting states to contextualize public HCBS waiver waitlist information to reflect the realities of variation in waiting list methodologies, as well as factors that have direct influence on availability of waiver slots and are substantially out of the control of the state agencies that manage the waivers (e.g., limited state appropriations and workforce constraints, among others);
- extending its proposed reporting cycle for waiting list information from annual to every two years, to reduce administrative burden on states;
- allowing states to choose among CMS' proposed criteria, or to propose an alternate metric on which to report; this would permit flexibility in reporting on and context for data related to timeliness of initiation of person-centered service plans that reflects the reality of inhibiting circumstances beyond the state agency's control (e.g. hospitalization, unavailability of, refusal by member; unavailability of or change in provider) as well as the potential that while all authorized services have not been initiated, the member is receiving another service that effectively fulfills their immediate needs; and
- clarifying whether and how the timeliness requirements would apply to self-directed services.

### **HCBS Quality Measure Set**

We strongly support CMS's proposal to implement a mandatory HCBS Quality Measure Set as a means of identifying common priorities for quality improvement, standardizing data collection and stratification based on demographic features, and enabling longitudinal analysis and assessment of impact. The proposed set reflects historical and continuing engagement with and perspectives of those who lead this work at the state level and appropriately relies on evidence-based processes (testing, validation). We particularly support CMS's proposal to include National Core Indicator (NCI) measures as 48 states and the District of Columbia already use them.

We do, however, urge CMS to consider:

- modifying the proposed time frame for updates to the measure set from two to five years, to permit more time for implementation and testing to determine whether a measure yields useful results;
- authorizing states to phase in implementation of the new quality measure reporting requirements, to accommodate the need to develop or modify system capacity; and
- longer timelines for implementation of requirements around stratification of data, even if that will occur through imputed modeling, as that work will require new staffing and systems capacity.

We commend CMS for proposing regulations that seek to ensure smooth and timely access to and improved quality and outcomes from HCBS services, as well as transparency and increased public literacy around waiting lists for and Medicaid funding of HCBS. HCBS is an essential component of the continuum of LTSS and deserves continued attention and prioritization as a means of honoring individual's preferences, supporting caregivers, addressing disparities and optimizing use of public funding.

For all of these reasons, we respectfully request that CMS consider extended timeframes for implementation of each of the HCBS aspects of the Access Rule and that CMS start the clock on these timeframes from the dates on which it issues explanatory sub-regulatory guidance. This will help to ensure that state Medicaid and operating agencies have the time, resources, and direction to effectively implement each provision.

We greatly appreciate the opportunity to provide comment on the Access Rule and look forward to continued partnership between CMS and state and territorial agencies in furtherance of our mutual aims around improved access, experience and outcomes in Medicaid-funded HCBS.

Sincerely,



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