April 26, 2021

The Honorable Sherrod Brown
Senator
U.S. Senate
Washington, DC 20510

The Honorable Bob Casey
Senator
U.S. Senate
Washington, DC 20510

The Honorable Maggie Hassan
Senator
U.S. Senate
Washington, DC 20510

The Honorable Debbie Dingell
Representative
U.S. House of Representatives
Washington, DC 20515

Dear Senator Brown, Senator Casey, Senator Hassan, and Representative Dingell:

LeadingAge appreciates the opportunity provide feedback to the Home and Community-Based Services Access Act (HAA) discussion draft.

LeadingAge and our more than 5,000 nonprofit aging services providers and other mission-minded organizations touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including home and community-based services (HCBS) providers like adult day services, Programs for All-Inclusive Care for the Elderly (PACE) and home care and personal care services. We bring together the most inventive minds to lead and innovate solutions that support older adults wherever they call home.

The HAA represents an important step toward improving the country's HCBS system and ensuring that everyone who needs Medicaid HCBS is able to actually receive those critical supports. Since the discussion draft's release on March 16, the Biden Administration announced its proposed American Jobs Plan (AJP), which calls for a $400 billion investment in home and community-based services. Provisions in the HAA could be adopted into any AJP legislative proposals, and the draft bill as a whole could very well shape the discussion of how HCBS fits into jobs and infrastructure legislation.

LeadingAge strongly supports expanding access to Medicaid HCBS, including through classifying these benefits in the mandatory category, and our feedback to HAA is through the lens of ensuring both that individuals and families can get the care they need, and that the providers who serve them have the resources necessary to deliver high-quality services and supports. We also want to underscore the potential to broaden federal authority over Medicaid HCBS through this proposal. The HAA includes a proposed 100% federal medical assistance percentage (FMAP) for Medicaid HCBS, and we encourage Congress to pair full federal coverage of these services and supports with enhanced authority to the federal government, including with respect to rate setting, eligibility determination processes, establishing minimum services and standards, network adequacy and more.

Our comments include responses to the legislative text as drafted, the discussion points in the stakeholder memo, and more general comments on policy considerations.

Benefits and Scope of Benefits
The proposed HAA borrows from existing statute in listing the benefits available to Medicaid HCBS beneficiaries under this proposal, including from statutory language covering state plans, 1915(c) waivers and 1915(k) state plans. We support this comprehensive approach, and LeadingAge members provide many of these important services, including adult day services, home/personal care, and more.

Future drafts of the HAA may consider the following as bill authors determine next steps:

1) Statutory language for 1915c waivers include specifically adult day **health** services. Many providers operate **social** model adult day without medical/health care services, or a model that integrates medical and social model care, and the HAA should include these types of care in addition to adult day health.
2) We support including Programs for All-Inclusive Care for the Elderly (PACE) in the benefit package. See more on PACE in the next section.
3) With respect to the housing support benefit, we encourage Congress to take as expansive an approach as possible when determining the benefit's scope, including locator services, moving support, and support with rental deposits/initial months' rent. Secure housing is paramount to a person's ability to receive HCBS, and the Medicaid program under HAA could help improve integration between the health and housing systems.
4) We also encourage Congress to consider ways to expand access to assisted living in Medicaid, including as a standalone benefit in the HAA.
5) Statutory language and/or administrative guidance may help operationalize the benefits and how providers would be reimbursed for these. For example, many states offer an add-on rate to other services (e.g., adult day) for providing transportation. Would this be allowed to continue? Or would transportation need to be paid as a standalone service?

HCBS benefits should be covered retroactively as participants move through the eligibility determination process, at parity with retroactive nursing home care and other Medicaid services.

In addition, Congress and/or CMS should drive the development of minimum services and standards versus state agencies. Future drafts of the HAA could write in minimum standards, set a floor for states to build on and/or delegate regulatory authority to CMS. A consistent approach will help beneficiaries across the country receive HCBS regardless of where they live.

Programs for All-Inclusive Care for the Elderly (PACE)
Programs for All-Inclusive Care for the Elderly (PACE) organizations are a proven model of integrated care for eligible Medicare-Medicaid enrollees. We support including PACE in the HAA as a benefit. Many provisions in the PACE Plus Act, introduced by Sen. Casey in April 2021, could fit well into a revised HAA to ensure robust access to the model among beneficiaries.

- The PACE Plus Act offers a 90% FMAP to states; in HAA, PACE could be included as a service line eligible for 100% FMAP. If a revised HAA includes an increased FMAP for HCBS, the same FMAP should apply to PACE.
- The PACE Plus Act outlines a process for two-way PACE Agreements between PACE organizations and the federal government. Adopting that idea in HAA would expand access to the service across states that do not currently have a PACE presence. We would support expanding access to two-way agreements to all states, including those with PACE organizations in operation. With the HAA's full federal funding, state agencies should not be a barrier to PACE access.

- Additional provisions that streamline application processes, allow new populations to enroll in PACE, and make enrollment easier throughout the year should also be adopted into the HAA.

In addition, 100% FMAP in PACE could also lead to further expansion of the model, including through lifting state-imposed limits on enrollment and eased expansion into new service areas for existing organizations.

As mentioned earlier, we support classifying PACE as a mandatory benefit in Medicaid, and also recognize that since PACE organizations operate within specific geographic catchment areas, nationwide coverage may not be immediately feasible. We encourage the HAA to include provisions that expand the presence of PACE to reach as many older adults as possible, including grant programs for states and/or current and prospective PACE organizations, direction to CMMI to develop a PACE model, and more.

Implications of 100% FMAP for HCBS

Fully funding the Medicaid HCBS program will certainly expand access to the system and free up state resources for other purposes (assuming no maintenance of effort provision is included in a final HAA). Such a shift in financing, however, raises some key questions about the role of states in a potential federally-funded Medicaid HCBS program.

Eligibility

For example, if the federal government is paying for coverage, why should states be the entities operationalizing the definition of an eligible individual, as called for in the implementation plan? Even with each state working from the HAA text, these state-by-state determinations could drive unequal access to HCBS from one state to another. Similar implementation concerns could arise from state-by-state functional assessment processes as detailed earlier.

Rate Setting

Adequate rate setting has long been a struggle for Medicaid HCBS providers, and has had the effect of limiting provider availability, restricting the ability to pay workers a living wage and ultimately access to services among beneficiaries. An analysis from LeadingAge found that in 2019, for example, adult day services rates in state Medicaid programs varied widely. States on the lower end reimbursed providers at roughly half the amount of states on that paid among the highest rates for this support, and there was not clear association between a given state's rate and its cost of care or cost of living. This is likely true across other HCBS service types.

Given that the HAA proposes full federal coverage of Medicaid HCBS, it may also make sense for the federal government to play a more active role in rate setting. This could range from establishing rate floors and/or by adopting a more prescriptive approach such as those we see in the Medicare prospective payment systems. Language similar to the Boren amendment, which ensured rate adequacy for Medicaid institutional care in the 1980s and 1990s, may also be useful for in the context of HCBS rate setting.

For states with managed HCBS/LTSS environments, similar oversight should be enforced to the MLTSS plans to ensure that the federal dollars these plans receive actually go to services and adequate provider reimbursement rates. Beneficiaries in managed care states must not have their access limited to care because of a given plan's low HCBS rates. To the degree possible, the HAA should help bring more transparency to the managed care HCBS rate setting process and the outcomes (e.g., actual rates) of those.

There is a role the federal government can play in ensuring Medicaid HCBS providers receive adequate reimbursement, and the HAA could benefit from language that does so in conjunction with the full federal match.

Provider Network Adequacy
Reclassifying HCBS as a mandatory benefit changes what oversight the federal government has over the benefit. As with other aspects of the system, having enough workers and providers of HCBS is essential to the HAA's success. While the implementation plan calls for states to describe how they will build capacity, more rigorous oversight may be more appropriate in practice. In its letter to the Committee, the Disability and Aging Coalition outlines potential processes for ensuring adequate networks, including network tests, and we support those recommendations. We would also support expanding the scope of the Access Rule to cover HCBS.

Potential Impact on Nursing Home Residents
Mandating two types of LTSS but only fully funding one them could easily lead to negative outcomes for the less funded type. Namely, nursing facilities. Regardless of how the HAA is implemented, there will always be a need for nursing facility care and this need will likely increase as more adults age into the 75+ category. States will be newly incentivized to encourage HCBS, and while this is overall a positive shift, guardrails should be in place to protect residents and staff of nursing facilities from state actions that both disincentive and damage nursing home care.

For example, there could be a maintenance of effort requirement for current state spending on Medicaid nursing home care paired with the HAA, or new federal oversight of nursing facility rates (e.g., Access Rule) to protect against improper rate cuts. Language similar to the Boren Amendment could also serve this purpose. If states defund Medicaid nursing home care, residents will have less access to the care, staffing and support they need and are eligible for, and the HAA should disallow states from taking these actions.

We also encourage increased federal funding for all aspects of the Medicaid LTSS program, and have called previously for dedicated FMAP increases for both facility-based and home and community-based care. We call for this investment again today.

The Benefits Advisory Panel
In addition to the benefits written into the draft HAA, the bill calls for an advisory panel to determine whether and what types of additional benefits and services should be available to Medicaid HCBS beneficiaries. The advisory panel must be at least 50% comprised of beneficiaries.

Such an advisory panel may provide flexibility over time to add benefits that emerge not currently in the HAA that beneficiaries need. That said, it appears that the proposed panel is less "advisory" in nature and more determinative of such benefits.

Future HAA drafts may want to rename the panel to reflect this, and consider potential accountability, oversight, and/or financial integrity mechanisms to help guide the panel's work, including potential budgetary/spending caps, a 2/3 or 3/4 advisory panel approval requirement, and administrative approval of changes. We also support the panel's scope to consider adding benefits to the program, and not removing or restricting any benefits included in the draft HAA.

The revised HAA should also include a process by which CMS can add benefits in a more streamlined manner as needed without going through the advisory panel process to respond to emergent needs.

Functional Eligibility
People experience functional impairments via limitations to performing both activities of daily living (ADLs) and instrumental activities of daily living (IADLs). As defined in 1915(k)(1)(A), these include "eating, toileting, grooming, dressing, bathing, and transferring" as well as "meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community."

The draft HAA is responsive to the different needs prospective Medicaid HCBS enrollees face. Future drafts of the HAA may benefit from clarifying whether a person can qualify with 2 ADLs or 2 IADLs, or with 1 functional limitation from each category. Alternatively, revised HAA functional eligibility criteria could replicate HIPAA, under which long-term care insurance functional eligibility is set as "2 activities of daily living for a period of at least 90 days due to a loss of functional capacity."

We also recommend considering the inclusion of severe cognitive impairment as a standalone functional eligibility pathway, as people experiencing such impairment would benefit from the supports included in the HAA before specific ADL or IADL needs manifest.

Functional Assessment
The functional assessment is a critical part of the process in getting a person enrolled in Medicaid HCBS. As reflected in the draft HAA, the functional assessment is meant to ensure that those with the necessary level of care needs receive Medicaid services, that there is no (or as limited as possible) conflict of interest in the provision of those services, and that ultimately a person will receive a person-centered care plan tailored to their needs.

For example, the HAA calls for a unified functional eligibility criteria as opposed to the state-by-state criteria that currently exists. A 2016 analysis from MACPAC found that more than 160 tools exist across states and the populations they serve. Would states be expected to transition to a new, singular functional assessment tool? Or could they keep what they have and just use the new eligibility criteria? The former could pose logistical challenges, as implementing a revised functional assessment instrument in a given state can be time consuming and resource intensive (e.g., cost of IT system changes, staff training), while the latter could lead to inequality across state lines depending on what tools states use. In addition, states use different instruments for different populations- we seek clarity if that practice would also be allowed to continue, given the unique needs across populations.

We seek clarity on how the HAA functional eligibility criteria would look in practice and encourage future drafts of the HAA to further detail expectations with respect to actual assessment tools.

Person Centered Care Planning and Who Performs these Functions
The draft HAA applies the statutory language from the 1915(i) program for person-centered care planning. Operationally, much of the details of the assessment and person-centered care planning in the draft HAA are delegated to the Secretary of HHS (in consultation with ACL). We support the need for administrative oversight and guidance in the care planning process, and encourage Congress to take a more active approach to shape these processes.

For example, identifying and ensuring an adequate supply of entities (and workers) to perform functional assessments is essential to the HAA's ultimate success. Understanding the need to minimize conflicts of interest, we support an expansive list for states to work from, including state agency workers, local/municipal staff, staff from independent agencies and entities in the aging and disability networks, workers from provider/health care organizations that would not ultimately serve the person,

and more. In limited cases, there is a need for the assessing agency to also be a service provider; this practice should be allowed with appropriate guardrails and firewalls in place.

We also support permanent access to remote functional assessments. Most states have adopted this on an emergency basis due to the pandemic, however a permanent remote option would bolster access to these important screenings across populations and geographies.

Functional Assessment and Care Planning Funding
The assessment and care planning processes are not cost-free. We encourage the HAA to fully cover the cost of these functions (100% FMAP), as well as for all associated administrative activities that support them.

An ambitious expansion of HCBS as proposed in the draft HAA will work only so well as it can be implemented, and full federal funding for this is necessary to ensure states will carry out the law and have the resources needed to properly do so.

Quality Metrics
The proposed quality metrics development process called for in section 6 would bring transparency to Medicaid and to Medicaid LTSS and make clear demographic trends that exist across settings and across states.

We encourage Congress and CMS to protect all personal data collected through this process, including sensitive topic areas like sexual orientation and gender identity. With respect to age, we encourage age groupings to go beyond the traditional "65+" framework and give more specificity, such as 75-84, 85+, and more. The care needs of a 67 year old are typically much different than that of someone in their 80s or 90s, and these data should reflect those unique needs.

We seek clarity on how and/or whether the metrics developed under this section would influence services. For example, assurance that performance on a given metric would not lead to provider penalties and/or disenrollment.

Workforce, Worker Pay and Family Caregivers
Workers and the workforce at large underpins the entire system of long-term services and supports, including HCBS.

We know that workers who perform direct care do not always earn a living wage under the current system (driven in large part by low reimbursement rates in Medicaid). Earlier in this letter, we discussed the need for improved rates and rate setting processes across Medicaid HCBS and the central implication of those being met is improved wages for workers and ultimately better access to care for beneficiaries.

As mentioned, the 100% FMAP gives the federal government additional leeway toward improving worker wages, and could take specific action like tying rates and/or rate add-ons to worker pay and benefits, and additional funding for states and providers to recruit, train and retain workers.

With respect to the role of family caregivers, we recognize the essential support that these caregivers provide their loved ones, however no person's access to HCBS should be negatively affected based on perceived or actual availability of family support. If the HCBS system expects families to fully or in part meet the care needs of a beneficiary spelled out in a care plan, the system should pay for that work.

Money Follows the Person
We support MFP and believe its important work should continue under the HAA, and are pleased that transition services are covered as a benefit in the proposed bill. With HCBS at a 100% FMAP, the enhanced FMAP in current MFP may need to look different if it continues to exist. Congress could potentially restructure MFP, for example, to provide enhanced federal funding to a state's administrative costs or to support a state's LTSS workforce.

Spousal Impoverishment Protections
Simply put, we support making these protections permanent. No spouse should have to impoverish themselves in order for their spouse to receive Medicaid LTSS regardless of setting.

Coordination with Medicare Benefits
Expanding access to HCBS benefits in Medicaid likely necessitates coordination with certain Medicare benefits, particularly home health. Medicaid home health is much less utilized compared to the Medicare benefit, but the expanded eligibility criteria in HAA could change this balance. Either Congress or the agencies should establish how certain overlapping benefits should complement one another, which payer should pay first (e.g., continuing to make Medicaid the dollar of last resort) and how beneficiaries and providers should navigate the two programs.

Similar coordination may be needed for other benefits, including hospice depending on how the HAA impacts utilization of hospice benefits in Medicaid, and as supplemental benefits continue to grow in Medicare Advantage plans, including for in-home care and adult day services.

Financing
Implementing the HAA will be an expensive undertaking, particularly if all beneficiaries ultimately receive the services and supports they need to remain in their homes and in the community, including those with very high acuities and needs for care. We recommend ensuring that there is a financing mechanism in place to pay for these services and ensure that the proposal as a whole remains viable.

The Biden administration through its American Jobs Plan and American Families Plan proposals include revenue inputs such as revisions to the tax code. The revenue from those provisions could be paired with the HAA so that expanded HCBS in Medicaid is paid for. Other options could include a payroll tax, with the financing mechanism set forth in Rep. Suozzi's WISH Act serving as a possible template.

Looking Forward
The HAA proposes transformative change in how the United States provides and pays for home and community-based services. Looking beyond immediate legislation, it may also behoove Congress to think bigger in the long term.

For example, if the federal government is going to fully pay for Medicaid HCBS, is Medicaid the right authority for that support over time? Or, would another program or a new program entirely be a better fit. Many of the protections under current Medicaid law that stakeholders correctly want to maintain could carry over to a non-Medicaid program. Such a program could include a fuller range of support, including nursing home care when it is needed and for those who wish to remain in the community but need help with affordable, accessible housing, access to that housing.

This conversation likely falls outside the scope of the HAA, but as this bill comes together we encourage continued strategic thinking for the years ahead.

Conclusion
We thank the cosponsors for their leadership on this issue and hope to continue collaboration as the HAA continues to work its way through Congress. We and our members stand ready to help however we can with the development of this legislation, including providing further information, answering follow up questions or requests for comment, and more.

Please contact Brendan Flinn (bflinn@leadingage.org) with questions or requests for more information.

Sincerely,

Katie Smith Sloan
President and CEO
LeadingAge