July 3, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2442-P
P.O. Box 8016
Baltimore, MD 21244

[CMS-2442-P] RIN 0938-AU68 Medicaid Program; Ensuring Access to Medicaid Services

Submitted electronically via: https://www.federalregister.gov/documents/2023/05/03/2023-08959/medicaid-program-ensuring-access-to-medicaid-services#open-comment

Dear Administrator Brooks-LaSure,

LeadingAge appreciates the intent of CMS to improve the quality of and access to Medicaid covered services through rule making process. We are grateful for the opportunity to submit comments on the CMS notice of proposed rulemaking: ([CMS-2442-P] RIN 0938-AU68) "Medicaid Program; Ensuring Access to Medicaid Services (the Access Rule)."

The mission of LeadingAge is to be the trusted voice for aging. We represent more than 5,000 mission driven aging services providers that 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. We bring together the most inventive minds to lead and innovate solutions that support older adults wherever they call home.

As advocates for high quality long-term services and supports across the aging services continuum, LeadingAge applauds CMS goals to move the Medicaid program towards more accountability, transparency, and quality. We feel the sentiment and major provisions of the rule are well intentioned and could meaningfully transition archaic state Medicaid programs into the 21st century, while still lifting expectations and minimum standards for programs already working towards equitable access to quality home and community-based services (HCBS).

Our broad perspective on the rule

LeadingAge is supportive of the majority of the provisions within the proposed rule. If implemented as proposed, we believe the rule would take significant strides towards transparency through revamped stakeholder groups, development of standardized reporting for rate comparisons and enrollment numbers, participant satisfaction and quality of services in HCBS, and enhancements to critical incident management reporting and trending systems. Despite these positive provisions, there is one provision about which we are very concerned: CMS proposes that 80% of Medicaid payments for three specific HCBS (homemaker, home health, and personal care) services authorized under §1915 or §1115 Medicaid authorities be directed to direct care staff compensation. This would specifically not include times when the services were delivered to a Medicaid participant under a State Plan authorization in

2519 Connecticut Ave., NW | Washington, DC 20008-1520
P 202.783.2242 | F 202.783.2255 | LeadingAge.org

§1905 of the Social Security Act. While we are supportive of the intent, this threshold is not tenable for LeadingAge members, and we fear unintended consequences including erosion of service quality, inadequate clinical support for direct care staff causing unnecessary stress on front line staff, and access issues – the antithesis of the goal of the Access Rule.

=

LeadingAge opposes the proposal that would require 80% of Medicaid funds to be passed through to direct care staff compensation until adequate data, rates, and funding are available to amend the proposal in a way that could be feasible for providers. As proposed, it creates perverse supervisory and training incentives, is lacking adequate data on providers' ability to accomplish this threshold and would cause access issues.

The proposal requiring that 80% of funds received by a Medicaid provider be spent on compensation to direct care staff is driven by a desire of CMS to increase wages for direct care staff. LeadingAge understands the humanity in the proposal for individual workers – we strongly believe that the direct care workforce needs a range of supports to be successful including a living wage.[1]

CMS' proposal does not give providers enough room in their budgets to cover necessary costs – including those important for high quality care, like training and supervision. If a provider were to remain operational in the face of this requirement, they would likely end up not raising pay to try to achieve compliance, but rather cut back on other administrative functions that support quality. If this provision is enacted as proposed, we will see more people go without care and not see the growth in wages that CMS is seeking. CMS needs to go back to the drawing board – there are a number of structural issues we will address in our comments regarding data collection and infrastructure that need to be addressed before a conversation about a passthrough could begin. More research is needed on how implementation of such a threshold could really occur -- the examples that CMS cites are either not yet implemented or have a vastly different definition than CMS proposes. It is also not clear why CMS chose these three services. LeadingAge does not support implementing this proposal in any Medicaid services without more data, infrastructure, and funding.

Most critically, a proposal like this cannot be considered without more federal dollars. In the current environment, the math does not work for this proposal – there is no way, even if a state legislature were to provide substantially more state Medicaid dollars towards closing the gap would an 80/20 split as defined by CMS be achievable – nor do we feel it has the right incentives considered in its inception. The Administration knows that this type of proposal needs more dollars – President Biden has been calling for a massive investment in home and community-based services since his campaign. As mission driven providers of aging services – our members are already teetering on the edge by offering these services through the Medicaid program. This proposal would make most if not all of them reconsider whether they could continue to provide care. The rhetoric of this Administration has been squarely focused on providing care in the home and community and this provision, in combination with the HCBS settings rules' chilling impact on aging services, is creating a regulatory environment that will drive our members out of Medicaid services. Please consider your goal of access carefully and do not enact this provision as proposed.

[1] https://www.ltsscenter.org/wp-content/uploads/2020/09/Making-Care-Work-Pay-Report-FINAL.pdf

Data supporting the 80/20 provision is weak

There is not sufficient data to tell us what this type of proposal could look like without substantially more data collection particularly on rates, rate setting, and provider infrastructure.

CMS presents no data to show why a threshold of 80% was chosen for this proposal. Only two states have attempted to implement any sort of similar passthrough – neither of which are at a threshold of 80%. Furthermore, only one state has implemented a similar requirement, with another state proposing to implement soon. In these two cases, the existing states implemented proposed thresholds below 80% and have differing definitions of what can be included in the definition of the portion of funds that is to be passed through to workers. In short, CMS has very little data to incorporate this proposal into the rule and we strongly recommend that neither this provision nor any threshold be implemented until more analysis on how to construct a threshold, what the appropriate threshold should be, and the infrastructure through which it would be equitably administered across the wide variety of Medicaid programs is presented.

Notably absent from CMS' rationale from the requirement is any data about rate adequacy. As we will discuss further below, CMS does not currently have the information necessary to analyze what the impact on providers (and as a result, workers) would be if this requirement were implemented in a low-rate environment. As part of their justification, CMS references states that implemented wage pass through requirements for additional funding provided through the American Rescue Plan Act (ARPA), citing that states indicate that the 80% threshold is appropriate. The ARPA scenario is not applicable to this proposal. ARPA *gave states more dollars to utilize.* If CMS were proposing that a certain threshold of *new* dollars were to be passed through to the direct care workforce- either from federal or state allocations - our stance would likely be different, though we must consider the long-game in assessment of short-term objectives. Using a scenario in which more dollars were available (albeit temporarily) as the basis for proposing that a percentage of *all* Medicaid funding can be directed to workforce is the very definition of comparing apples and oranges. CMS cannot use this logic to push forward with their proposal; the premise does not apply to the conclusion.

Rate and enrollment transparency is essential to developing any proposal around wages

CMS' proposal to enhance rate and enrollment transparency is an essential precursor to any future work around a wage passthrough. CMS is proposing that states will be required to develop an accessible website for rate and data transparency. Proposed requirements include current rate breakdowns by service type, geographic variation, and population characteristics. For services that are shared or similar across different service populations (consider personal care for aging vs individuals with an intellectual disability), those differences and specifics must be outlined. Additionally, for populations and waivers in which the state maintains a waiting list, states will be required to post the total number of individuals on the waiting list and the estimated amount of time an individual will spend on the waiting list before becoming enrolled in services. States are required to include in their posting, information on the amount of time it takes a new enrollee to begin services. We strongly support these efforts and urge CMS to monitor access across enrolled populations to maintain a comprehensive picture of populations receiving services in each state. Specifically, we would have concerns that CMS attention to waiting lists and service start wait times could adversely affect service availability and state oversight for other waiver populations. Concern with attention to waitlists and individuals in need of services could compel states to prioritize services to individuals on current waitlists while offsetting those new enrollees with

waitlists on other programs that currently don't experience waitlists. CMS should take care to ensure that increased access for one population does not adversely affect access to another population equally in need of services.

For homemaker, home health, and personal care services, states would be required to post average hourly rates, total claims, and total enrollees annually in §1915 and §1115 authorities. For bundled services that include a number of service types, states will be required to include percentages of the rate that are attributable to each included service. It is well documented in research publications[2] and the press[3, 4] alike that inadequate Medicaid rates contribute to access problems as providers make decisions about whether to deliver those services under Medicaid reimbursements. Providers are also forced to assess losses on Medicaid programs, and determine payer mix ratios to ensure ongoing business viability. Promoting transparency across all administrative authorities will provide a holistic picture of a state's Medicaid payment policies.

These requirements are intended to offer both providers, enrollees, and those waiting for services more information and leverage for advocacy efforts. While transparency and increased data helps both providers and applicants, with limited state budgets, these data points will continue to pit providers seeking rate increases against advocates seeking increased waiver slots to reduce waiting lists. With limited funds, legislatures will decide whether to increase funding to serve more people, or better fund inadequate provider rates.

We urge CMS to expand these requirements to be inclusive of reporting for all authorities including state plan services by including state plan HCBS services in transparency requirements. Limiting transparency to services delivered under specific authorities, while omitting other identical services rendered under state plans doesn't allow for comparative nor comprehensive analysis of the HCBS landscape within or across states. Implementation of this proposal is a critical precursor, necessary before considering a wage passthrough proposal.

Infrastructure to implement the passthrough does not exist

As Medicaid programs vary, so too do states' data collection processes. Few states require cost reporting for home and community-based services. If CMS is serious about proposing any type of unform requirement regarding wages, the reporting structure needs to be universal – whether that be in the form of a cost report or some other mechanism. Any data collection infrastructure needs to be inclusive of the information on rates discussed above. We understand this poses generality concerns as uniform data reporting would be tremendously difficult with unique variability in state Medicaid programs. This is precisely the reason we urge careful consideration of broad payment allocation provisions, without adequate and adequately specific data to support the proposal.

Training is critical to high quality care and cannot be discounted as an important cost

Each of the three proposed included services which would be required to meet the proposed threshold have dramatically different training requirements. For example, there are federal training minimums for home health aides and no such minimums for personal care aides. States can, and do, mandate training

[2] https://www.macpac.gov/publication/estimates-of-medicaid-nursing-facility-payments-relative-to-costs/

[3] https://www.mcknights.com/news/81-percent-of-nursing-homes-receive-less-than-cost-of-care-for-medicaid-patients-analysis/

[4] https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact

minimums for various categories of direct care workers, depending upon the service they are providing and to which population. With different training requirements across providers in the same state, the proposed threshold will have varying effects on different provider classes and even within the same category of service. In tandem with internal state differences in training across provider types, different states have varying training requirements for the same provider type. The imposition of a singular threshold will have extremely disparate consequences when considering provider type, location, and training requirements.

In collecting feedback for this rule response, our members underscored that training is an important investment in their workforce. As staff competencies increase through additional training, providers are able to create internal certifications and offer additional wages. Providers are able to incentivize employee loyalty through organizing and offering training that provides job ladders and lattices as well as opportunities for advancement within their field with their same employer. Training staff on clinical best practices, cultural competency, and other critical aspects of care provision and regulation increases direct care staff acumen in important areas to be measured by the HCBS quality metrics CMS proposes in this rule. Imposition of the proposed threshold and definition of compensation would limit providers' ability to maintain these job training and promotional opportunities within their organization, thus stifling employee advancement and serving to undermine recent efforts to professionalize the direct care workforces. Our members' perspective on the value of training is supported by the literature – more consistent, skills-based training is an important part of job satisfaction and quality care.[5]

The exclusion of clinical supervision in the threshold is a threat to quality care

Possibly the most egregious perverse incentive that this threshold would invoke is a limitation on clinical supervision. For home health aides, there are federal minimum supervisory standards in 42 CFR 484.80(h) with varying timetables for onsite assessment of the aide's delivery of services from 14 days for delivery of skilled care to 60 days for unskilled care delivery. Individual needs can differ greatly within each of those categories. While it seems unlikely that CMS considered these significant costs in the 80% proposal, there certainly wasn't consideration for more supportive and interactive clinical oversight above mandatory federal minimums.

One member noted limitations on RN to aide ratios dependent upon travel distances between clients. Compliance with federal minimums may mean different ratios are feasible in different areas of a state depending upon geographically rural areas. This type of threshold would put a significant burden on rural providers serving a smaller total patient load and requiring more clinical oversight than providers in more densely served areas. More explicitly, this proposal could *eliminate* access to the included services in rural and frontier areas of states.

Another member noted that for very high acuity patients, aide services are assessed weekly. The same provider also noted a commitment to staffing continuity and noted the importance of manageable clinical supervisor to home health aide ratios to assure that aides always have access to clinical support. Their company promotes a culture of questioning and aide empowerment through constant access to their clinical supervisor. The CEO of the organization noted that this threshold was untenable for home health broadly, but she would have to stop taking Medicaid if this were to take effect because she is

[5] https://www.ltsscenter.org/wp-content/uploads/2021/06/State_Sponsored_Home_Care_Aide_Training_Approaches.pdf and https://leadingage.org/wp-content/uploads/drupal/Workforce%20Vision%20Paper_FINAL.pdf

unable and unwilling to change her supervisory structure that ensures front line staff have round the clock access to and are encouraged to use their clinical supervisors as resources when providing care. This member's process is consistent with the research on best practices -- utilization of effective nurse management is correlated with higher job satisfaction, higher quality of care, lower turnover, greater effectiveness, lower job stress, more autonomy to make decisions, and enhanced ability to use best practice research findings in clinical care.[6]

Disincentivizing strong clinical supervisory structures in these services, where aides are most apt to see changes in a person's condition, or be informed of a recent event (fall, self-administered medication error, etc.), will undermine service quality and lead to unnecessary critical incidents and emergency department utilization. These limitations coupled with exclusion of training for direct care staff demonstrates an incomplete understanding of the effects the 80% proposal would have on providers and their ability to provide and increase the quality of care and services they render - for those that are able to remain in business.

Other administrative overhead not contemplated in the proposal

Beyond training and supervision requirements, we want to highlight other aspects of provider costs not contemplated by CMS in this proposal:

1) geography and travel obligations between clients in rural areas cause additional administrative costs for provider agencies. Time spent traveling between clients is not billable to Medicaid programs, though may be reimbursed in some manner by employers. Access in rural areas is already a problem, this would make it worse.
2) Onboarding, completion of required training, and compliance with background check requirements can be costly to providers. Multiple members referenced workforce shortages, noting that scheduling 20 interviews in a day may mean twelve people show up for the interview, and eight are hired on the spot. Upon being scheduled, following completion of background checks, often only four arrive for their first shift. The provider has completed background checks, in good faith, on staff they have provisionally hired, incurring the associated costs, but some of these new staff don't show up.
3) Administrative burden on providers in billing Medicaid is inconsistent across states. In states with multiple managed care organizations (MCOs) operating in a single area, providers must be adept at billing procedures, portals, and protocols for each MCO. Proficiency in clean claim submission requires billing and electronic visit verification administrative compliance – all of which requires staff time and training.
4) In choosing these three services, CMS seems to be assuming that there are no "facility" overhead costs – this is not true. Our members still have to rent office space for back office and administrative workers and to store supplies.
5) Costs for things like cellphones, which are essential for compliance with other CMS regulations such as EVV, and other similar ancillary costs.
6) Administrative fixed costs are borne disproportionately on small and culturally competent providers serving enclaves of diverse populations further threatening CMS objectives in service access equity.

LeadingAge asks that CMS withdraw the passthrough proposal until necessary data, infrastructure, and funding exist to support a different proposal aimed at supporting the direct care workforce.

[6] https://ltsscenter.org/reports/Enhancing_Frontline_Nurse_Management_in_LTSS.pdf

LeadingAge supports the rest of the proposals in the rule and provides specific comments below. One overarching concern is the timeline for implementing all of these proposals. Imposing simultaneous comprehensive systems reform on states in the timelines CMS has proposed will be impossible for states to comply with due to time, financial, and human capital limitations. We suggest that CMS extend the timeframes rather than risking unnecessary spending, omission, and duplication.

Administrative and financial burdens on states to implement a number of monitoring, reporting, and quality programs will further strain already fragile departments and infrastructure.
LeadingAge is concerned that the rules and timelines included for compliance with many of the proposed provisions of the rule will impose significant burdens on states. These requirements include but are not limited to development of websites and transparency reporting, critical incident management systems, quality reporting metrics for HCBS, adoption of a grievance system within FFS Medicaid, and restructuring of stakeholder advisory groups. We should be clear – we are supportive of each of these proposals individually and collectively. It is worth noting that the burden on states will be very significant and we urge care in adoption of any singular or group of these proposals. Shifting state resources from program monitoring and ongoing functions to development of new systems and policies could have the unintended consequences of adversely affecting current services and recipients.

States struggle with limited funding and human capital to support Medicaid programs. As states continue to work through significant complexities with Medicaid renewals which recently restarted, while continuing quality improvement efforts and system transformation, there is concern that implementation of more than one of these requirements in the short term will be impossible for state staff. Systems procurement processes for information technology that would be used for critical incident management or grievances systems can take years when undertaken as a single major transformation. Each of these administrative requirements for states should not be stacked but staggered to optimize success. CMS seems to understand these long timeframes for each individual proposal, but doesn't address that each requirement alone will take significant attention to complete with integrity. Pursuing all of these projects at once will surely cause increased costs, lack adequate oversight, and result in avoidable errors.

Similarly, each of these requirements individually will be costly to states. Understandably CMS notes that administrative financial participation is available at 90% for applicable projects. These projects will cost millions of dollars. State legislatures are under no obligation to adequately fund Medicaid programs or their administrative requirements from CMS. States will be left with decisions to spend their state's tax dollars on administrative infrastructure developments required by CMS or services to individuals desperately needing the Medicaid program for their HCSB. These administrative proposals could serve to limit participant access to services because of budgetary constraints.

Implementation by states of singular critical incident management system
CMS acknowledges that there is no consistency across state requirements or definitions for critical incident reporting. They are therefore proposing to require states to adopt a standard definition of critical incidents to include, "at a minimum, verbal, physical, sexual, psychological, or emotional abuse; neglect; exploitation including financial exploitation; misuse or unauthorized use of restrictive

interventions or seclusion; a medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death; or an unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect"

Additionally, states are to implement an electronic system for reporting aforementioned critical incidents that will track, trend, and predict unreported incidents. LeadingAge understands many states already use electronic reporting and have extensive definitions for incidents. Though adoption of new systems and definitions may require providers to retrain staff both on new definitions and new software interfaces for reporting, we feel this could be a positive step to raise the bar for poor performing providers.

As CMS reviews ways to implement this, flexibility should be offered that allows states to make upgrades to existing programs and portals. This includes adequate runways for implementation and the development of timely sub-regulatory guidance that ensures states are provided adequate understanding of requirements for compliance. Conceivably, once the system is set up, critical incidents for HCBS participants could be handled by augmenting staffing and support to states' long-term care ombudspeople. Training and education of the ombuds program staff would be necessary to fully understand HCBS and the unique vulnerabilities not typically present in facilities. The program would also need additional funding.

Critical incidents are separate from grievances, though there is good reason for them to be considered and analyzed by the same team and administrative system. While critical incidents are staff reported, grievances are participant or caregiver reported. Many grievances will not rise to the level of demonstrating systemic problems with a poor provider, though when patterns arise in both grievance and critical incident management systems, additional oversight may be warranted. Requiring state administrations to implement more coordinated tools to monitor poor providers will elevate the level of care and quality of services for participants receiving services.

Grievance system for HCBS Participants

CMS is proposing to require states to develop a standalone grievance system for HCBS participants. Participants could express concerns about their services, the manner in which they are provided, or the provider from which they were received. The intent is to offer individuals receiving HCBS in fee for service programs a parallel process to report dissatisfaction as individuals receiving services through managed care delivery models.

Similar venues for grievances exist for individuals in nursing facilities through their state's long-term care ombudsman. These watchdog offices could be bolstered and offered additional training to support review of HCBS grievances. CMS should also consider integrating the HCBS grievance process with the critical incident management process to offer a more comprehensive and coordinated picture of inappropriate provider and case management behaviors. Limiting the harm of poor providers will promote the level of professionalism across the industry, curtail bad press, and better serve recruitment and retention efforts of all providers. Improving the industry and its image will lead to improving service quality and participant experience.

Service planning and reassessment timelines

LeadingAge supports the proposal that all individuals should be reassessed and have care plan adjustments made at least annually. We understand that the percentage increase is small but feel care

coordination entities should take all necessary steps to ensure that participants service plans are reflective of their true need.

Conclusion

LeadingAge thanks the Administrator and CMS for their attention and ongoing commitment to home and community-based services, the providers, and the participants within the Medicaid program. We believe transparency and accountability coupled with adequate rates will elevate the quality of services provided, and access to necessary services. We ask that CMS consider these goals when reviewing our comments and moves forward with proposals that will demonstrably increase access to services. As additional standards are considered, we hope CMS will use LeadingAge as a trusted resource and stakeholder in the aging services space.

Sincerely,

Georgia Goodman
Director of Medicaid Policy
LeadingAge
ggoodman@leadingage.org