Submitted electronically

June 28, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue S.W.
Washington, DC 20201

Re: Agency/Docket Number CMS-2442-P, proposed rule aimed at improving access to care, quality and health outcomes, and better addressing health equity issues in the Medicaid program across fee-for-service (FFS), managed care delivery systems, and in home and community-based services (HCBS)

Dear Administrator Brooks-LaSure:

As a leading organization representing Medicaid home and community-based service (HCBS) providers and other partners, the Partnership for Medicaid Home-Based Care (PMHC) is pleased to provide our comments regarding the proposed rule, **Medicaid Program: Ensuring Access to Medicaid Services**, released on May 3, 2023 (Proposed Rule).[1] As an organization that is comprised of home care agencies, Managed Care Organizations, technology innovators, and other entities that support HCBS, PMHC is committed to ensuring access to high-quality home-based care to the many individuals who participate in Medicaid programs. Our provider members serve over hundreds of thousands of HCBS beneficiaries across the country, employing a vast workforce to support these essential services.

PMHC strongly shares and appreciates the Administration's commitment to strengthening HCBS. As CMS has stated consistently, long-term care services provided in the home and community through HCBS allow Medicaid recipients to receive critical supports for daily living activities in their preferred home setting. Such home-based care helps to promote the overall health and well-being of critical populations and moreover, helps to play an integral role in reducing emergency room utilization, hospitalizations, hospital length-of-stay, unnecessary institutionalization, and other improved outcomes.

General Input on Proposed Rule

While PMHC has significant concerns about one core proposal in the Proposed Rule, we do want to acknowledge many of the very favorable regulatory changes proposed in the Medicaid Access Rule. We enthusiastically support and appreciate CMS's recognition of the

[1] Proposed Rule: Medicaid Program; Ensuring Access to Medicaid Services (CMS–2442–P), 88 FR 27960 (Pages 27960-28089) May 3, 2023.

importance of HCBS and CMS's efforts to improve overall access to HCBS for Medicaid beneficiaries.

- **New HCBS transparency and reporting requirements.** PMHC is supportive of the proposal to rescind the 2015 final rule reporting requirements and instead propose new state reporting requirements that would for the first time include transparency, reporting, and advisement from stakeholders on reimbursement rates for HCBS programs. PMHC applauds this inclusion and would encourage that these transparency measures be extended across HCBS services. PMHC is supportive of the creation of an advisory committee to support input on reimbursement rate setting and further PMHC suggests requiring core stakeholders including individual provider agencies and provider state associations along with beneficiaries and individual workers be included as vital parts of this advisory committee construction.

- **Proposal related to HCBS quality measures.** PMHC is a staunch supporter of measuring care quality accurately and appropriately in ways that aim to improve outcomes. We believe it is crucial that quality measures accurately represent the quality being provided and continue to express our strong belief that measures focus on adequacy, transparency, and improvement of the individual receiving HCBS. Updating the HCBS Quality Measure Set should be done in a timely manner in accordance with the state process, and through this process allow for public input and comment.

- **Proposal for standard reporting requirements for waiting lists.** PMHC is pleased to see CMS focus on updating requirements addressing the issue of time between joining a waiting list and receiving a service, a policy proposal also reflected by PMHC to Congress and CMS. The Medicaid and CHIP Payment and Access Commission (MACPAC) and Kaiser Family Foundation have documented that HCBS waiver waiting lists do not provide a complete picture regarding the need among Medicaid enrollees for HCBS services nor can data be compared across states because each state manages and reports data about its waiting list differently. This reporting needs uniformity to translate properly to a measurement like a national waiting list. For instance, a waiting list in one state may denote 0 individuals on the waiting list, but individuals may actually be waiting for services whereas another state may denote a larger waiting list but with comparable challenges to providing services. These disparities in reporting data do not translate well to federal policymaking and need to be addressed. It also concerning that the majority of states report 0 on waiting lists for home care HCBS when that does not seem to reflect provider experience.

- **Proposal for incident management system.** PMHC supports improved reporting systems and endorses this new requirement to require states to provide assurance that they operate and maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. It is important to track incidents through an updated incident management system that is created based on input from a variety of stakeholders, including providers, managed care organizations, and innovators of technology along with states to ensure feasibility and accountability. There

are similarities to be drawn from implementation of electronic visitation verification (EVV) where the collaboration of states along with these stakeholders is crucial and has become an important part of the official CMS stakeholder calls around implementation.

- **Proposal for a grievance system development.** As CMS focuses on improving the Medicaid Program, we are supportive of the new development of a grievance system and are hopeful that it will enhance the beneficiary experience. PMHC and our provider members want to ensure that systems are built that reveal clear facts about the system so that policymaking that results from this information can be accurate and impactful. We ask that CMS work with a variety of stakeholders, especially beneficiaries, to create a grievance system that is practical and sets realistic expectations for its users. Millions of individuals whom PMHC members support depend on these services daily, and it is critical that a grievance system results in meaningful resolution of their grievances in a timely manner. PMHC members provides services predominately to elderly beneficiaries as well as people with disabilities; therefore, we encourage CMS to create a grievance system that it is easy to use for these individuals and their families and support systems. A grievance system should be accessible and have clarity around what to expect once a grievance is submitted. So that states have flexibility around process, PMHC also recommends that the grievance system be aligned with the state Medicaid Programs' appeals process and that state agency staff be engaged to simplify the experience for recipients.

- **Implementation and timing of all proposals in the Proposed Rule.** PMHC urges CMS to be thoughtful about implementing meaningful policy across all of these proposals in the Proposed Rule. As an industry, we have experienced how States grappled with the three-year reporting requirement of select Medicaid measures as required by the 2015 Medicaid Access Rule. Similarly, Electronic Visit Verification timelines were extended, the HCBS Settings Rule had a significant extension and several other Medicaid policies endured similar fates. The requirements of states greatly impact home care providers and above all the beneficiaries that our members support, and it is critical that all stakeholders are able to onboard a new process in a systematic way that is thorough and allows time for technical assistance and clarity during the complex process. States have had to endure tight timeframes in the past and, based on those experiences, some new proposals take at least ten years to begin compliance. Medicaid is a complicated program and to orchestrate and implement compliance programs that are different in each state is challenging. Many have existing onboarding requirements and state legislative processes and new technology development that need to be taken into consideration. Relatedly, with the expiration of the Public Health Emergency (PHE), ongoing redetermination process and severe deficits in state staffing, PMHC asks that CMS reconsider the proposed timing and acknowledge that proper implementation of most of the proposals in this proposed rule will take much longer than five years to be executed correctly. We ultimately will defer to and rely on State Medicaid Agency comments with regard to timeframes however voice our recommendation for more realistic timeframes that allow sufficient time to mitigate unintended consequences and address inconsistencies with existing state rules and processes.

PMHC Urges CMS to Not Move Forward with the 80 Percent Wage Threshold/Payment Adequacy Proposal

PMHC's most grave concern is the specific proposal for states to require that at least **80 percent of all Medicaid payments** be spent on compensation to direct care workers performing homemaker, home health and personal care services. **We urge the Agency to withdraw this proposal from the proposed rule.** PMHC believes the proposal does not meet legal requirements for federal rulemaking, which is laid out further in this letter, and we submit the following comments related to content-related feedback to the proposal below.

Lack of Data on the 80/20 Threshold and HCBS Services Selected for Threshold

We understand why CMS would look to include a workforce-related proposal as we appreciate the linkage between caregiver wages and benefits, which if materially increased, can help improve caregiver recruitment and retention and, through this, enhance access to care for HCBS recipients. As an organization that represents providers, our members work every day to balance the challenges of recruitment/retention within the parameters of state reimbursement and the necessary program compliance and operating requirements.

A massive challenge that PMHC members faced in responding to this proposal was the lack of data presented or available to even assess the state of workforce wages and reimbursement rates for HCBS services across states, or even within one state. As a membership that represents local, state, and multi-state providers, it is our collective reflection that the unique nature of each waiver, the non-uniformity of state program requirements and the disparity of reimbursement rates across and within states does not support implementation of a federal standard for a minimum percentage threshold for direct care worker wages and benefits of the overall payment and will be problematic to implement without causing significant unintended consequences – particularly for those in states with lower Medicaid rates.

The proposal does not appear to be accompanied by any data to support establishing a specific threshold and only cites two states who have done somewhat similar, but differently categorized and defined threshold requirements, that apply to just a few of their waiver programs. Additional citations referenced some state requirements for passing through American Rescue Plan (ARP) Act funds, which in our view is an "apples to oranges" comparison, given that ARP Act payments were designed as temporary supplemental payments specifically designed to enhance direct care worker payments, separate from base reimbursement rates. The additional fact that some, not all, states imposed certain pass-through requirements for ARP funds without a federal requirement to do so is evidence that states are in the best position to understand what the best course of action is to address the home care worker shortage.

Additionally, there appears to be no justification included to explain why an 80 percent threshold was chosen. Note that PMHC researched a number of data sources, including those produced by other federal and state agencies, and was unable to identify any existing data to help assess the impact if applied uniformly across the country as currently proposed. Without having

any data and analyses on smaller-scale initiatives, it seems very premature to propose any nationwide threshold solution at all.

Finally, there is no evidence of why the three services for personal care, home health, and homemaker are selected except for that they are not "facility-based" and an assumption that there are not significant costs beyond workforce. Below we explain why this is a mischaracterization of home care/personal care services, but it is important to note there is very little information about why these three services are isolated in major wage-related rulemaking.

Lack of Data on Varying Reimbursement Rates and Costs to Providers

The proposal does not acknowledge that reimbursement rates across and within states vary significantly. Home care wages for direct care workers wage can range from as low as $15 to over $30 and can vary significantly even within state waiver programs as well as between states. A twenty percent cap on non-wage and benefit costs of a low rate simply does not support the same level of fixed costs as a state with a higher reimbursement rate. We document state variation in administrative costs below and would also stress that state licensing laws for providers establish very different requirements for office locations (i.e., "bricks and mortar" expenses) that result in vastly different costs of rent or mortgage costs across states. Further, guaranteeing 80% of a low rate to direct care workers will not always materially raise pay rates or address the current workforce crisis. This is notable in states like Illinois, a state with a threshold highlighted in this proposal, where the workforce continued this year to rally the state legislature for higher wages.

In our experience PMHC has found the most significant financial impact on recruitment and retention is payment of a wage above state minimum wage or the prevailing market wage in a specific geography with a reimbursement rate fully funded to support that wage.

The proposal also does not acknowledge the uniqueness of HCBS waivers - not one of over 300 HCBS waivers in the country are identical with regard to the population served, services provided, staff required to provide the service, compliance and regulatory requirements or the rate reimbursed to providers.

In 2006, HHS/OIG issued a report titled *HHS OIG - REQUIREMENTS FOR MEDICAID FUNDED PERSONAL CARE SERVICE ATTENDANTS*.

In the executive summary of the report HHS/OIG concluded the following:

> ***States had established 301 sets of attendant requirements nationwide.*** *Requirements often varied among the programs within a State and/or the delivery models within programs. As a result, we identified 301 sets of requirements for attendants. We defined a requirement set as any combination of requirements (i.e., background checks, training, age,*

supervision, health, literacy or education, or other requirements) established for attendants within a program.

Wide variations exist in the six most common requirements. *The six most common requirements identified were background checks, training, age, supervision, health, and education/literacy; however, States defined these requirements differently. For example, background check requirements were included in 245 requirement sets. However, a background check requirement in one program could include conducting a national criminal background check, checking abuse and neglect registries, and/or checking Federal or State exclusion lists; in another program, the background check requirement could include only checking references. Even when two programs require a criminal background check, one may bar an attendant for certain offenses while the other may allow an attendant with the same offenses to provide services.*[2]

Although the report is from 2006 this finding has not changed and, if anything, more disparity and sets of requirements exist today.

PMHC also finds that the proposed rule is vague as to what costs are included in the calculation of the percentage of direct worker costs to reimbursement to propose a specific threshold across states. While we do not support federal regulation requiring 80% of payment for direct care employee wages and benefits for all these reasons specified, at a minimum the following list of costs should be captured in any definition of direct care workers costs with current inflationary impacts being taken into consideration.

- All Wages including overtime for all staff including administrative and supervisory
- Travel Time (time paid traveling between clients and also with clients where provider pays full or partial amount varying by state and waiver)
- Health, dental, life, disability, and other benefits
- Any paid time off benefits (sick time, vacation, general use PTO)
- Tuition Reimbursement
- Payment for time spent in training
- Payroll taxes including federal and state unemployment insurance
- Workers' compensation insurance
- Mileage reimbursement (separate from travel time payment)
- Public transportation reimbursement
- Stipend or expense reimbursement for mobile devices used for Electronic Visit Verification (EVV)
- Retirement coverage
- Uniforms

[2] HHS Office of Inspector General, OEI-07-05-00250, STATES' REQUIREMENTS FOR MEDICAID-FUNDED PERSONAL CARE SERVICE ATTENDANTS (2006).

- General liability insurance
- Background check related costs
- CPR Training
- TB Testing and Pre-Service Physical Exams
- Employee Assistance Programs and other caregiver supports
- Any delineated direct care worker pay, or benefits included in a Collective Bargaining Agreement
- Personal Protective Equipment (PPE) costs

Similarly, CMS has defined the denominator in the calculation of direct care worker costs of payment as *"…Medicaid payments, including but not limited to base payments and supplemental payments…."* This description also could benefit from additional clarification as it may not capture all of the elements impacting Medicaid payments. Some additional items that were not considered by the proposal include:

- Only collected revenue and not billed charges would be considered base or supplemental payments.

- Revenue from value-based care (VBC) arrangements in MLTSS should be exempt so as not to disrupt state or managed care efforts moving toward VBC or to disincentivize providers from pursuing innovative strategies to improve health and financial outcomes such as lowering ER visits, Inpatient utilization, lowering attrition from HCBS to SNF.

- Providers must make numerous additional investments above and beyond typical compensation rates for a VBC or pay-for-performance (PFP) arrangement to work. Also, notably, VBC and PFP programs rely on lengthy cycles of data, tracking, analysis, and reconciliation before additional payments are made. If these types of payments are included, program types will have to be restricted disrupting already existing programs and progress made to date.

- Refunded or recouped payments from current or prior years based on program financial audits would be deducted from total Medicaid payments.

Lack of Understanding and Need for Interagency Collaboration on How Direct Care Worker is Defined

PMHC believes the way CMS attempts to define, "direct care worker," is confusing and does not follow the standard nomenclature for this space. The Department of Labor's Bureau of Labor Statistics' (BLS) Standard Occupational Classifications are generally used to assist with consideration of wages for development of state rate proposals. This vast definition captures many different types of workers, some that are individually recognized or not recognized at all or recognized in a grouping with BLS. Given the important role of BLS in the rate system, we urge CMS to provide an in-depth analysis of how this definition was formed. The Department of Labor (DOL) has an entirely different definition of direct care workers which in part helps

determine wages in states as aforementioned, but also defines whether they are entitled to federal minimum wage and overtime pay protections.

HHS appears to have relied on this DOL definition (referenced across reports like ASPE publications) and Congress has also relied on DOL definition when crafting legislation around direct care workers. The fragility of this definition and the advocacy efforts to improve it should not be overlooked and needs to be studied before proposing such a vast alternative which could prove extraordinarily confusing for all stakeholders. We encourage inter-agency discussion and additional stakeholder input regarding the role of these classifications and the purpose of the definition prior to creating an additional new definition.

Impact to Beneficiaries

While PMHC agrees with CMS that the workforce crisis must be addressed, PMHC feels strongly that the 80/20 threshold proposal will lead to significant unintended consequences for beneficiaries who are at the core of concern for Congress in the ACA and SSA sections cited for authority to propose this authority.

In a preliminary survey of hundreds of providers (majority small providers) across the country PMHC found that if finalized:

- 55% of these agencies be forced to close their doors [exit the market] while 35% of these agencies would narrow service offerings or geographies served.
- Over 93% of providers surveyed would be limited in their ability to take on new referrals.
- In order to meet the threshold, providers would make cuts to non-direct care staff (coordinators and other essential staff), clinical oversight, and training amongst other cuts. Several providers would also stop serving Medicaid recipients.
- Over 90% of providers would face challenges serving more administratively costly rural populations and 86% of providers would be impacted negatively in serving underserved populations.

Ultimately, our provider survey revealed that access for beneficiaries is at stake here if this proposal is finalized. PMHC implores CMS to take this initial data and the survey data collected by other associations very seriously in contemplating this proposal and the unintended consequences it could have on access to services.

Legal Considerations

PMHC has outlined several policy considerations regarding the 80/20 threshold proposal, moreover, we want to specify several legal concerns as well.

1. **CMS has not satisfied its notice obligations under the Administrative Procedure Act.** PMHC and the broader public lacks any level of detail on what led to this 80/20

proposal, what data or information (including state feedback) the proposal and threshold is based on, and the proposal lacks any citation to state-level information or research beyond two state references which are unique thresholds under 80 percent.

2. **CMS does not have the legal authority under Section 1902 of the Social Security or Section 2402 of the Affordable Care Act to impose a wage-pass through threshold.** CMS encroaches on the broad authority historically provided to states, oversteps the oversight authority assigned to the agency by Congress and creates its own unprecedented wage setting authority – this proposal is contrary to law and PMHC believes would set a dangerous precedent for future administrations.

3. **The 80/20 threshold proposal is arbitrary and capricious.** The proposal does not explain how the payment adequacy policy would achieve the statutory purpose of Section 1902(a)(30)(A) and makes no attempt to support it, but instead attempts to redefine Congressional intent. The agency fails to address the impact on the workforce and home care agencies (many which are small businesses). Finally, CMS fails to articulate a rational explanation for its decision – again not citing any state that has implemented an 80 percent threshold; not evaluating the efficacy of purportedly similar state requirements; not explaining how the federal requirement will work in the absence of the significant federal funding that accompanied the ARP Act examples; selecting a seemingly random threshold of 80 percent with no data or evidence to support it; and failing to explain why the requirement would apply to some services but not others.

Conclusion and Alternatives

It is based on the reasons and evidence cited above that we feel a uniform standard threshold for direct care worker wages and benefits is not in the best interest of beneficiary access to HCBS and that implementation of such a proposal will have the following unintended consequences resulting in reduced, rather than improved, access.

- Agencies closing and/or disenrolling from Medicaid program reducing access – many/most being small providers, providers in rural areas, or providers serving a specific underserved population.
- Provider agencies reducing service areas, particularly high cost and low volume rural areas or high-cost high crime areas.
- Access issues within Medicaid and other payer funded HCBS from disparities in wages between Medicaid Waiver programs requiring 80% and programs that do not require an 80% threshold including Medicaid State Plan services, services under Older American's Act or Veteran's Administration.
- Fluctuation in hourly wages paid due to changes in the state. For example, if implemented and a certain state meets the 80% wages and benefit threshold, but the state then passes a mandatory paid time off law without rate increase, wages would be reduced to pay for PTO benefit within the 80% requirement. Lowering wages for any reason creates considerable turnover in the workforce.

PMHC strongly supports workforce development and has historically and continues to support thoughtful solutions to our workforce crisis. Although many of PMHC's proposed workforce solutions have been legislative and outside the scope of this rulemaking, **it is our strong recommendation that CMS finalize its proposal to require reporting and transparency of HCBS reimbursement rates. This is the first essential step that will better enable states and other stakeholders to analyze actual data and assess thoughtful, evidence-based solutions to our workforce crisis.** As mentioned by CMS in reflection of the *Armstrong* decision, [3] this is precisely what the Court referenced in HHS being the appropriate agency to make determinations regarding a state's compliance with section 1902(a)(30)(A). Without a private right of action, providers must work with states to ensure sufficiency of provider payment rates, and look to HHS to vigorously enforce the law. PMHC therefore urges CMS to create the transparency and reporting structure that has not existed for these important programs.

PMHC continues to push for policy changes that aim to strengthen the workforce by directly addressing increases rates and wages and help further professionalize the career path for the direct care workers our members employ. In closing, we would like to thank you again for this opportunity to offer our perspective on the Medicaid Access Proposed Rule and look forward to continuing to engage with the agency developing amenable proposals that can improve the quality, efficiency, and integrity of Medicaid HCBS.

If you have any additional questions or would like to discuss our proposal in more details, please contact PMHC Executive Director, Jason Denby, at admin@medicaidpartners.org or PMHC Policy Committee Chair, Darby Anderson, at DAnderson@addus.com.

Sincerely,

Esmé Grewal
Chair, PMHC

Darby Anderson
Policy Committee Chair, PMHC

[3] 575 U.S. 320 (2015).