April 26, 2021

The Honorable Debbie Dingell
United States House of Representatives
Washington, D.C. 20515

The Honorable Bob Casey
United States Senate
Washington, D.C. 20510

The Honorable Sherrod Brown
United States Senate
Washington, D.C. 20510

The Honorable Maggie Hassan
United States Senate
Washington, D.C. 20510

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

On behalf of the Partnership for Medicaid Home-Based Care (PMHC), I would like to thank you for this opportunity to comment on the Home and Community-Based Services (HCBS) Access Act of 2021. PMHC is enthusiastic about the opportunity to achieve long overdue, fundamental change in long-term care policy in the United States and appreciates Congress's commitment to the necessity for increased investment in HCBS. PMHC fully supports increasing access to, and improving the quality of, HCBS services delivered to seniors, individuals with disabilities, and individuals with complex medical needs. The investment in HCBS will also provide the opportunity for higher wages and increased standard of living for the direct care workforce, and other HCBS workers.

By way of brief background, PMHC was established in 2015 to advance the delivery of high quality, cost-effective Medicaid home-based care and services. Our members bring to this important quest their experience as home care providers, state home care associations, managed care organizations, and technology providers. While such a diverse membership is somewhat unique, our members have come together due to a shared commitment to support legislative and regulatory efforts that improve the quality, accessibility, and integrity of home and community-based care and services in Medicaid.

PMHC's comments focus on providing a bold vision for transformative change in long-term services and supports (LTSS), which through a system of care delivery designed to address the needs of LTSS participants, would not only achieve improved quality outcomes and fiscal savings, but would elevate the position and services provided by the home care workforce. PMHC will also provide comments Medicaid HCBS private duty nursing services to individuals with complex medical needs and the proposed HCBS Access Act draft bill text.

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Dual Eligible Alignment

Home care providers and stakeholders have been advocating for decades for investments in HCBS at the state level, including efforts to simply obtain funding to meet state and local minimum wage mandates. Despite these efforts, the results in most states have been obtaining the bare minimum of program funding that perpetuates stagnant, low wages and significantly undervalues the health outcomes achieved through HCBS by the millions of dedicated direct care professionals.

For more than a year, our country has been dealing with the deadly consequences of the COVID-19 pandemic. Throughout the pandemic, over three million frontline home care workers have been delivering high-quality, cost-effective Medicaid HCBS services. The care provided by home care workers reduces the risk of COVID-19 infection by providing essential health sustaining long-term supports and services to at-risk Americans safely in their homes.

Home care workers are predominately female (87%), people of color (62%), immigrants (31%), over the age of 55 (33%), and nearly half live in low-income households. Forty-three percent of home care workers rely on public health care coverage, such as Medicare and Medicaid, and 16% are uninsured.[1]

A key reason for this lack of investment at the state level is the lack of alignment in funding sources for the health care services provided to seniors and individuals with disabilities. It is well documented that long-term care services provided in the home and community have been affording significant savings to state general funds and the Medicaid and Medicare programs for decades through diversion from institutional-based long-term care supports and services. What is less frequently studied, but is widely accepted, is that HCBS plays an integral role in reducing emergency room utilization, hospitalizations, hospital length of stay, and other profound positive impacts on the health and well-being of individuals receiving HCBS.

For the dually eligible population HCBS services provided flow through to generate savings to the Medicare program. However, the vast majority of state HCBS programs as currently structured provide no incentives to state Medicaid agencies to make investments in HCBS that drive better health outcomes to achieve savings within the Medicare program because the states do not derive any benefit from the savings or for the additional HCBS investment. In one state, Washington, the Dual Demonstration Project (MMP) reduced Medicare expenditures by $61 million (or 9%) in the first two years, which CMS retrospectively paid the State.

[1] PHI. "Workforce Data Center." Last modified September 14, 2020. https://phinational.org/policy-research/workforce-data-center/.

A key provision in the HCBS Access Act provides states with 100% FMAP for HCBS long-term care. Creating an alignment between the Medicaid and Medicare programs for health and social model care for the dual eligible population would achieve the following benefits.

1. Provides greater incentive to states to defer or deflect HCBS recipients from institutional settings.
2. Eliminates state funding barriers to HCBS reimbursement rates that supports increasing wages and benefits to a standard providing both a living wage to the workforce and a competitive compensation that would attract more individuals to the home care industry. The increased supply of workers would relieve the workforce limitations that have greatly impacted access to HCBS.
3. Allows the federal government to create uniform national standards for HCBS.
4. Allows the federal government to develop value-based initiatives which would incentivize and require improved integration of HCBS LTSS into the healthcare delivery system. Medicare program savings would be realized from reduced utilization of emergency department visits and hospital admission, and other fiscal savings from better quality of care delivery to poly-chronic beneficiaries receiving long-term care.

Workforce

The home care workforce has been undervalued and under-appreciated since the inception of HCBS services. PMHC strongly supports policy reforms that honor and protect these dedicated professionals that deliver high-quality, cost-effective services to a large and growing population of seniors and individuals with disabilities. These services enable individuals to remain in their homes and communities while providing relief to taxpayers from the much higher cost of institutionalized care.

Home care aides and other personal care professionals deserve compensation that reflects the tremendous human, clinical, and fiscal value of the care they provide every day. At present, however, inadequate Medicaid rates prevent these professionals from receiving compensation commensurate with the value they produce for our nation. The occupation's mean wage reimbursement set by states is currently $10.48 an hour reflecting an annual salary of $21,790 according to the latest figures from the Bureau of Labor Statistics.[2]

Research has demonstrated that in addition to low wages and no benefits, a lack of recognition and inclusion in overall patient care is as much a barrier for individuals entering the home care field, and a leading cause of turnover among the existing workforce. The lack of alignment and integration of care between Medicaid and Medicare services is a main contributor to this result.

[2] www.bls.gov/OES/Current/oes399021.htm#(3)

The following excerpts from Dr. Paul Osterman's[3] book, *Who Will Care For Us? Long-Term Care and the Long-Term Workforce: Long-Term Care and the Long-Term Workforce*, most aptly describe a system of fundamental change in long-term care that can achieve improved compensation and the expansion of the role of HCBS direct care professionals.[4]

> Contrary to much discussion, home care aides are broadly committed to their occupation. High turnover rates reflect not lack of commitment but low compensation: people move between agencies to find slightly better-paying work. But home care aides are generally committed to the occupation. There is some *evidence that improvement in compensation reduces turnover, both between employers and in and out of the occupation itself* [emphasis added]. (Osterman, 2017, p. 52).
>
> Three recent trends in the delivery of health care point directly to an expanded role for home care aides. First is the growing focus on the creation of health care teams, as opposed to the traditional top-down, doctor-focused practices. Second is the increased attention to the management of chronic conditions. The third is new interest in managing transitions from hospitals after acute incidents. *The importance of all three trends is supported by research-based evidence, and each creates new opportunities for home care aides to play an expanded role* [emphasis added]. (Osterman, 2017, pp. 77-78).
>
> Given this complex market, how can we move forward to improve opportunities for home care aides? Any strategy must...be based in large part on enlarging their scope of practice so that enhanced productivity can justify improved compensation. (Osterman, 2017, p. 52).
>
> ... we can move forward and take up the challenge of improving long-term care systems in this country. *In rethinking how care is delivered, the health care system must recognize that direct care workers, both paid and unpaid, spend more time with clients than anyone else* [emphasis added]...the reality is that better training, better compensation, and an expanded role will add up to both better care and reduced costs...[which] that not only improves the circumstances of consumers and workers but goes a long way toward paying for itself. (Osterman, 2017, p. 153).
>
> The coming explosion of demand, driven by demographics, will put these issues on the political map. The worst response would be to continue to muddle through, relying on a patchwork system composed of a poorly designed welfare system, expensive private insurance, burdensome out-of-pocket expenditures, and unpaid family labor. We certainly can do better. And we can also recognize that *without an*

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[3] Paul Osterman is Nanyang Technological University (NTU) Professor of Human Resources and Management at the M.I.T. Sloan School of Management.

[4] Osterman, P. (2017). *Who Will Care For Us? Long-Term Care and the Long-Term Workforce: Long-Term Care and the Long-Term Workforce*. New York: Russell Sage Foundation. doi:10.7758/9781610448673

> *army of paid direct care workers who are empowered and trained and compensated decently, no system of long-term care can work well* [emphasis added]. (Osterman, 2017, p. 154).

Paul Osterman's extensive research concludes that by expanding the participation and role of the direct care professionals in the integration of services and coordinated care to dual eligible individuals receiving HCBS will result in reduced utilization of acute care services, which in turn will reduce Medicare program expenditures. The Medicare program savings can then be redirected into improving HCBS workforce wages, benefits and training, which results in further beneficiary health improvements and savings to the Medicare program.

Without an alignment between the payment siloes between Medicaid and Medicare for HCBS recipients, progress will be challenging, if not impossible. While making Medicaid HCBS eligible for 100% FMAP may be an extraordinary level of change, the results can be equally extraordinary. Recognizing that such transformational change will be met with doubt, PMHC proposes CMMI undertake a demonstration to test the increased FMAP to 100% and expanded role of HCBS and the impact on savings to the Medicare program.

There is considerable discussion and proposals specific to additional training of home care aides. While not uniform across the states, most home care aides receive a considerable amount of pre-service and in-service training. While all training is beneficial, additional training to improve the quality of the primary role home care aides have in supporting a consumer's activities of daily living (ADLs), is difficult to evaluate in terms of return on the investment and to correlate to higher compensation for the home care aide, particularly when HCBS reimbursement rates are fixed regardless of how much training the aide has received.

PMHC proposes that new home care workforce training investments should be targeted to focus on expanding the role of home care aides as we have proposed, and Dr. Osterman describes. Training focused on general health education and awareness related to the chronic conditions seen in the population receiving HCBS will equip home care aides with the tools to recognize changes in condition of the recipients they serve and observe and report these changes to other disciplines on the health care team, thus facilitating early interventions that drive better outcomes. Additionally, training focused beyond ADL delivery will help establish a career advancement ladder to positions such as health navigators, certified home health aides, nurses and other clinical-based roles within health care.

Federal Minimum Wage

PMHC has two primary concerns related to the proposed increase of the federal minimum wage. First, states will not have the resources nor political will to make the required increases in Medicaid HCBS reimbursement rates to support the federally mandated minimum wage increase. The results would be disastrous for individuals currently receiving and those wanting to access HSBC. Second, establishing a higher but uniform wage floor for all positions, job

seekers will forego the challenging position in the home care industry for less demanding work at the same rate of pay.

While our vison for a new national long-term care policy described in this comment letter would resolve the challenges from increases in the federal minimum wage and address the low-level home care average hourly wage, we recommend, as another solution that the FMAP for HCBS be increased to 100% for the amount of increase in the current state HCBS long term care reimbursement rates required to support a minimum wage of 2x the federal minimum wage including annual cost of living adjustments. **PMHC also proposes requiring states to provide a uniform rate justification in all state plan and waiver amendments demonstrating compliance with the proposed wage funding mechanism and require that CMS deny any state plan or waiver amendments that do not comply with reimbursement rate setting that supports a wage floor of 2x or greater than the federal minimum wage for the direct care workforce.**

The resulting benefits of PMHC's proposal would provide an incentive to states to defer or deflect recipients from institutional settings and eliminating barriers to economically sound reimbursement rates that support increased wages and benefits resulting in an increased standard of living and competitive compensation that would attract more individuals to home care which would assist with meeting the current workforce crisis limiting current and future access to HCBS.

Uniform Presumptive Eligibility

Since the Medicaid program's establishment in 1965, its operations and eligibility rules have traditionally favored nursing home placement rather than home-based care. This model made sense in 1965, when "rest homes" were often the only option for people as they aged. Today, however, numerous community-based options offering high quality and low-cost care are readily available.

As a result, we believe Medicaid rules should be modernized to encourage utilization of HCBS. Such reform would enable individuals to remain out of more costly settings, decrease health care expenditures, and satisfy consumers' strong preference to remain in their own homes. This reform would also achieve compliance with the U.S. Supreme Court's Olmstead decision[5] which established that people with disabilities have the right to community-based services in the most integrated setting.

In light of the above factors and the many clinical and technological advances that have been achieved since 1965, **PMHC respectfully urges the adoption of Medicaid placement rules that allow new applicants for HCBS LTSS be screened to determine their suitability for home-based care first, rather than institutional placement.** Subject to consumer choice, this policy

[5] Olmstead v. L.C., 527 U.S. 581 (1999).

would enable all Medicaid consumers to be offered home-based care if they qualify for and desire such placement.

<u>Medicaid HCBS Private Duty Nursing Services</u>

Under federal law, states participating in Medicaid are required to cover certain mandatory services, which include the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit providing comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. Under the EPSDT benefit, private duty nursing (PDN) is a service category available to provide ongoing medical care and interventions that are necessary to correct or ameliorate the individuals' status.[6]

Private duty nursing is defined as "nursing services for...[individuals] who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility...[and provided by]...a registered nurse or a licensed practical nurse [u]nder the direction of the...[individual's] physician". Private duty nursing services can be provided in the home, hospital, or skilled nursing facility.[7] An Individual is able to use their private duty nursing hours when normal activities take them outside of the home to participate in activities outside the home.[8]

Since passage of the Medicaid Act, the ability to care for individuals with complex medical conditions that may require skilled interventions or be dependent on medical technology in the home has vastly improved. However, there are widespread misperceptions and lack of understanding of HCBS PDN services, which has resulted in a burdensome maze of programs for families to navigate in order to obtain the benefits their children are entitled to receive.

HCBS PDN is often thought of, and confused with, privately paid services, services provided by personal care aides, or custodial non-medical care. The lack of a clear federal definition for PDN services does not reflect the level of care delivery being provided in home and community-based settings. Further, the lack of a clear federal definition for Medicaid HCBS PDN services leads to a reduction in access to care and potential missed funding opportunities.

CMS noted in a 1987 Final Rule[9] that [i]n the original Medicaid legislation...Congress listed private duty nursing services among the services that could be covered under the program, without defining them. By not defining the term "private duty nursing services" in the legislation or accompanying committee reports, Congress left the responsibility to [HHS] for developing a reasonable interpretation of this term...[t]he private duty nursing benefit is an optional one, and States generally have considerable latitude in defining the scope of optional

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[6] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)(5)

[7] 42 U.S.C. §1396d(a)(8); 42 C.F.R. 440.80

[8] <u>Detsel v. Sullivan</u>, 895 F.2d 58 (2d Cir. 1990)

[9] 52 FR 47934

services. *This flexibility serves as an incentive ...to tailor optional services to the specific needs of their populations* [emphasis added]."[10]

However, the flexibility that was granted under the federal definition to meet the specific needs of a state's population is often used not to expand the scope of services offered to an individual with complex medical needs, but rather to restrict services due to the high-cost nature of the benefit and state decision-makers desire to reduce spending in the Medicaid programs.

Updating the Definition of HCBS Skilled Nursing Services

PMHC has drafted a revised federal definition of HCBS private duty nursing services and strongly urges Congress to engage stakeholders to make the appropriate updates to the federal definition reflecting the level of care being provided in the home to individuals with complex medical needs. The revised definition should, at a minimum, reflect the following.

- Skilled nursing services provided in the home and community to an eligible individual who requires daily ongoing medical care, including skillful observations and monitoring, clinical judgments, interventions to sustain, correct or improve the individual's status.
- Services provided by a registered nurse, licensed practical nurse, or licensed vocational nurse under the direction of the individual's physician and defined by the highest scope of nursing licensure with regard to safety, medical necessity, and level of care.
- Beyond what is authorized under the home health care benefit.
- Provide the ability for the individual to remain in their home rather than a hospital or a skilled nursing facility.

National Standard and Quality Measures

As noted in the 1987 Congressionally-mandated *Fostering Home and Community-based Care for Technology-dependent Children, Report of the Task Force on Technology-Dependent Children*[11], barriers existed related to a "lack of nationally recognized and implemented minimal safety and performance standards for care at home" and a "lack of accountability for quality provided in the home." The Task Force recommended that national standards should be developed and implemented, and that a mechanism for quality assurance be developed. **However, to date, there are no federal standards for HCBS private duty nursing services or standardized national quality measures.**

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[10] As noted in Detsel, documents for the rationale for the definition were lost or destroyed in 1977, when records of the newly-created Health Care Financing Administration were moved from Washington to Baltimore. Only existing document that discusses §440.80 is a memorandum prepared in 1981 by the HCFA Task Force for Regulatory Reform. The authors of that memorandum could find "no files available which indicated the source or rationale for this definition..."

[11] Fostering Home and Community-based Care for Technology-dependent Children: Report of the Task Force on Technology-Dependent Children. (1988). United States: Department of Health and Human Services, Health Care Financing Administration.

PMHC strongly supports a federal standard for the delivery of HCBS skilled nursing services to individuals with complex medical conditions and urges Congress to grant HHS administrative authority to develop, with the input of key stakeholder groups, a national core set of quality measures specific to this population.

In closing, we would like to thank you again for this opportunity to offer our perspective on the HCBS Access Act of 2021 and stand ready to serve as a resource to Congress in further developing policy proposal 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 Stacey Smith at (202) 742-5274 or ssmith@medicaidpartners.org.

Sincerely,

David J. Totaro
Chairman

Attachment: PMHC Redline Comments HCBS Access Act of 2021

Partnership for Medicaid Home-Based Care Members
Addus HomeCare, AlayaCare, Aveanna Healthcare, Axxess, BAYADA Home Health Care, BrightSpring Health Services, CareCentrix, Caring Associates, Inc., CellTrak Technologies, Inc., Centene, Council of State Home Care Associations, Help At Home, HHAeXchange, Home Assist Health, Interim HealthCare Inc., KanTime, LHC Group, Inc., MatrixCare, Sandata, Simplura Health Group, Team Public Choices, Tendercare Home Health Services, Inc., and Thrive Skilled Pediatric Care.

....
(Original Signature of Member)

117TH CONGRESS
1ST SESSION

H. R. ______

To amend title XIX of the Social Security Act to require coverage of home and community-based services under the Medicaid program.

IN THE HOUSE OF REPRESENTATIVES

Mrs. DINGELL introduced the following bill; which was referred to the Committee on ______________________

A BILL

To amend title XIX of the Social Security Act to require coverage of home and community-based services under the Medicaid program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 "HCBS Access Act of 2021".
6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Purpose.

Summary of Comments on PMHC Redline_HCBS Access Act of 2021.pdf

This page contains no comments

Sec. 3. Requiring coverage of home and community-based services under the Medicaid program.
Sec. 4. Medicaid eligibility modifications.
Sec. 5. Home and community-based services implementation plan grant program.
Sec. 6. Quality of services.
Sec. 7. Workforce development.

1 **SEC. 2. PURPOSE.**

2 It is the purpose of this Act to require coverage of
3 home and community-based services (in this section re-
4 ferred to as "HCBS") under a State plan (or waiver of
5 such plan) under title XIX of the Social Security Act (42
6 U.S.C. 1396 et seq.) for the following reasons:

7 (1) In order to fulfill the purposes of Americans
8 with Disabilities Act to ensure people with disabil-
9 ities and older adults live in the most integrated set-
10 ting.

11 (2) To eliminate waiting lists for HCBS, which
12 delay access to necessary services and civil rights for
13 people with disabilities and aging adults.

14 (3) To build on decades of progress in serving
15 people with disabilities and aging adults via HCBS
16 and not in institutions, nursing homes or other con-
17 gregate settings.

18 (4) To fulfill the purposes of the Medicaid pro-
19 gram to provide medical assistance for those whose
20 income and resources are insufficient to meet the
21 costs of necessary medical services, and to provide
22 rehabilitation and other services to help such fami-

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, and individuals with complex medical needs

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, and individuals with complex medical needs

1 lies and individuals attain or retain capability for
2 independence or self-care.
3 (5) To eliminate silos and ensure that people
4 with all kinds of and with multiple disabilities, in-
5 cluding intellectual disabilities, developmental dis-
6 abilities, mental health disabilities, physical disabil-
7 ities, and substance use disorders, and aging adults,
8 receive the services they need to live in their commu-
9 nities.
10 (6) To streamline access to HCBS by elimi-
11 nating the need for States to repeatedly apply for
12 waivers.
13 (7) To continue to increase the capacity of com-
14 munity services to ensure people with disabilities and
15 aging adults have safe and meaningful options in the
16 community are not at risk of unnecessary institu-
17 tionalization.
18 (8) Because decades of research and practice
19 show that everyone, including people with the most
20 severe disabilities, can live in the community with
21 the right services and supports.
22 (9) To support over 65,000,000 unpaid family
23 caregivers who are often providing complex services
24 and supports to aging adults and people with dis-
25 abilities because of a lack of affordable services,

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, and individuals with complex medical needs

1 workforce shortages, and other inefficiencies of the
2 Medicaid system.
3 (10) To improve direct care work quality and
4 address the decades long workforce barriers for
5 nearly 4,600,000 direct care workers giving support
6 to people with disabilities and aging adults in their
7 homes and communities.
8 (11) To eliminate the race and gender dispari-
9 ties that exist in accessing information and HCBS
10 and to prevent the unnecessary impoverishment and
11 institutionalization of black and brown individuals
12 with disabilities and aging adults.

13 **SEC. 3. REQUIRING COVERAGE OF HOME AND COMMUNITY-**
14 **BASED SERVICES UNDER THE MEDICAID**
15 **PROGRAM.**

16 (a) DEFINITION OF HOME AND COMMUNITY-BASED
17 SERVICES.—
18 (1) IN GENERAL.—Section 1905 of the Social
19 Security Act (42 U.S.C. 1396d) is amended by add-
20 ing at the end the following new subsection:
21 "(hh) HOME AND COMMUNITY-BASED SERVICES.—
22 "(1) IN GENERAL.—For purposes of this title,
23 the term 'home and community-based services'
24 means those services specified in paragraph (2) fur-
25 nished to an eligible individual (as defined in para-

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Add (11) To improve the access to skilled nursing services that provide care to individuals with complex medical need.

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1 graph (3)), based on an individualized assessment
2 (as described in paragraph (4)) of such individual,
3 in a setting that—
4 "(A) meets the qualities specified in para-
5 graph (1) of section 441.710(a) of title 42,
6 Code of Federal Regulations (or a successor
7 regulation);
8 "(B) is not described in paragraph (2) of
9 such section (or successor regulation); and
10 "(C) meets such other qualities as the Sec-
11 retary determines appropriate.
12 "(2) SERVICES SPECIFIED.—
13 "(A) IN GENERAL.—For purposes of para-
14 graph (1), the services specified in this para-
15 graph are services described in any of para-
16 graphs (7), (8), (13)(C), (19), (20), (24), and
17 (29) (as applied without regard to the reference
18 to 'September 30, 2025') of subsection (a) or in
19 any of subsections (c)(4)(B), (c)(5), (k)(1)(A),
20 (k)(1)(B), or (k)(1)(D) of section 1915, includ-
21 ing the following:
22 "(i) Supported employment and inte-
23 grated day services.
24 "(ii) Personal assistance, including
25 personal care attendants, direct support

Page: 5

Author: PMHC Subject: Comment on Text

Uniformity in HCBS services should come with uniformity in names for service types and personnel.

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and

PMHC recommends that Section 3(a)(2)(A) include home care as a type of service

1 professionals, home health aides, private
2 duty nursing, homemakers and chore as-
3 sistance, and companionship services.
4 “(iii) Services that enhance independ-
5 ence, inclusion, and full participation in
6 the broader community.
7 “(iv) Non-emergency, non-medical
8 transportation services to facilitate commu-
9 nity integration.
10 “(v) Respite services provided in the
11 individual’s home or broader community.
12 “(vi) Caregiver and family support
13 services.
14 “(vii) Case management, including in-
15 tensive case management; fiscal inter-
16 mediary, and support brokerage services.
17 “(viii) Services which support person-
18 centered planning and self-direction.
19 “(ix) Direct support services during
20 acute hospitalizations.
21 “(x) Necessary medical and nursing
22 services not otherwise covered which are
23 necessary in order for the individual to re-
24 main in their home and community, includ-
25 ing hospice services;

Page: 6

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Home health and private duty nursing benefits are a mandatory benefit for children under the age of 21 pursuant to EPSDT. HCBS services provided under the home health and private duty nursing benefit should be addressed under a separate sub bullet.

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and services which support person-centered planning.

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, including fiscal intermediary and support brokerage services.

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, and not otherwise available to the individual.

1 "(xi) Home and community-based in-
2 tensive behavioral health and crisis inter-
3 vention services.
4 "(xii) Peer support services.
5 "(xiii) Housing support and wrap-
6 around services.
7 "(xiv) Necessary home modifications
8 and assistive technology, including those
9 which substitute for human assistance.
10 "(xv) Transition services to support
11 an individual's transition from an institu-
12 tional setting to the community, including
13 such transition services provided while the
14 individual resides in an institution.
15 "(xvi) Any other service specified by
16 the panel convened pursuant to subpara-
17 graph (B).
18 "(B) SPECIFICATION OF SERVICES.—
19 "(i) IN GENERAL.—Not later than 6
20 months after the date of the enactment of
21 this subparagraph, and not less frequently
22 than once every 10 years thereafter, the
23 Secretary shall convene an advisory panel
24 (in this subparagraph referred to as the
25 'panel') for purposes of specifying services

Page: 7

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Explicitly add home care as a type of service.

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1 which shall be included as home and com-
2 munity-based services under this para-
3 graph.
4 "(ii) COMPOSITION.—
5 "(I) SELECTION.—The panel
6 shall be composed of individuals se-
7 lected by the Secretary from the fol-
8 lowing groups:
9 "(aa) Individuals with dis-
10 abilities receiving home and com-
11 munity-based services under this
12 title and individuals with disabil-
13 ities in need of such services, in-
14 cluding those with physical dis-
15 abilities, behavioral health dis-
16 abilities, or intellectual or devel-
17 opmental ~~disabilities, and includ-~~
18 ~~ing elderly individuals~~.
19 "(bb) Representatives of
20 beneficiary-led disability rights
21 organizations, disability organiza-
22 tions representing families and
23 providers, aging organizations,
24 the Protection and Advocacy sys-
25 tem, the Centers for Independent

Page: 8

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Add (bb) Aging individuals receiving home and community-based services under this title and aging individuals in need of such services.

1 Living, ~~health care~~ providers, the
2 National Association of Medicaid
3 Directors, the National Associa-
4 tion of State Directors of Devel-
5 opmental Disabilities Services,
6 the National Association of State
7 Mental Health Program Direc-
8 tors, ADvancing States, the Cen-
9 ters for Medicare & Medicaid
10 Services, the Administration for
11 Community Living, and other rel-
12 evant representatives from local,
13 State, and Federal home and
14 community-based service systems.
15 "(II) REQUIREMENT FOR EQUAL
16 REPRESENTATION.—The Secretary
17 shall select an equal number of indi-
18 viduals described in items (aa) and
19 (bb) of subclause (I) in convening the
20 panel.
21 "(iii) DUTIES.—Not later than 6
22 months after a panel is convened under
23 clause (i), the panel shall submit to the
24 Secretary and to Congress a report speci-
25 fying services which shall be included as

Page: 9

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HCBS

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organizations exclusively focused on providing the delivery of Medicaid HCBS, HCBS providers of skilled nursing care to individuals with medical complexities,

1 home and community-based services under
2 this paragraph. Such services shall be so
3 specified with the goal of increasing com-
4 munity integration and self-determination
5 for individuals with disabilities receiving
6 such services.
7 "(iv) IMPLEMENTATION OF SPECIFIED
8 SERVICES.—
9 "(I) IN GENERAL.—Services
10 specified by the panel in a report sub-
11 mitted under clause (iii) shall be
12 treated as services described in sub-
13 paragraph (A)(xvi) for calendar quar-
14 ters beginning on or after the date
15 that is 1 year after the date of such
16 submission.
17 "(II) NOTIFICATION.—Not later
18 than 1 year after the first report is
19 submitted under clause (iii), and not
20 later than 1 year after the submission
21 of each subsequent such report, the
22 Secretary shall notify States of any
23 additions or removals of home and
24 community-based services based on
25 services specified under such report

Page: 10

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and aging adults

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, and increasing HCBS access to care to individuals with complex medical needs.

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The recommendations should be subject to a public input process (rulemaking).

1 through State Medicaid Director let-
2 ters.
3 "(3) ELIGIBLE INDIVIDUAL.—
4 "(A) IN GENERAL.—For purposes of para-
5 graph (1), the term 'eligible individual'
6 means—
7 "(i) an individual who is determined,
8 on an annual basis or on a longer basis
9 specified by the State, by a health care
10 provider approved by the State under a
11 process described in subparagraph (C) to
12 have a functional impairment (as defined
13 in subparagraph (B)) (not taking into ac-
14 count any items or services, or any other
15 ameliorative measures, furnished to such
16 individual to mitigate such impairment)
17 that is expected to last at least 90 days; or
18 "(ii) an individual receiving or deter-
19 mined to be eligible for, as of the date of
20 the enactment of this subsection, home and
21 community-based services under this title
22 under a waiver or State plan option in ef-
23 fect under section 1915 or 1115.
24 "(B) FUNCTIONAL IMPAIRMENT.—For
25 purposes of subparagraph (A), the term 'func-

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1 tional impairment' means, with respect to an
2 individual the inability of such individual to
3 perform, without assistance, 2 or more activities
4 of daily living (as described in section
5 7702B(c)(2)(B) of the Internal Revenue Code
6 of 1986) or 2 or more instrumental activities of
7 daily living (as defined for purposes of section
8 1915(k)(1)(A)).
9 "(C) HEALTH CARE PROVIDER STATE AP-
10 PROVAL.—For purposes of subparagraph (A)(i),
11 a process described in this subparagraph is a
12 process established by the State to approve
13 health care providers to make determinations
14 described in such subparagraph that meets such
15 standards as the Secretary may prescribe.
16 "(4) INDIVIDUALIZED ASSESSMENT.—
17 "(A) IN GENERAL.—For purposes of para-
18 graph (1), an individualized assessment de-
19 scribed in this paragraph is an independent as-
20 sessment, with respect to an eligible indi-
21 vidual—
22 "(i) to determine a necessary level of
23 services and supports to be provided, con-
24 sistent with an individual's functional im-
25 pairments, to facilitate an individual's

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1 community integration, self-determination,
2 and well-being;
3 "(ii) to prevent the provision of un-
4 necessary or inappropriate care;
5 "(iii) to establish a person-centered
6 care plan (as described in subparagraph
7 (C)) for the individual;
8 "(iv) that includes each of the ele-
9 ments described in clauses (ii) through (v)
10 of section 1915(i)(1)(F); and
11 "(v) that occurs not later than 30
12 days after such individual is determined to
13 be an eligible individual.
14 "(B) PRESUMPTION.—The assessment de-
15 scribed in subparagraph (A) shall be conducted
16 with the presumption—
17 "(i) that each eligible individual, re-
18 gardless of type or level of disability or
19 service need, can be served in the individ-
20 ual's own home and community; and
21 "(ii) at the option of the individual,
22 that services may be self-directed (as de-
23 fined in section 1915(i)(1)(G)(iii)(II));
24 "(C) PERSON-CENTERED CARE PLAN.—
25 For purposes of subparagraph (A)(iii), a per-

Page: 13

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or self-delegated to an appropriate and approved HCBS provider.

1 son-centered care plan described in this sub-
2 paragraph is a written plan with respect to an
3 individual that meets the requirements of sec-
4 tion 1915(i)(1)(G)(ii).
5 "(D) STANDARDS.—An individualized as-
6 sessment described in subparagraph (A) shall
7 be conducted in accordance with standards
8 specified by the Secretary, in consultation with
9 the Administration for Community Living,
10 that—
11 "(i) safeguard against conflicts of in-
12 terest;
13 "(ii) specify qualifications for who
14 may perform such assessments;
15 "(iii) ensure transparency in the fur-
16 nishing of such assessments, including en-
17 suring the provision of the results of such
18 assessments that includes information in
19 plain language necessary to interpret the
20 methodology and results of such assess-
21 ments;
22 "(iv) ensure that the methodologies
23 used in such assessments are sound and
24 evidence-based; and

Page: 14

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The national standards should be subject to public input and APA and not determined by one Administration.

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1 "(v) require such methodologies to be
2 made available on the public website of the
3 State and tested for reliability and valid-
4 ity.".
5 (2) INCLUSION AS MEDICAL ASSISTANCE.—Sec-
6 tion 1905(a) of the Social Security Act (42 U.S.C.
7 1396d(a)) is amended—
8 (A) in paragraph (30), by striking "; and"
9 and inserting a semicolon;
10 (B) by redesignating paragraph (31) as
11 paragraph (32); and
12 (C) by inserting after paragraph (30) the
13 following new paragraph:
14 "(31) home and community-based services (as
15 defined in subsection (hh)); and".
16 (b) MANDATORY BENEFIT.—Section 1902(a)(10)(A)
17 of the Social Security Act (42 U.S.C. 1396a(a)(10)(A))
18 is amended by striking "and (30)" and inserting ", (30),
19 and (31)".
20 (c) ENSURING COVERAGE OF HCBS FOR ALL MED-
21 ICAID-ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(D)
22 of the Social Security Act (42 U.S.C. 1396a(a)(10)(A))
23 is amended—
24 (1) by inserting "(i)" after "(D)";
25 (2) by adding "and" after the semicolon; and

1 (3) by adding at the end the following new
2 clause:
3 "(ii) for the inclusion of home and community-
4 based services (as defined in section 1905(hh)) for
5 any individual who—
6 "(I) is eligible for medical assistance under
7 the State plan (or waiver of such plan);
8 "(II) is an eligible individual (as defined in
9 such section); and
10 "(III) elects to receive such services.".
11 (d) FEDERAL MEDICAL ASSISTANCE PERCENTAGE
12 FOR HOME AND COMMUNITY-BASED SERVICES.—Section
13 1905 of the Social Security Act (42 U.S.C. 1396d), as
14 amended by subsection (a), is further amended—
15 (1) in subsection (b), by striking "and (ff)" and
16 inserting "(ff), and (ii)"; and
17 (2) by adding at the end the following new sub-
18 section:
19 "(ii) SPECIFIED FMAP FOR HOME AND COMMU-
20 NITY-BASED SERVICES.—Notwithstanding any other pro-
21 vision of law, the Federal medical assistance percentage
22 for amounts expended for medical assistance for home and
23 community-based services (as defined in subsection (hh)),
24 including any such services furnished under a waiver in

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1 effect under section 1915, on or after the date of the en-
2 actment of this subsection shall be equal to 100 percent.''.
3 (e) CONFORMING AMENDMENTS.—Title XIX of the
4 Social Security Act (42 U.S.C. 1396 et seq.) is amended—
5 (1) in section 1902(a)(10)(A)(ii)(V), by insert-
6 ing ''or who are eligible individuals (as defined in
7 section 1905(kk)(3))'' after ''such period)'';
8 (2) in section 1905(a)(xvii), by striking ''pursu-
9 ant to a State plan amendment under such sub-
10 section'' and inserting ''(as defined in section
11 1905(hh))''; and
12 (3) in section 1915, by adding at the end the
13 following new subsection:
14 ''(m) SUNSET OF PROVISIONS RELATING TO HOME
15 AND COMMUNITY-BASED SERVICES.—
16 ''(1) IN GENERAL.—Except as provided in para-
17 graph (2), the preceding provisions of this section,
18 insofar as such provisions relate to a waiver for
19 home and community-based services, shall not apply
20 beginning with the first calendar quarter beginning
21 on or after the date that is 5 years after the date
22 of the enactment of this subsection.
23 ''(2) EXCEPTION.—The Secretary may waive
24 the application of paragraph (1) for a calendar quar-
25 ter and a State if the State requests such a waiver

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1 and the Secretary determines that such a waiver is
2 appropriate."; and
3 (4) in section 1943(b)(5), by striking "the
4 State" and all that follows through the period at the
5 end and inserting "an annual determination be con-
6 ducted in accordance with section 1905(gg) for pur-
7 poses of providing home and community-based serv-
8 ices under the State plan (or waiver of such plan).".
9 (f) EFFECTIVE DATE.—
10 (1) IN GENERAL.—Except as provided in para-
11 graph (2), the amendments made by this section
12 (other than the amendments made by subsection
13 (d)) shall apply with respect to calendar quarters be-
14 ginning on or after the date that is 5 years after the
15 date of the enactment of this Act.
16 (2) EXCEPTION.—In the case of a State with
17 an exception in effect under section 1915(m)(2) of
18 the Social Security Act, the amendments described
19 in paragraph (1) shall apply with respect to calendar
20 quarters beginning on or after a date determined ap-
21 propriate by the Secretary.

22 **SEC. 4. MEDICAID ELIGIBILITY MODIFICATIONS.**

23 Section 1902(a)(10)(C)(iii) of the Social Security Act
24 (42 U.S.C. 1396a(a)(10)(C)(iii)) is amended—

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1 (1) by striking "and (II)" and inserting "(II)";
2 and
3 (2) by inserting ", and (III) home and commu-
4 nity-based services (as described in section
5 1905(hh))" after "delivery services".

6 **SEC. 5. HOME AND COMMUNITY-BASED SERVICES IMPLE-**
7 **MENTATION PLAN GRANT PROGRAM.**

8 (a) IN GENERAL.—Not later than 1 year after the
9 date of the enactment of this Act, the Secretary of Health
10 and Human Services shall award to each State a grant
11 for purposes of enabling such State to implement the re-
12 quirement to provide home and community-based services
13 under title XIX of the Social Security Act (42 U.S.C.
14 1396 et seq.).

15 (b) USE OF FUNDS.—A grant awarded under sub-
16 section (a) shall be used by a State to develop an imple-
17 mentation plan described in subsection (c).

18 (c) IMPLEMENTATION PLAN.—An implementation
19 plan described in this subsection is a plan developed by
20 a State that includes the following:
21 (1) An explanation of how the State will
22 operationalize the definition of an eligible individual
23 under section 1905(hh) of the Social Security Act,
24 including the process for determinations specified in
25 paragraph (3)(A)(i) of such section.

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1 (2) A description of the State's plan to ensure
2 a stable and high quality workforce and how the
3 State plans to ensure a living wage for individuals
4 furnishing home and community-based services and
5 identify and address any additional workforce issues.
6 (3) A list of any home and community-based
7 services provided under the State Medicaid plan (in-
8 cluding any waiver of such plan) [as of the date of
9 enactment of this Act], including a breakdown of
10 use of such services by different disability popu-
11 lations and by gender, race, ethnicity, geography,
12 and other demographics, compared to such services
13 that are required under the amendments made by
14 section 3, and a description of numerical goals to in-
15 crease access to such services that have barriers to
16 access for populations in need of such services.
17 (4) A description of how the State will incor-
18 porate existing State disability agencies into the new
19 unified provision of home and community-based
20 services and how such State will ensure that such
21 services address all functional impairments.
22 (5) An explanation of how the State will ensure
23 access to such services.
24 (6) A plan for carrying out outreach and edu-
25 cation activities with respect to the availability of

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1 such services through Aging and Disability Resource
2 Centers and other similar entities (such as entities
3 receiving funds from the Administration for Commu-
4 nity Living or the Substance Abuse and Mental
5 Health Services Administration), including a pro-
6 gram that ensures that an individual is not denied
7 such services based on the fact that the individual
8 contacts the wrong entity (commonly referred to as
9 a "No Wrong Door Program").

10 (7) A plan for how such services will be coordi-
11 nated with other relevant State agencies, such as
12 housing, transportation, child welfare, food and in-
13 come security, and employment agencies.

14 (8) A description of how the State will build ca-
15 pacity prior to the implementation of the require-
16 ment described in subsection (a) to ensure that such
17 services are available to every eligible individual
18 under the Medicaid program and how the State will
19 ensure that such services are provided in a setting
20 that meets the requirements specified in paragraph
21 (1) of section 1905(hh).

22 (9) In the case of a State that utilizes an alter-
23 native benefit plan, a description of how the State
24 will ensure that all individuals who are eligible indi-
25 viduals (as defined in such section) are appropriately

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1 identified as medically frail and exempted from such
2 plan.
3 (10) How the State will coordinate eligibility for
4 such services with other disability eligibility pro-
5 grams, such as disability buy-in programs.
6 (11) Data and milestone requirements to ensure
7 community integration, including such requirements
8 with respect to utilization of such services by gender,
9 race, ethnicity, geography, and other demographics.
10 (d) STATE PLAN REQUIREMENT.—Section 1902(a)
11 of the Social Security Act (42 U.S.C. 1396a(a)) is amend-
12 ed—
13 (1) in paragraph (86), by striking "and" at the
14 end;
15 (2) in paragraph (87), by striking the period at
16 the end and inserting "; and"; and
17 (3) by adding at the end the following new
18 paragraph:
19 "(88) provide for the submission to the Sec-
20 retary of an implementation plan described in sec-
21 tion 5(c) of the HCBS Access Act of 2021 prior to
22 the beginning of the first calendar quarter beginning
23 on or after the date that is 5 years after the date
24 of the enactment of this paragraph.".
25 (e) DEFINITIONS.—In subsections (a) through (c):

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1 (1) HOME AND COMMUNITY-BASED SERV-
2 ICES.—The term ''home and community-based serv-
3 ices'' has the meaning given such term in section
4 1905(hh) of the Social Security Act.
5 (2) STATE.—The term ''State'' has the mean-
6 ing given that term in section 1101(1) of the Social
7 Security Act (42 U.S.C. 1301(1)) for purposes of
8 title XIX of such Act (42 U.S.C. 1396 et seq.).
9 **SEC. 6. QUALITY OF SERVICES.**
10 (a) IN GENERAL.—
11 (1) DEVELOPMENT OF METRICS.—Not later
12 than 1 year after the date of enactment of this Act,
13 the Director of the Agency for Healthcare Research
14 and Quality, in consultation with State Medicaid Di-
15 rectors, shall develop standardized, State-level
16 metrics of access to, and satisfaction with, providers,
17 ~~including primary care and specialist providers,~~ with
18 respect to individuals who are enrolled in State Med-
19 icaid plans under title XIX of the Social Security
20 Act, broken down by gender, race, ethnicity, geog-
21 raphy, and other demographics. Such metrics shall
22 include metrics on the total number of individuals
23 enrolled in the State plan or under a waiver of the
24 plan during a fiscal year that required the level of
25 care provided in a nursing facility, intermediate care

Page: 23

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1 facility for individuals with intellectual disabilities,
2 institution for mental disease, or other similarly re-
3 strictive or institutional setting, disaggregated by
4 the type of facility or setting, race, ethnicity, pri-
5 mary language, disability status, age, sex, sexual ori-
6 entation, and gender identity.

7 (2) PROCESS.—The Director of the Agency for
8 Healthcare Research and Quality shall develop the
9 metrics described in paragraph (1) through a public
10 process, which shall provide opportunities for stake-
11 holders to participate.

12 (b) UPDATING METRICS.—The Director of the Agen-
13 cy for Healthcare Research and Quality, in consultation
14 with the Deputy Administrator for the Center for Med-
15 icaid and CHIP Services and State Medicaid Directors,
16 shall update the metrics developed under subsection (a)
17 not less than once every 3 years.

18 (c) STATE IMPLEMENTATION FUNDING.—The Direc-
19 tor of the Agency for Healthcare Research and Quality
20 may award funds, from the amount appropriated under
21 subsection (d), to States for the purpose of implementing
22 the metrics developed under this section.

23 (d) APPROPRIATION.—There is appropriated to the
24 Director of the Agency for Healthcare Research and Qual-
25 ity, out of any funds in the Treasury not otherwise appro-

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1 priated, $200,000,000 for fiscal year 2021, to remain
2 available until expended, for the purpose of carrying out
3 this section.

4 **SEC. 7. WORKFORCE DEVELOPMENT.**

5 【*To be supplied.*】

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