PARTNERSHIP FOR MEDICAID HOME-BASED CARE

The Biden-Harris Administration issued a Request for Information on Access to Care and Coverage for People Enrolled in Medicaid and CHIP on February 17, 2022. The Partnership for Medicaid Home-Based Care (PMHC)[1] submitted the following responses to the Centers for Medicare and Medicaid Services' questions, which appear in bold.

PMHC was established in 2015 to advance the delivery of high quality, cost-effective Medicaid home-based care and services. Our membership is comprised of providers, associations, managed care organizations, and technology solutions companies united in improving the quality and integrity of cost-effective Medicaid home and community-based services (HCBS). Home care workers, also known as direct care workers or caregivers, provide essential care and supports to the most vulnerable populations, including seniors, individuals with disabilities, and medically complex children, to help them with activities of daily living so they can remain in their homes. PMHC member companies employ approximately 300,000 direct care workers throughout the country.

Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage. CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.

2. **What additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?**

The Partnership for Medicaid Home-Based Care (PMHC) appreciates the opportunity to provide a response to Centers for Medicare & Medicaid Services (CMS) Access to Coverage and Care in Medicaid and Children's Health Insurance Program (CHIP) Request for Information (RFI). PMHC was established in 2015 to advance the delivery of high-quality, cost effective Medicaid home-based care and is comprised of organizations representing providers, state associations, payers and business affiliates who came together to work with decision makers to improve the quality and integrity of home- and community-based services (HCBS).

Eligible individuals should be able to apply, enroll in and receive HCBS benefits in a timely and streamlined manner that promotes equitable coverage. PMHC recommends consideration of the following proposed improvements and strategies.

[1] Members of PMHC include: Addus Homecare, AlayaCare, Aveanna Healthcare, Axxess, BAYADA Home Health Care, BrightSpring Health Services, CareBridge, CareCentrix, Caring Home Care Inc., CellTrak Technologies, Centene Corporation, Council of State Home Care and Hospice Associations, Help at Home, HHAeXchange, Home Assist Health, LHC Group, Sandata Technologies, Simplura Health Group, TEAM Public Choices, Tendercare Home Health Services, and Thrive Skilled Pediatric Care.

Presumptive Eligibility. PMHC recommends that CMS provide states with additional flexibility and matching funds to enable wider use among states of presumptive eligibility, so that states bear less of the risk. Currently, states bear all the financial risk if someone presumptively determined eligible does not ultimately enroll in Medicaid. Use of presumptive eligibility is more common in institutional placement like nursing homes and skilled nursing facilities (SNF) than in HCBS, which results in more individuals electing institutional long-term care than HCBS simply due to a lack of options.

The Connecticut Association of Area Agencies on Aging estimated in 2013 that the state could save $6,033 per month for every client deemed presumptively eligible for HCBS rather than paying for institutional care. The Connecticut Home Care Program explores Medicaid eligibility for approximately 2,157 clients annually. The estimate also showed preventing premature institutional care for one month and for 25 percent of the 2,157 applicants could save the state $3,251,787.[2] Similar results have been achieved in Washington, Colorado, Kansas and Ohio. These examples demonstrates that presumptive eligibility could offer states tremendous cost savings, and is the right thing to do for Medicaid clients.

Premature institutional placement also increases pressure on programs like Money Follows the Person to return individuals to their home and community after institutional placement versus HCBS placement from the onset. HCBS providers could assist with making presumptive eligibility more common. States should be held to a target percentage of successful Medicaid enrollment following presumptive eligibility determinations and could be responsible for the cost of care for individuals not Medicaid enrolled above the target percentage. One way to reduce the burden on states bearing the risk of presumptive eligibility is for the federal government to provide an enhanced Federal Medical Assistance Percentage (FMAP).

Estate Recovery. CMS should provide states with additional flexibility and matching funds to eliminate estate recovery requirements and efforts related to HCBS under Medicaid. In its March 2021 report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) acknowledged that the fear of estate recovery might deter some individuals from seeking Medicaid long-term services and supports (LTSS). MACPAC highlighted that estate recovery contributes to generational and wealth inequality, especially among people of color. Additionally, estate recovery recoups only 0.55 percent of total fee-for-service LTSS spending.

Individuals opting not to accept Medicaid services for fear of state efforts to recoup funds from their estate after death often end up receiving more expensive care under Medicaid as they age or decline in functioning due to their chronic condition. Very often, this results in Medicaid institutional placement at significantly higher cost, which also significantly outweighs the funds recouped under estate recovery efforts by states. We also believe that it is important for providers to have more knowledge about when estate recovery applies and when it does not.

[2] Connecticut Association of Area Agencies on Aging, Legislative Testimony, Aging Committee, February 26, 2013, https://www.cga.ct.gov/2013/AGEdata/Tmy/2013HB-06396-R000226-Marie%20Allen%20CT%20Association%20of%20Area%20Agencies%20on%20Aging-TMY.PDF.

Enrollment Process Aligned to Population. State Medicaid enrollment applications are typically processed by one state agency and are uniform for all Medicaid applicants regardless of age, disability or chronic condition. Different populations have different asset and income types as well as the capacity to respond to requests for information and otherwise follow through on applications. For example, older adults who overwhelmingly have Medicare coverage that covers most of their health care costs may only be applying to Medicaid to receive HCBS. Seniors may not have the support system to help them navigate and follow through on the enrollment process of a state foregoing HCBS, which could result in institutional placement down the road. Some states do rely on the fact that some eligible Medicaid individuals abandon the application process as a measure to suppress Medicaid enrollment. This is a very shortsighted strategy regarding HCBS eligible beneficiaries as it results in higher costs to the state, as well as state and federal taxpayers. In 2018, Illinois initiated efforts to increase Medicaid enrollment among individuals receiving state funded HCBS. Credited with the success of an 11 percent increase in Medicaid enrollment among this population was targeted case management support and centralized processing of applications submitted by seniors.

Additionally, as has been reported,[3] state Medicaid agencies are experiencing labor shortages, which results in enrollment delays. For example, Missouri had more than 70,000 pending Medicaid applications in February and the state Medicaid agency took on average 119 days to process each application, which is significantly longer than the 45-day requirement in federal law.

3. **In what ways can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups, which include, but are not limited to: people living in urban or rural regions; people who are experiencing homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); people with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?**

Medicaid eligibility rules place low importance on an applicant's cognitive needs and focus more on whether individuals require assistance to meet functional needs. It is easy to imagine a scenario in which a senior with dementia is fully capable of performing activities of daily living on their own, yet they still require supervision and cueing to stay safe at home. Based on commonly used assessment items for Medicaid functional eligibility, which examine an individual's abilities to use the bathroom, dress and eat on their own, the individual would not score low enough to trigger Medicaid services unless the person's cognitive impairment is weighted adequately. This flaw in the functional assessment leads many individuals with dementia to be found ineligible for Medicaid services. CMS should consider a benefit redesign, in concert with a functional assessment redesign that allows more functionally capable individuals with dementia to qualify for services. Without Medicaid coverage, these individuals are often cared for by family members who may be ill equipped to meet their cognitive needs or they go without care. While this may result in an increase in Medicaid enrollees in the short term, it would prevent these patients from

[3] Sable Smith, Bram and Rachana Pradhan, A Staffing Crisis is Causing a Monthslong Wait for Medicaid, and It Could Get Worse, April 3, 2022, https://www.npr.org/sections/health-shots/2022/04/04/1089753555/medicaid-labor-crisis.

declining rapidly and later requiring more expensive care in institutional facility settings. Simple redirection and supervision from a home care aide, for example, could allow an individual to stay at home longer and prevent further decline.

Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage. CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income SSI/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).

1. **How should states monitor eligibility redeterminations, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?**

The above recommendations regarding eligibility are directly applicable to ongoing enrollment efforts and minimizing gaps in enrollment.

Aligning enrollment and reenrollment of Medicaid processes to specific populations utilizing HCBS has proven effective at reducing abandoned applications and is directly applicable to ongoing reenrollment. Engaging and, if necessary, compensating the HCBS case management resources to assist HCBS recipients with their Medicaid reenrollment applications, including notification of reenrollment deadlines, would reduce the incident of Medicaid disenrollment, gaps in enrollment and interruption of services among HCBS recipients.

Objective 3: Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this care will be aligned with the beneficiary's needs as a whole person. CMS is seeking feedback on how to establish minimum standards or federal "floors" for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or "floors" would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., by specific state regions and rural versus urban), language needs, and cultural practices.

1. **What would be the most important areas to focus on if CMS develops minimum standards for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?**

Although state and federal measures of quality are important on the administrative front, PMHC recommends that CMS focus on the quality of care for the HCBS recipient. CMS should establish a minimum home care HCBS data set that supports measurement in the following domains across states—consumer health, welfare, quality of life and satisfaction, financial accountability and service provision and delivery.

PMHC recommends that CMS deemphasize compliance regulations mandated by states that do not affect the quality of service to recipients and emphasize measures that are important to recipients and families. As these quality care measures are implemented, CMS should also deemphasize compliance regulations mandated by states requiring provider documentation, which have essentially no impact on the quality of service provided to recipients.
Specifically, PMHC recommends the following quality and process measures:

- Days to start of care from the date of authorization of services.
- Amount of delivered units of service as a percentage of authorized units of service.
- Missed appointments for service delivery and documentation of reason.
- Percentage of appointments for service delivery start timely to the consumers preferred and scheduled start time.
- A measure to capture the continuity of direct service professional providing service to a recipient (turnover of staff specific to the recipient).
- Measures related to recipient discharge such as death, institutional placement, improvement in condition and other*.
- Measures related to physical health costs such as emergency department visits (or alternatively days at home), falls, urinary tract infections (UTIs) and hospitalizations*.

**Such measures are only recommended if implemented in conjunction with value-based programs for dual eligible beneficiaries requiring coordination of services to improve outcomes in these measures.*

Historically, CMS has not provided states with detailed standards regarding HCBS program requirements, employee qualifications and compliance documentation. Instead, CMS has relied on a limited set of requirements and a state plan to ensure compliance and appropriate credentialing. This has led to significant variations in program requirements between state programs. More critically, it places requirements on providers that have little or no correlation to the importance of quality care as would be evaluated by recipients. Over time, such requirements have delved into documentation requirements that distract providers from the focus of care delivery to the client's care plan and recruitment and retention of direct service professionals. Home care providers also face administrative burden in complying with various audits that are not standardized across states or auditing entities.

A common framework to evaluate quality care is the fundamental benefit that helps shape policy decision on access and value of care. The challenges are: lack of a uniform data set, platform for collecting and reporting; vast differences in LTSS programs and services making meaningful measures difficult; and increased unfunded administrative burden that taxes an already stretched provider network. These challenges do not begin to address the differing program goals. However, there is value in undertaking quality initiative to help transform care delivery into a dynamic value-based system where patients are placed over paperwork. The National Quality Forum has developed 11 domains – service delivery and effectiveness; workforce; choice and control; person-center planning and coordination; system performance and accountability; human and legal rights; caregiver support; community inclusion; equity; holistic health and functioning; consumer leadership in system development – that could help inform standardized measure. However, we caution on the use of measures where HCBS providers are held accountable for areas outside of their control or area of influence.

Specific to important service quality metrics for Private Duty Nursing (PDN) and related continuous care services, provided to medically fragile children and adults in their home, we recommend the following measures that are important to recipients and families. As these quality care measures are implemented CMS should also deemphasize compliance regulations mandated by states requiring provider documentation that have essentially no impact on the quality of service provided to recipients.

Structural, process, and outcome measures, along with balancing measures, are all uniquely necessary in evaluating and addressing population health. Special attention is necessary to the type of individuals - short-term acute care verses chronic care recipients who are likely not to get better. The most important structural measure is having an electronic health record that allows for seamless coordination of care across the continuum. Process measures should be based on care practices that support recipients to stay as independent as possible and at home with appropriate support. Such metrics are impossible without a common platform and uniform data set. Low Medicaid reimbursements makes it difficult to invest in such frameworks. As CMS looks to the future, the following quality measures for PDN should be considered as initial measures:

- Hospitalization Measure Description: Percent of pediatric (0-17 years) Medicaid / Managed Medicaid private duty nursing (PDN) recipients in which patients where admitted to an acute care hospital (planned / unplanned) in the 60-days following the admission to PDN.
    - Planned Hospitalization
    - Unplanned Hospitalization
- Unplanned Emergency Department Use Measure Description: Percent of pediatric (0-17 years) Medicaid / Managed Medicaid private duty nursing (PDN) recipients in which patients used the emergency department (ED) but were not admitted to the hospital during the 60 days following the admission to PDN.

Other measures are necessary to address patient/family satisfaction, workforce, such as staff turnover, and continuity of care. Further, and most importantly, measures to address clinical outcomes are necessary, including skin integrity, managing airway/respiratory, hydration/nutrition, infections, and medication management.

CMS should also consider the lack of portability of benefits, especially among individuals receiving PDN care. Children and their families should not be forced to move to another state simply to receive home and community based medically complex nursing care.

The federal government should not provide a financial incentive to states to prioritize the self-directed mode of personal care delivery over other modes of care. From the onset, the value of consumer choice with regards to their services has been foundational to home and community-based services. Consumer choice in all forms includes state choice on structure of program; choice of setting; choice of services (within waiver menu); choice of mode of services; and choice of HCBS provider. CMS should be mindful of the different modes of care and direct the Medicaid Fraud Control Units to disaggregate data on fraud convictions and criminal and civil recoveries to separately reflect fraud in self-directed and agency-provided modes of care.

2. **How could CMS monitor states' performance against those minimum standards? For example, what should be considered in standardized reporting to CMS? How should CMS consider issuing compliance actions to states that do not meet the thresholds, using those standards as benchmarks for quality improvement activities, or recommending those standards to be used in grievance processes for beneficiaries who have difficulty accessing services? In what other ways should CMS consider using those standards? Which of these ways would you prioritize as most important?**

The data collection should align with existing frameworks or care processes to minimize administrative burden. While a state (MCO) must report compliance with waiver assurances and sub-assurances (levels of care, service plans, providers network, welfare and free from abuse, claims payments, and administrative support), these compliance issues cannot be a proxy for outcome measures. Since states are evaluated based on the extent to which these assurances are met, states/MCO will continue to focus program integrity and quality assurance metrics rather than quality improvement, innovation, value-based care, and improved health outcomes. CMS should align measures to focus on patients over paperwork. Metrics should be simple to integrate into existing systems of care so that it minimizes additional administrative burden. There are no uniform data sets for HCBS. Personal care services providers have electronic visit verification (EVV); however, those data are used for billing and cannot be used as a proxy to health outcomes.

PMHC supports the implementation and adoption of open EVV systems, which allows providers to select the EVV system used by their workforce. EVV is a technology solution that, among other benefits, helps to ensure that Medicaid home-based care is provided at the right place and right time. These systems utilize the consumer's own telephone or other mobile technology (smart phones) to verify that care is being provided. EVV provides real-time visibility and accountability to ensure the integrity of Medicaid personal care and home care benefits.

CMS should encourage states to use an open model system to maximize efficiency created by technology. States are in the midst of implementation of EVV systems. A number of states are implementing a closed model EVV system, which requires all providers to use a single selected vendor from the state. One of the benefits of EVV systems is to create efficiency for providers by eliminating the need to collect and process paper timesheets for the purpose of billing and employee payroll. In these closed model systems, providers do not have direct access to the service

data for use in processing employee payroll, therefore requiring a duplicative process to collect employee time worked and requires the provider to ensure the employee time records match the data that is entered into the EVV system. This creates more work than existed under the paper timesheet process. A few states that initially adopted closed model EVV systems have, or are in the process of, converting to an open model system. CMS should provide additional education and outreach to states to encourage the use of open model systems.

States should be able to provide CMS with many of the recommended quality measures proposed above through the aggregation of provider data within the EVV system. CMS should ensure that states and providers have sufficient technical assistance to guarantee the successful implementation of EVV systems. Additional measures could be collected through provider surveys and required reporting that could also be coordinated with the assistance of state trade associations.

CMS should consider using these data and quality measures as benchmark rankings of state performance for use in sharing best practices and ongoing quality improvement within HCBS programs. States or CMS could also use data to rank providers in a provider rating system such as, or similar to, the star rating program.

3. **How could CMS consider the concepts of whole person care or care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?**

PMHC recommends that at a minimum CMS incorporate more information related to physical health, behavioral health and health-related social needs within an LTSS care plan; however, integrating care for dual eligible beneficiaries is the best way to achieve whole person care.

Comprehensive care plan information is critical in engaging HCBS providers in greater whole person care and achieving the objective of improving health and financial outcomes for dual eligible and other HCBS beneficiaries. In-home care direct support professionals spend more time with poly chronic HCBS beneficiaries than anyone in the larger health care delivery system but are frequently kept in the dark as to the nature, acuity and past treatment history of the beneficiary.

HCBS providers identify real-time changes in the condition of this high-risk and high-cost population; however, there is little coordination or incentive within the LTSS system to utilize this information for interventions that would significantly improve an individual's physical health care and reduce Medicaid or Medicare costs. Including the home care aide and/or other HCBS personnel on an individual's care team would enhance whole person care.

CMS needs to develop and implement efforts to better coordinate care for dual eligible beneficiaries receiving HCBS and align incentives for states to integrate care. Currently, there is

no incentive for states to invest state dollars to improve the care for dual eligible beneficiaries when the savings from those efforts benefit the Medicare trust fund much more significantly than to state Medicaid programs. This must be addressed in collaborative demonstration projects engaging states, providers and risk-bearing entities with ongoing support from CMS.

4. **In addition to existing legal obligations, how should CMS address cultural competency and language preferences in establishing minimum access standards? What activities have states and other stakeholders found the most meaningful in identifying cultural and language gaps among providers that might impact access to care?**

The key to ensuring the availability of cultural and foreign language providers within a state HCBS program lies in the overall established structure of the specific Medicaid provider network. States that operate an open all willing and qualified (AWAQ) provider enrollment system generally have more providers than they need and very low engagement from their provider network. Specifically, providers are not focused on the improvement of the overall program as few providers serve enough recipients to be vested in the outcomes and improvements of the program. The result of this type of provider network is higher cost of compliance monitoring, increased incident of provider fraud or non-compliance, and lower Medicaid recipient census per enrolled provider.

CMS should redefine or at least reevaluate, through consultation with states and other stakeholders, the benefits of an AWAQ requirement within HCBS provider networks and what the appropriate qualifications are for a robust but vested network of providers. In-home care services under Medicaid and MLTSS are reimbursed at lower rates than other payers and what agencies charge to private paying consumers. Therefore, the margin after labor costs is very low and results in challenges for providers to ensure sufficient funds to pay for the fixed costs of rent, supervisory staff, systems, compliance and quality, and other operating expenses without having a significant volume of recipients to serve. The larger number of providers there are in the enrolled network, the more difficult it is to attract a sufficient volume of recipients leaving the average provider more financially vulnerable. While choice among providers is an absolute value and necessity, too many choices can denigrate the quality and reliability of services.

Ethnic and foreign language providers are particularly vulnerable to these economic factors as they compete for an overall fewer number of consumers and often lack the resources to invest in systems to better manage their operations. Incubators and coalitions of these providers can give them additional resources and strength in a market. For example, the state of Illinois supports the Coalition for Limited English-Speaking Elderly (CLESE), which provides information, policy interpretation and support for both the state and their coalition provider members.

5. **What are specific ways that CMS can support states to increase and diversify the pool of available providers for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?**

PMHC believes that compensation affects the lack of diversity in the pool of available providers. CMS could improve the diversity of the HCBS workplace and frontline employees by increasing the compensation for employees. Higher compensation has a tendency to result in successful requirement of high quality workers, but to also retain high-quality workers, which in turn decreases turnover rates.

Objective 4: CMS has data available to measure, monitor, and support improvement efforts related to access to services (i.e., potential access; realized access; and beneficiary experience with care across states, delivery systems, and populations). CMS is interested in feedback about what new data sources, existing data sources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

1. **What should CMS consider when developing an access monitoring approach that is as similar as possible across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care programs) and programs (e.g., HCBS programs and dual eligibility in Medicaid and Medicare) and across services/benefits? Would including additional levels of data reporting and analyses (e.g., by delivery system or by managed care plan, etc.) make access monitoring more effective? What type of information from CMS would be useful in helping states identify and prioritize resources to address access issues for their beneficiaries? What are the most significant gaps where CMS can provide technical or other types of assistance to support states in standardized monitoring and reporting across delivery systems in areas related to access?**

CMS needs more valuable and reliable data sources for Medicaid HCBS. EVV is a technology solution that holds the promise to collect additional data points after it is fully implemented in 2023. Waiting lists reflecting individuals who are eligible, but not yet receiving HCBS, are estimates self-reported by states. Data collection through EVV on measures of importance to individuals and their families, such as days to start of care from the date of authorization of services, could supplant estimates that do not allow comparisons across states or the visibility that CMS needs to monitor access to HCBS.

CMS should develop standards for states to report information regarding HCBS to the federal government. The Agency should consider enforcement mechanisms available to ensure state compliance.

Whatever measures are used should be evidence-based, reliable, and valid to produce meaningful metrics. The metrics should be simple to collect and interpret to meet its intended purpose – process, outcomes, structural. Having the ability to consistently compare measures across state-lines, plans, or populations would be extremely important for public policy decisions.

PMHC also recommends CMS mandate biannual rate studies by state Medicaid agencies that include a comprehensive examination of current costs, current and anticipated enrollment numbers and general capacity to fulfill patient needs based on the number of enrolled Medicaid providers in each category of HCBS covered benefits. Rate studies should also include a review and list of rates paid for like services within the state through sources including but not limited to: Older American Act services through Area Agencies on Aging, Centers for Independent Living, State-funded programs, commercial and long-term care insurers and private pay consumers.

2. **What measures of potential access, also known as care availability, should CMS consider as most important to monitor and encourage states to monitor (e.g., provider networks, availability of service providers such as direct service workers, appointment wait times, grievances and appeals based on the inability to access services, etc.)? How could CMS use data to monitor the robustness of provider networks across delivery systems (e.g., counting a provider based on a threshold of unique beneficiaries served, counting providers enrolled in multiple networks, providers taking new patients, etc.)?**

CMS already requires providers to establish and document a rate setting methodology; however, these methodologies are set by each state and approved by CMS. PMHC recommends that CMS be more proactive in offering states a preferred or required methodology that captures all of the costs in the delivery of care including federal and state mandates regarding labor costs including but not limited to minimum wage and mandatory benefits such as sick or vacation time. Costs of compliance, training and other program regulations must also be included in an established rate setting methodology. A review of existing state methodologies to determine best practices could be undertaken and serve as the basis for a recommended or mandated methodology.

CMS should develop a method to approval states' Medicaid Waiver amendments for rate increases more efficiently than the current methodology, which takes 120 days for approval. CMS has up to 120 days to approve these amendments and does not, outside of Appendix K amendments, provide approval retroactive to the date of the increase set by the state. This delay has a direct impact on providers, state administration and legislatures who must often approve the rate increases. This lag in approval also negatively impacts recruitment and retention of direct service professionals. PMHC recommends that CMS approve these amendments retroactive to the effective date of the increase or that CMS shorten this approval timeframe to 30 days. Assuming there is an approved methodology or mandated methodology, the review of the rate increase amendment should be perfunctory. Managed care rates should be similarly adjusted to ensure actuarial soundness and preserve access to HCBS.

Previously provided in our comments are a set of metrics and measures that truly impact quality and recipient satisfaction, we recommend that CMS review and focus more on quality care efforts on these measures and less on documentation requirements.

Other Feedback

1. **Please provide any additional feedback you have for this Request for Information that does not apply to one of the previous questions.**

We appreciate CMS's efforts to improve access to and quality of HCBS and address workforce challenges underlying barriers to access. The home care workforce has been undervalued and underappreciated for too long.

Research shows that in addition to low wages and benefits, a lack of respect and inclusion in overall patient care is another significant barrier to individuals entering the home care field and a leading cause of turnover among the existing workforce. The programmatic structure that establishes Medicaid and Medicare as independent silos is the main contributor to this result. Little improvement has been achieved through the many initiatives requiring integration and coordination among providers and can only truly be addressed by breaking down existing Medicaid and Medicare silos.

We recommend that CMS develop and implement a robust demonstration project to measure the affect that coordinated and integrated Medicaid HCBS care provided to dual eligible beneficiaries has on lowering Medicare physical health costs, improved outcomes and satisfaction of dually eligible beneficiaries.