Recommendations for Subregulatory Guidance
Access Rule: Payment Adequacy Provision

States need clear guidance regarding habilitation services for people with intellectual and developmental disabilities.

The 80/20 requirement of the payment adequacy provision in the Access Rule is applicable only to homemaker, home health aide, and personal care services. However, without a uniform service taxonomy, states and territories have developed their own names and descriptions for the services rendered to individuals with I/DD. As a result, some states may inappropriately apply the 80% direct care compensation threshold to habilitation services for people with I/DD that were not intended to be covered in the Access Rule's payment adequacy provision.

For example, without clear guidance, states may determine that if a habilitation service includes a component of support for activities of daily living, then it is a personal care service and thereby subject to the 80/20 requirement. This is further confused by the recently released companion guide from CMS, which offers that "…a state has the option to indicate when a habilitation service rate includes personal care services or otherwise provide further data nuances while meeting the requirements of the final rule." Allowing states to redefine federally designated terms, such as habilitation services, will inevitably lead to inconsistencies in reporting and thereby thwart future attempts by CMS to perform meaningful and accurate data analysis.

It is important to remember that habilitation services were excluded from the 80/20 provision of the rule due to CMS's recognition of the varied and extensive programmatic costs associated with that service. Habilitation services, such as those provided in residential services and community support programs, for people with I/DD assists those individuals with the acquisition and maintenance of daily living skills, active participation in their communities, and self-advocacy. Programmatic expenses required to support these activities are extensive and variable with the needs of the people being supported and the communities they live in, including but not limited to supplies to assist in skill development, facilities, quality oversight, support costs to participate in community events, and other expenses associated with engagement in self-advocacy opportunities.

When a state categorizes its services for purposes of compliance with the Access Rule, it must consider the service as a whole and not as discrete tasks. Habilitation services can include support with activities which are also addressed in home health, personal care, and homemaker services. However, if these activities are approached as part of a broader service that is intended to support acquiring, retaining, and improving self-help, socialization, and/or adaptive skills necessary to reside successfully in home and community-based settings, then it is a habilitation service. Most states offer home-based, residential, and day habilitation services for people with I/DD, although those services may be named, defined, and described differently in state regulation and waiver applications. Given this variation among states, it is necessary for CMS to provide guidance.

Recommendation: CMS should issue guidance to states to clarify that habilitation services for people with I/DD are not subject to the 80/20 payment adequacy requirement and habilitation services cannot be broken down and redesignated as separate services.

Clear definitions are necessary to ensure accurate reporting.

Although the Access Rule does not require that 80% of payments for habilitation services be spent on direct care worker compensation, it does require *reporting* direct care compensation percentages beginning in four years. Since this data will be reported to CMS, it is of the utmost importance that service delivery expenses are appropriately identified and addressed.

Direct Care Worker

The current definition of direct care worker needs further clarification that frontline supervisors and program managers are direct care workers for purposes of the Access Rule. Due to ongoing and pervasive staff shortages, front line supervisors and program managers often cover shifts and render direct care services to ensure quality. Such positions play a critical role in ensuring accountability and quality as well as creating a career path for experienced direct care workers and should not be left out of efforts to strengthen the direct care workforce. CMS should take steps to ensure compensation to these individuals is included when states report percentages of direct care compensation.

Recommendation: CMS should issue guidance to states that clarifies that frontline supervisors, program managers, other supervisors performing and overseeing direct care are included in the definition of direct care workers.

Benefits

The term "benefits" needs further clarification to better reflect the full extent of beneficial programs offered to direct care workers supporting people with I/DD. Due to decades of underinvestment in home and community-based services, providers have struggled to increase direct care worker wages without adequate reimbursement rates. As a result, providers have developed a wide variety of benefit programs in an attempt to attract and retain the direct support workforce.

Recommendation: At a minimum, benefits included in direct care compensation should reflect the full spectrum of programs offered to direct care workers, including but not limited to:

- Career counseling and coaching;
- Tuition stipends and reimbursement;
- Childcare subsidies;
- Housing assistance;
- Transportation assistance; and
- Employer-funded immunizations (and any associated travel and paid leave).

The list of included expenses should be expansive but not exclusive; in other words, the subregulatory guidance should mention expenses from the above list but also allow for the inclusion of other costs not specifically identified within the guidance.

Excluded costs

Excluded costs also require additional clarification to better reflect expenses related to training, travel, and personal protective equipment. Training and travel expenses for direct care workers vary drastically by service, region, and person being supported. The excluded costs must be flexible enough to capture these expenses to ensure there is sufficient funding available to preserve these crucial activities.

Recommendation: At a minimum, excluded costs should be flexible enough to capture the following expenses related to training and travel, including but not limited to:

- Compensation for an in-house trainer;
- Travel expenses to travel to a training program;
- Interpreter and translation expenses required for trainings;
- Expenses related to train-the-trainer activities; and
- Vehicle and travel expenses when utilized by direct care workers.

The list of excluded expenses should be expansive but not exclusive; in other words, the subregulatory guidance should mention expenses from the above list but also allow for the inclusion of other costs not specifically identified within the guidance.

States should be encouraged to develop small provider percentages and hardship exemptions.

While some providers may have revenue from other areas in order to fund investments in technology, quality assurance, and programmatic expenses, there are limited opportunities for Medicaid-funded providers supporting people with I/DD to use other revenue sources to accommodate (non-compensation) expenditures. If required to meet an 80% threshold, by state direction or otherwise, such providers will be forced to forgo quality-related improvements to their operations or reduce/suspend services, a result that would certainly undermine the proposed rule's intent to ensure greater access to services.

Recommendation: CMS should encourage states to develop, with public input, and implement criteria for small provider percentages and payment adequacy exemptions, for providers who cannot otherwise meet the rule requirements without reducing quality and/or limiting services.