July 3, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-0057-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Proposed *Ensuring Access to Medicaid Services, CMS-2442-P*
Submitted via regulations.gov

Dear Administrator Brooks-LaSure:

On behalf of the American Network of Community Options and Resources (ANCOR), we are grateful for the opportunity to provide feedback to the Centers for Medicare & Medicaid Services (CMS) proposed rule *Ensuring Access to Medicaid Services* (Access Rule). We support CMS' broad goals to increase transparency, standardize data, create opportunities for active beneficiary engagement, and improve access to Medicaid services as required by the statutory equal access provision. The proposed Access Rule includes many provisions that seek to identify issues impacting access which ANCOR has urged recognition of for many years. We greatly appreciate the time and effort CMS has invested to propose the Access Rule and effectuate many of the provisions within it.

In its preamble, CMS acknowledges that the *Armstrong v. Exceptional Child Center* decision underscores HHS' and CMS' unique responsibility "to make determinations *regarding the sufficiency of Medicaid payment rates."*[1] For this reason, it is deeply concerning to ANCOR that the proposed Access Rule does little to address the core objective of the enacting equal access statute: *to assure state plans include payments* which are consistent with efficiency, economy, and quality of care and sufficient to enlist enough *providers*. While the proposed Access Rule would create benchmarks and reporting measures to identify the symptoms of insufficient payments, it is virtually silent in providing redress to the underlying cause and ensuring sufficiency of Medicaid payment rates to enlist enough providers.

Perhaps even more concerning is the proposed Access Rule appears to inappropriately shift the burden of this federal statutory requirement to providers of certain services through the proposed

[1] Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. 27,960, 27,997 (May 3, 2023) (to be codified at 42 CFR pts. 431, 438, 441, 447) (emphasis added) (citing *Armstrong v. Exceptional Child Center*, 135 S. Ct. 1378 (2015) as the basis for CMS' authority to regulate the statutory Equal Access provision, 42 U.S.C. §1396a(a)(30)(A)).

HCBS Payment Adequacy provision.[2] If expanded to services for people with intellectual and developmental disabilities (I/DD), community providers will be forced to cut funding from other areas which also ensure access, such as training, supervision, quality oversight, transportation, technology, and innovation. As discussed below, we urge CMS to remove this provision and support access by addressing the sufficiency of payment rates as required by the governing equal access statute.

Although we recommend specific policy amendments within the proposed Access Rule, including removal of the 80/20 payment adequacy mandate, it is not without recognition of the inherent difficulty of addressing a system in crisis and the enormity of the task before CMS in addressing diminishing access. It will take all stakeholders working together to recommend policy solutions that address the workforce crisis without creating unintended negative consequences to other areas of access. ANCOR remains ready to continue working together with CMS to offer support and solutions that will ensure access to high-quality supports for people with I/DD who rely on these critically important services.

**ANCOR**

Founded more than 50 years ago, ANCOR is a national, nonprofit association representing more than 2,000 private community-based providers of long-term supports and services to people with I/DD, as well as 54 state provider associations. Combined, our members support more than one million individuals with I/DD across their lifespan and are funded almost exclusively by Medicaid. Our mission is to advance the ability of our members to support people with I/DD to fully participate in their communities.

ANCOR offers the following comments, questions, and recommendations to amend certain provisions of the proposed Access Rule. We have organized our feedback by section below, touching upon broad themes and specific recommendations that arise within those topics.

**Direct Support Workforce Crisis**

We appreciate CMS' recognition of the direct support workforce crisis and the impact it has on access to providers and quality of care. Providers must be able to attract and retain qualified workers to remain in operation and available to provide high quality services and supports. Beyond a sufficient number of workers, the direct support workforce must also have adequate training, expertise, and experience to meet the diverse and often complex needs of individuals with disabilities. Without both a sufficient supply of workers and the ability to provide training and quality oversight, providers are unable to meet regulatory requirements and will be forced to close programs and services. The resulting insufficient supply of providers will prevent individuals from transitioning from institutions to home and community-based settings or from receiving HCBS at all, leaving individuals on ever-growing waiting lists.

[2] Proposed § 441.302(k) transposes direct care workforce for providers in the equal access provision by requiring that payments "are adequate to ensure a sufficient direct care workforce" instead of the statutorily required payment sufficiency "to enlist enough providers."

There is, and has been for many decades, a workforce crisis in community-based settings, due to stagnant reimbursement rates and the inability of providers to offer wages that enable them to compete with industries offering entry-level positions, such as fast-food restaurants or retail and convenience stores. This crisis is the greatest barrier to accessing community-based support and services for people with I/DD. The effects of underinvestment in the direct support workforce can be seen in turnover rates of approximately 44% nationally.[3] The onset of COVID-19, brought new pressures and hazards of providing essential, close-contact services and further exacerbated and accelerated the workforce crisis with full-time vacancy rates rising to 16.5% in 2021—a roughly 94% increase from 2019.[4]

Without sufficient and qualified staffing, community-based providers have been forced to close programs and reject referrals at a rapid pace. The recent results of ANCOR's *The State of America's Direct Support Workforce Crisis* found that 83% of providers are turning away new referrals, 92% of providers are struggling to achieve quality standards, and 71% of case managers are struggling to find available providers to connect families with services. As a direct consequence of the workforce crisis, 63% of providers are discontinuing services now with 55% of providers considering additional service discontinuations at the current rate of turnover and vacancy. This represents a staggering 85.3% increase in service closures since the beginning of the COVID-19 pandemic.[5]

ANCOR has consistently proven to be an open and transparent partner in bringing forward these concerns to CMS. We have previewed early findings from *The State of America's Direct Support Workforce Crisis* and shared quotes and testimonials from community providers closing services and programs. These briefs and survey findings are often cited by the Biden Administration in presentations, reports, and grant proposals which identify the direct support workforce crisis and its impact on the community.[6] We continue now, as we have always, to urge collaborative solutions to addressing the root cause of the direct support workforce crisis: stagnant and insufficient Medicaid payment rates that do not include adequate funding for competitive direct support wages.

**HCBS Payment Adequacy Provision**

While we appreciate and support CMS' goal of addressing the workforce crisis, we are gravely concerned that the HCBS Payment Adequacy provision mandating 80% of all payments for certain services go toward direct care worker compensation will have the opposite impact of improving access and could ultimately lead to additional closures, decreased availability of direct care worker positions, and diminished access to services. The 80/20 mandate—requiring at least 80% for compensation of direct care workers and necessitating a cap of 20% on all other necessary expenses—would not ensure adequate payment, but rather force drastic cuts to

[3] NAT'L CORE INDICATORS INTELLECTUAL & DEVELOPMENTAL DISABILITIES, 2021 STATE OF THE WORKFORCE SURVEY REPORT (2022).
[4] *Id.*
[5] AM. NETWORK OF CMTY. OPTIONS & RES, THE STATE OF AMERICA'S DIRECT SUPPORT WORKFORCE CRISIS 2022 (Oct. 2022)[ANCOR 2022 SURVEY].
[6] *E.g.,* Exec. Order No. 14,095 88 Fed. Reg. 24,669 (2023); ADMIN. FOR CMTY. LIVING CTR FOR INNOVATION & P'SHIP, STRENGTHENING THE DIRECT CARE WORKFORCE: A TECHNICAL ASSISTANCE AND CAPACITY BUILDING INITIATIVE (2022).

programmatic and administrative expenses that are also necessary to ensure access. We urge CMS to remove the HCBS Payment Adequacy provision from the final Access Rule and consider proposals pursuant to the equal access statute which would address insufficient Medicaid payment rates.

1. *HCBS systems are not one-size-fits-all, and a single percentage threshold does not adequately capture the inherent and unique differences in programmatic and administrative expenses across distinctly separate services and states.*

States are required to conduct rate-setting activities for HCBS services which identify critical components of service delivery necessary to ensure quality supports and meet federal and state regulatory requirements.[7] While direct care compensation is a crucial factor in rate-setting, it is not the only category of expenses necessary to delivering services. Sufficient funding for infrastructure-related expenses is also a critical element of high-quality service delivery as providers need resources to train and supervise direct care workers, invest in expanding program offerings, coordinate paid and unpaid supports across providers and within the community, and monitor service delivery. Program expenses, such as quality assurance, direct care supervision, and administrative reporting measures, are a key component of service providers' infrastructure and of service quality. Additionally, providers need sufficient administrative structures, such as billing and accounting, human resources, and office supplies and leases, to successfully manage their organizations and remain in compliance with state and federal laws.

We are concerned that some of CMS' public statements on the proposed 80/20 mandate inaccurately state that expenses outside of direct care compensation are "administrative overhead or profit."[8] No rate model includes an allowance for profits. Furthermore, administrative expenses for I/DD services are almost always expressed as a single line item, rarely exceeding 10% of the overall rate, even though that line item must encompass the extensive expenses necessary to remain in compliance with state and federal labor and business laws. Setting a single percentage compensation threshold will not assure competitive compensation or substantive increased wages, but it will create drastic cuts to infrastructure-related expenses necessary to remain operational as well as to deliver and monitor quality services and supports across geographies and levels of need.

It is imperative that each cost component within the payment rate is accounted for and appropriately funded as different services and states have unique expenses. For example, rural geographic areas may require a higher percentage allocation for transportation to support access in areas that can be only reached through extended vehicle or air travel. Moreover, states that require additional licensing and reporting measures may require a higher programmatic expense allocation to meet a higher degree of oversight. Even within the same service of the same state, CMS' HCBS technical guidance recommends states consider additional rate adjustment percentages to account exclusively for increased programmatic expenses for serving individuals

[7] CTRS. FOR MEDICARE & MEDICAID SERVS., TECH. GUIDE, APPLICATION FOR A §1915(C) HOME AND COMMUNITY-BASED WAIVER V. 3.6 (2019) [2019 CMS TECH. GUIDE].
[8] *E.g.,* Ctrs. for Medicare & Medicaid Servs., *Fact Sheet: Ensuring Access to Medicaid Services (CMS 2442-P) Notice of Proposed Rulemaking* (Apr. 27, 2023).

who have differing support needs as well as geographic adjustment factors to reflect differences in the costs of furnishing services in different parts of a state.[9]

Further, simply assigning a percentage does not equate to consistency of raised wages for the direct care workforce. If the state already limits investments in quality oversight and program support, it may have fewer expenses to cut from (e.g. transportation, staff training, higher staffing ratios), which would mean decreased quality of care for minimal, if any, substantive increase to wages across thousands of direct care workers. Moreover, since the threshold is expressed as a percentage, the dollar value will vary vastly across reimbursement rates. For example, assuming the program cuts could be shouldered, a $100/unit reimbursement rate would equate to $80 for direct care compensation whereas a $50/unit reimbursement rate would only equate to $40. Accordingly, the mandate could exacerbate issues of parity across the same direct care workforce.

When any rate is left unadjusted for increased costs and inflation for years at a time, each of these cost components become insufficiently funded and risk access to services. If a payment rate does not already allocate 80% of its rate to compensation, community providers will be forced to cut the remaining already under-funded components related to programmatic and administrative functions to meet the mandate. If a payment rate already allocates 80% of its rate to compensation, direct care workers and all other cost components will remain under-compensated at the same funding level. This will inherently cause disparate negative impacts on services and states with higher programmatic needs and leave the remaining states and workforce without impact of any kind.

The HCBS Payment Adequacy provision does not account for inherent differences in programmatic and administrative requirements across distinctly separate services and states and we urge its removal from the final rule.

2. *The 80/20 mandate is neither driven by data nor tested by community practice and the proposed rule has failed to articulate how it would mitigate the likelihood that establishing such a threshold would further damage access to the provider network.*

CMS does not cite relevant data to support the imposition of an 80% threshold, instead requesting commenters to provide the data and justification for its proposed mandate. CMS appears to rely exclusively on two sources of insufficient data: "feedback from States that have implemented similar requirements for payments for certain HCBS under section 9817 of the ARP" and "other State-led initiatives."[10] CMS does not identify the states referenced and the unspecified feedback it reports receiving is inconsistent with feedback ANCOR has received from both states and community providers.

CMS suggests that HCBS initiatives funded by the American Rescue Plan Act (ARPA) included similar successful initiatives. However, inherent in the spending plan narratives pursuant to ARPA was a temporary 10% FMAP increase. No state spending plan narratives created a rebasing of underlying reimbursement rate as indicated by the 80/20 mandate; rather some states

[9] 2019 CMS TECH. GUIDE, *supra* note 7.
[10] Medicaid Program; Ensuring Access to Medicaid Services, 88 Fed. Reg. at 27,983.

offered a *percentage of the increase* to go toward direct care compensation, recognizing the rate as underfunded across all components.[11] Moreover, these increases were temporary and only available against one-year of billing from April 1, 2021 through March 31, 2022.[12] ANCOR's research has been unable to identify a single state which rebased its underlying reimbursement model to assess a new direct care compensation threshold pursuant to its ARPA spending plan narrative and CMS has not provided citation in the preamble to suggest otherwise.

With reference to "other State-led initiatives," CMS cites only two states with limited statutorily mandated percentage thresholds: Illinois and Minnesota. However, neither state requires an 80% threshold, and the impacted services and expense categories are distinctly different from those proposed by CMS. Illinois' mandate is 77% of reimbursement for limited services specific to Illinois' Medicaid program and includes different expenditure categories, including "the participant incurred expense that may have been applicable for direct service worker costs prior to July 1, 2010"[13] and allowing flexibility for the state to establish "other costs approved, in advance, as direct service costs."[14] Minnesota's mandate is 72.5% of reimbursement and similarly impacts a distinct set of services specific to Minnesota and includes explicit disregards for expense categories such as "reasonable costs associated with the worker training and development services."[15]

CMS has not proposed the 80/20 mandate consistent with either of the two states it references, nor has it produced data which indicates whether these initiatives were successful in raising wages or expanding access. As relatively new statutory measures, this may be due to a lack of available data assessing the impact which may inform later revisions. Notable also are the comments submitted to the proposed Access Rule from 51 state associations of community providers urging removal of the 80/20 mandate with concerns for inconsistency in state application and unintended consequences of diminishing access if the mandate were to apply to I/DD services.[16] This letter includes representation from community providers of both Illinois and Minnesota.

The HCBS Payment Adequacy provision fails to articulate supportive data or mitigating measures against further damaged access to the provider network and we urge its removal from the final rule.

**Habilitation Services**

In its preamble, CMS requests comment on whether the proposed requirements at § 441.302(k)(3)(i) should be expanded to apply to habilitation services provided to people with intellectual and developmental disabilities. ANCOR responds to this question with a resounding no. As addressed above, the 80/20 mandate would not ensure adequate payment, but rather

[11] *See* Ctrs. for Medicare & Medicaid Servs., *ARP Section 9817 State Spending Plans and Narratives and CMS Approval Letters*.
[12] American Rescue Plan Act of 2021, Pub. L. 117–2, § 9817 (2021).
[13] ILL. ADMIN. CODE tit. 89 § 240.2040 (2019).
[14] ILL. ADMIN. CODE tit. 89 § 240.2050 (2008).
[15] MINN. STAT. § 256B.85, subd. 11(e) (2022).
[16] Letter from 51 State Associations of Community Providers, to Ctrs. for Medicare & Medicaid Servs. (Jun. 27, 2023) (filed on federalregister.gov).

necessitate drastic cuts to programmatic and administrative expenses which are also necessary to ensure access in order to meet the mandate. As acknowledged in the preamble, habilitation services have additional direct and indirect costs which CMS lacks adequate information, data, or historical community practice to assess.[17] Habilitation services require the ability to adapt funding to meet the differing needs of individuals to integrate successfully into their communities. States must retain the flexibility to assess programmatic funding which reflects the unique characteristics of their communities and the needs of people with I/DD to successfully achieve community integration.

Identified with the provision of services to people with I/DD and other related conditions, habilitation services are distinctively designed to assist in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.[18] While they may include components of support for activities of daily living, the facility, training, quality oversight, and support costs are extensive and variable with the needs of the participants and the community. These services go beyond simply performing an act on behalf of the person, to establishing a structure of support and learned skill building to offset the impact of hundreds of years of routine institutionalization, discrimination, and stigma.

1. *Without commensurate funding to meet the mandate, community providers would be forced to cut funding from other areas which also ensure access and health equity, such as training, supervision, quality oversight, and transportation.*

ANCOR fielded a survey of community providers to assess the impact of the HCBS Payment Adequacy mandate if expanded to services for people with I/DD.[19] The following is an overview of the approximate topline survey findings:

- **81%** of respondents indicated that the HCBS Payment Adequacy provision would negatively impact their ability to provide services.
- **79%** of respondents indicated that the HCBS Payment Adequacy provision would negatively impact the quality of services provided.
- **84%** of respondents indicated that they were concerned that the HCBS Payment Adequacy provision would reduce access to services.

Respondents were asked which service expenses they would need to reduce or eliminate, if any, in order to comply with the mandate. The highest identified expense category for reduction or elimination was quality oversight. **Sixty-five percent** of respondents indicated that they would need to reduce or eliminate quality oversight expenses—such as internal systems that monitor service delivery, quality assurance and incident management—to comply with the 80/20 mandate.

[17] Notably, the requirements for certain services in Minnesota and Illinois cited by CMS in the preamble do not extend to habilitation services.
[18] 2019 CMS TECH. GUIDE, *supra* note 7.
[19] ANCOR 2022 SURVEY, *supra* note 5.

These findings are especially concerning given the high degree of new quality oversight requirements and reporting measures within the proposed Access Rule. As one respondent from Washington reported, "We would be spending a higher percentage on DSP wages [were the HCBS Provider Adequacy provision to impact I/DD services], but those DSPs would be relatively unsupervised, unsupported, untrained, and unprepared to do their jobs."

While we understand CMS' focus on compensation, the mandate would undercut other areas that support the direct support workforce. The remaining 20% of payments expected to cover all programmatic and administrative expenses would force cuts to positions of career advancement. For example, many states mandate positions of direct support supervision for habilitation services, such as a home/facility manager or clinical and professional oversight to meet an individual's medical, behavioral health, and/or community integration needs. These positions fall outside of the scope of direct care compensation but are crucially important to support the workforce and meet state regulatory compliance. These supervisory and/or clinical oversight positions would need to be significantly reduced or struck entirely, effectively closing a career path for direct support professionals seeking promotions and advancement. Accordingly, states which have made these investments and instituted regulatory requirements in quality oversight may find themselves in a place of reduced access if unable to quickly remove these additional expenses to meet the 80/20 mandate.

Community-based providers often incur additional non-Medicaid reimbursable expenses to support beneficiaries to access resources that have an impact on social determinants and health equity. This may include lowering or subsidizing fair market rent to support beneficiaries to have accessible affordable housing or purchasing unfunded items to support individual needs. It may also include providing funding for life enhancement activities such as special events, holidays, and vacations. While providers offer these opportunities to beneficiaries distinctly and separately from Medicaid reimbursement, it is likely community providers would need to divert this funding away from non-regulatorily required initiatives in order to meet the mandate.

If expanded to I/DD services, community providers would be forced to cut funding from other areas which also ensure access and health equity, such as training, supervision, quality oversight, and transportation and we urge the mandate's removal from the final rule.

2. *Community providers unable to shoulder the cuts to infrastructure will be forced to close, thereby decreasing access, and creating a disparate impact to smaller rural providers.*

The most significant concern expressed by respondents to our survey is that if the proposed 80/20 mandate were applied to I/DD services, they feared that inadequate resources would lead to the further discontinuations of services.

Specifically:

- **35%** of respondents indicated that they were concerned that they would need to discontinue key services to comply with the HCBS Payment Adequacy provision.
- **31%** of respondents indicated that they were concerned that they would need to narrow their range of service offerings or serve a more limited geography in order to comply with the HCBS Payment Adequacy provision.

Respondents expressed significant concern for the proposed rule's lack of recognition of the expenses necessary to operate a service delivery organization in compliance with all oversight measures, quality reporting, and state and federal regulatory requirements. A respondent from Maine summed up this concern succinctly by saying, "[w]e are so lean as it is there is not much to cut from, so we would likely need to close several service lines."

When asked what currently presents the greatest barriers to access, respondents indicated the top three barriers as follows:

- Reimbursement rates do not allow for a competitive wage (90% of respondents).
- Regulatory burdens make it difficult or impossible to direct more resources to DSP wages (63% of respondents).
- There are not enough people in the overall workforce (62% of respondents).

This part of the survey also revealed that respondents feel strongly that the proposed HCBS Payment Adequacy provision would not overcome core barriers to access. A respondent from Alaska, for example, shared, "Programs are not one-size fits all [and] many of our costs are fixed or unavoidable, so much depends on the [reimbursement] rate, and the rate has historically been far below market."

CMS is aware of the unique challenges faced by beneficiaries seeking community-based services, including limited transportation options, shortages of health care services, and an inability to fully benefit from remote and broadband dependent supports and services, which often result in worse health outcomes and higher rates of preventable illness than for those living in urban areas.[20] Moreover, rural America faces a "fragmented heath care delivery system, stretched and diminishing rural health workforce, affordability of insurance, and lack of access to specialty services and providers."[21] People with I/DD and the community providers in rural areas that support them face these same challenges and would be further disadvantaged if the 80/20 mandate were implemented and expanded. Accordingly, the proposal is inconsistent with the CMS Rural Health Strategy objective to improve access to care through provider engagement and support.[22]

If expanded to I/DD services, community providers unable to shoulder the cuts to infrastructure would close, thereby decreasing access. We urge the mandate's removal from the final rule.

3. *The 80/20 mandate is vague, ambiguous, and lacks clarity in implementation.*

We also have significant concerns that the rule is unclear and would lead to confusion and inconsistency in implementation at the state level. The proposed Access Rule, as written, applies the 80/20 mandate to personal care services, home health aide services, and homemaking services. While it is clear from the preamble that CMS did not intend the Payment Adequacy

[20] CTRS. FOR MEDICARE & MEDICAID SERVS, COMMUNITY HEALTH ACCESS AND RURAL TRANSFORMATION (CHART) MODEL (last visited July 2, 2023).
[21] *Id.*
[22] *See* CTRS. FOR MEDICARE & MEDICAID SERVS, RURAL HEALTH STRATEGY GUIDE (last visited July 2, 2023).

provision to apply to I/DD services, it is less clear how states will interpret the rule as currently drafted.

It is evident that I/DD services are distinctly habilitation services, as skill-building services focused on supporting individuals through community integration. States, however, do not consistently report service taxonomy with references to these categories within their waiver applications, often using nonspecific type-of-service codes or unique state-specific codes and classifications. This may make it difficult for states to clearly identify the impacted personal care, home health aide, and homemaking services against identified services with facility or other indirect costs such as adult day health, habilitation, and day treatment. It risks even broader devastation to an already fragile system of care if the rule were to be inconsistently applied from state to state or inappropriately expanded into services for people with I/DD.

A clearer method of ensuring sufficient payment for direct support workers is to require regular review and update of all state Medicaid payment rates. Although I/DD services are composed of habilitation services and not currently within the HCBS Payment Adequacy provision's purview, addressing stagnant and insufficient payment rates supports the direct care workforce across all HCBS without potential for inconsistent application. Regular review of payment rates to adjust for inflation and include competitive compensation and adequate programmatic expenses within the underlying payment rate model would more effectively further the rule's intent to address the direct care workforce crisis and increase access.

The 80/20 mandate is vague, ambiguous, and lacks clarity in implementation and we urge its removal from the final rule.

**Payment Rates**

We appreciate the efforts CMS has made within the proposed Access Rule to support transparency of payment rates. Requiring states to publish their rates in a clearly accessible, public location on the state's website with the date the rates were last updated will help stakeholders identify when rates have stagnated without adjustment for inflation, cost of living, and increased costs of service delivery. Further, we support the proposed requirements that trigger additional analysis and rationale for rate reduction or restructuring which could diminish access, and we urge CMS to require this level of analysis for any reduction or restructuring which results in a decreased expenditure of any kind to all HCBS services.

That said, it can be difficult to interpret payment rates without additional information about the service rate model (i.e. underlying cost factors and assumptions which compose the rate) and the frequency of rate review (i.e. how often the rate is assessed for adequacy against current expenses). States are currently required to review their rate setting methodology, at minimum, every five years to ensure that rates are adequate to maintain an ample provider base and to ensure quality of services. Moreover, states are further required to include in their waiver applications and amendments the following:

- When rates were initially set and last reviewed;
- How the state measures rate sufficiency and compliance with §1902(a)(30)(A);
- The rate review method(s) used; and
- The frequency of rate review activities.

However, providers and community stakeholders report difficulty accessing this level of detailed state assurances. This information, alongside the rate model, is critically important not only for CMS, but also for stakeholders assessing risks and threats to access. For example, changes to rates are often conducted without comprehensive review and assessment against the underlying rate model. This can lead to confusion in the community as to whether an increase or cut is applied to a single component (e.g. direct care wages) or applied proportionately across each component. Furthermore, if a state has conducted a comprehensive rate review which recommends increases in each component, the impact to the rate model is unclear and distorted if the rate is only partially funded. Ensuring transparency of these issues would allow stakeholders to better assess the impact reimbursement rates have on access to quality services.

The need for greater transparency is especially apparent in the discussion of direct care wages which are inextricably linked to adequacy of reimbursement rates. Transparency of the underlying rate model would allow stakeholders the opportunity to assess the sufficiency of the wage, benefits, and other employee related expenses within the rate itself. Moreover, it would allow informed discussion within the Medicaid Advisory Committee, beneficiary representation, and other stakeholder groups in assessing whether a rate model appropriately values the policy requirements of the position and remains competitive with the needs of the workforce.[23]

To support greater transparency and adequacy of review, we recommend CMS amend § 447.203(b)(1) to include alongside the payment rate and date of last update:

- The date when rates were initially set with hyperlink to the underlying rate model;
- The last rate review method(s) used and any corresponding adjustment to the underlying rate model; and
- A schedule of future rate review activities not to exceed two (2) years from the date of last review for each service.

**Medicaid Advisory Committee**

ANCOR supports the strengthening of stakeholder engagement and representation through the establishment of the proposed Medicaid Advisory Committee (MAC) with dedicated beneficiary representation within it.[24] However, it is critically important that there is also dedicated and sufficient provider representation. Without adequate provider representation for each geographic area and service sector, the MAC will lack insight and input on how services are delivered and what the impact of policy initiatives are to service delivery.

[23] In particular, we encourage CMS to advise and consult with the U.S. Bureau of Labor Statistics on the role of direct support professionals as distinct from other direct care occupations like home health aides or personal care aids and the importance of establishing a separate standard occupational classification for direct support professionals. Creating a discrete classification for direct support professionals reinforces CMS' goal of bolstering wages, as states utilize the federal occupational classification code when determining wage assumptions within rate models for direct support professionals. *See* HEALTH MGMT. ASSOCS., REVIEW OF STATES' APPROACHES TO ESTABLISHING WAGE ASSUMPTIONS FOR DIRECT SUPPORT PROFESSIONALS WHEN SETTING I/DD PROVIDER RATES (July 6, 2022).

[24] We recommend CMS consider a different title for beneficiary representation, with beneficiary input, to ensure the corresponding acronym adequately captures the importance of this representation.

We support the broadening of engagement from the Medical Care Advisory Committee's (MCAC) prior review of health and medical services to the MAC's expanded purview into policy development and administration. Not only will this better allow for discussion on social determinants of health, but it will support states to integrate an equity focus more comprehensively and effectively into rulemaking. It may also allow for early recognition of access violations and opportunity to address systemic barriers to access through policy changes.

It is crucial that the MAC and beneficiary representation are empowered and supported with the tools and resources necessary to perform their advisory function. For example, current regulation requires that states seek sufficiency of access to care information from MCACs to inform their access monitoring review plans (AMRP).[25] However, some community providers participating in MCACs report they did not have opportunity for input, do not know whether their state is in compliance with AMRP requirements, and are rarely able to engage state policy-making other than to receive information after decisions have been made.

We urge CMS to require all MAC meetings to be open to the public with adequate public notice and a dedicated time during the meeting for the public to make comment. We further recommend adding requirements to ensure equitable representation across the MAC. We also recommend including procedural requirements which are transparent and accessible to the public on how the MAC and beneficiary representation will be selected and requirements to serve, including allowing a process for at-cause removal if necessary. Moreover, we urge CMS to amend §431.12(g) to require the scope of the MAC's authority to extend advice to all listed topics, at minimum, with the opportunity to expand into other issues determined by the MAC, beneficiary representation, and states. Stakeholder representation is critical to each of the listed topics from changes to services to cultural competency and health equity.

Finally, and most importantly to the equal access provision, we urge CMS to amend §431.12(g) to include a separate item which empowers the MAC and beneficiary representation to review and establish recommendations related to reimbursement rate adequacy and the scheduled frequency of rate reviews across Medicaid services. Policy and reimbursement considerations are often siloed without recognition for the added expense of complying with additional administrative and substantive policy changes. Expanding this scope of authority will allow the MAC to integrate policy recommendations with any increased funding needs and subsequent necessity for rate review.

To support the MAC and better integration of policy with payment adequacy, we recommend CMS amend § 431.12(d) to include a minimum of 25% of dedicated positions for providers across different services and geographies and make the following amendments to subsection (g):

… At a minimum, the MAC and BAG must provide advice on topics related to –

(1) Additions and changes to services;
(2) Coordination of care;
(3) Quality of services;
(4) Eligibility, enrollment, and renewal processes;

[25] 42 C.F.R. § 447.203(b)(2016).

(5) Beneficiary and provider communications by State Medicaid agency and Medicaid managed care plans;
(6) Cultural competency, language access, health equity, and disparities and biases in the Medicaid program;
(7) Sufficiency of scheduled rate-review activities to support the expenses of current and proposed policy requirements; and
(8) Other issues that impact the provision or outcomes of health and medical care services in the Medicaid program as by the MAC, BAG, or State.

**Administrative Capacity**

The current fragility of access to community-based services has created a constant state of flux in service availability. Unnecessary or overly burdensome administrative requirements on community providers must be approached cautiously with recognition for the workforce crisis and the impact on already limited personnel and resources. Community providers are stretched to capacity with the majority of community providers undergoing and considering additional service closures. Administrative workload without commensurate adjustment to reimbursement rates can unintentionally cause more closures and further reduce already diminishing access to community-based services.

We also urge recognition of the implementation and timing of all proposals in the proposed Access Rule. While we support many of the provisions within the rule, each will take considerable time and resources for states and providers to implement successfully and sustainably. Most states have pending corrective action plans to address their inability to meet the compliance deadline for the HCBS Settings Rule. The Electronic Visit Verification compliance deadlines were similarly extended with still many states requiring good faith extensions. States are currently engaged in ongoing redetermination processes and face the termination of emergency flexibilities pursuant to Appendix Ks over the next few months, prompting concern for additional program closures from approximately 78% of surveyed community providers.[26]

1. *States must assess for unfunded administrative burden to ensure the inclusion of new quality measures to the HCBS Quality Measure Set does not unintentionally have a negative impact on access.*

We are supportive of CMS establishing metrics to assess the quality of services and promote public transparency related to the administration of Medicaid-covered HCBS. We appreciate the inclusion of an advisory group that informs the composition of the HCBS Quality Measure Set with dedicated positions for providers and beneficiaries. However, it is crucial in defining the HCBS Quality Measure Set that there is adequate provider input and state assessment to identify and prevent unnecessary administrative barriers to new reporting measures.

The proposed Access Rule allows significant discretion for the Secretary to change the quality measures included in HCBS Quality Measure Set every other year. While we appreciate the inclusion of providers within the list of interested parties, simply allowing for consultation does

[26] Lydia Dawson & Alli Strong-Martin, *Public Health Emergency Unwinding Impact Assessment* (Apr. 18, 2023).

not necessarily ensure new measures that require substantial administrative burden are adequately funded. If new reporting measures are imposed on providers bi-annually without commensurate funding, it may have the unintended impact of forcing additional cuts to activities that ensure greater quality of services—thus undermining the goal of this provision.

We recommend CMS require states to conduct an assessment prior to the imposition of new measures, with sufficient opportunity for provider input, to determine funding needs for any increased reporting requirements.

2. *States must provide adequate time and resources for providers to learn and transition to a new system of reporting*.

We appreciate CMS' inclusion of measures that standardize critical incident reporting and require accountability for operating and maintaining an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. Creating this standardization of data and processes will support states and stakeholders to identify state trends and appropriate response. It will also ensure timely oversight response to incidents which risk the health and safety of people receiving services.

While we support these assurances that states operate and maintain the incident management systems created by this proposed rule, we urge recognition that it will require time and funding for each state to respond and adjust their systems accordingly. Community providers may be required to learn a new system of reporting which will necessitate additional training and administrative reporting. In significant system transitions, community providers are often left to negotiate two separate simultaneous systems at a time of insufficient staffing. Given the gravity of critical incidents, it is crucial that providers are given the tools to be successful through any necessary system changes.

Moreover, we urge CMS to require states to provide payment when delegating critical incidents back to providers to complete investigation. While providers maintain their own policies and procedures for critical incidents which allege employee misconduct, these reviews are separate and have a different focus and purpose than those identified within the proposed Access Rule. Conducting a critical incident investigation on behalf of the state requires separate timeframes and deliverables for response, thus requiring additional resources.

We recommend CMS require states to provide adequate payment when delegating investigation to providers as they would contract any external investigative entity.

**Waiting Lists**

We support CMS' proposal to require annual reporting on state waiting lists metrics, including how the state maintains a list of individuals waiting to enroll, the number of individuals on the waiting list, and the average amount of time that individuals newly enrolled in the program were on the waiting list. Beneficiaries, providers, and other stakeholders will benefit from the increased transparency of how states maintain their waiting lists. We anticipate this level of

transparency will demonstrate the need to develop standardized processes to better quantify accessibility of services.

We urge CMS to consider including additional measures which make clear the criteria in which states determine who is eligible to be on a waiting list, how the state determines prioritization for who comes off the waiting lists, and whether the state maintains separate lists or registries for eligible beneficiaries the state has determined to lack "sufficient need." Without additional metrics, waiting list statistics can be misleading. For example, between 2018 and 2021, 108,000 fewer people were recorded on waiting lists for HCBS. However, just two states – Louisiana and Ohio – account for about 85% of the decrease in that number.[27] Those states achieved that decrease not by providing more funded openings, but through changing their prioritization methodology.

We recommend CMS include additional metrics which would identify any supplemental waiting lists or denials which identify eligible beneficiaries without a state-priorities need.

**Additional Protections for Beneficiaries**

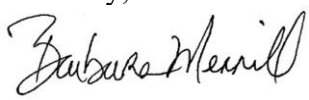
We appreciate the proposed rule's attention to additional provisions that will benefit beneficiaries of home and community-based services and their families, such as clear processes that allow for the filing of grievances, requirements to reassess person-centered plans every year and with changing needs, and the transparency of reporting to the state's website. These protections strengthen the infrastructure of HCBS systems by creating more transparency, clarity, and opportunity for stakeholder engagement and response.

**Conclusion**

Thank you for your work and the opportunity to share this feedback with you. We are grateful for CMS' attention to improving the HCBS service system. Several provisions of the proposed rulemaking present promising opportunities to improve quality, transparency, and consistency. However, the HCBS Payment Adequacy provision will constrain access to HCBS, rather than improving it. We urge CMS to remove the HCBS Payment Adequacy provision in the final rule and instead include measures that will ensure competitive compensation through regular review, transparency, and adjustment of state Medicaid payment rates.

Please do not hesitate to reach out if we can provide additional information or clarification to the above and we look forward to continuing to work together to offer support and solutions that will ensure access to high-quality supports for people with I/DD relying on these critically important services.

Sincerely,



Barbara Merrill, Chief Executive Officer

[27] AM. NETWORK OF CMTY. OPTIONS & RES & UNITED CEREBRAL PALSY, THE CASE FOR INCLUSION: MAKING GOOD ON OUR NATION'S PROMISE OF COMMUNITY INCLUSION FOR ALL (2023).