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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2404-NC
P.O. Box 8013
Baltimore, MD 21244-8013

January 9, 2017

RE: CMS-2404-NC

Dear Mr. Slavitt:

On behalf of the National Association of States United for Aging and Disabilities, please accept these comments regarding the recent Request for Request for Information that you published seeking feedback on Federal Government Interventions to Ensure the Provision of Timely and Quality Home and Community Based Services (CMS-2404-NC). NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities. Our members are responsible for the administration of a wide range of long-term services and supports (LTSS), including state-funded services, Older Americans Act programs, and Medicaid LTSS. NASUAD supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support home and community based services for older adults and individuals with disabilities.

We would like to express our appreciation for CMS' efforts to improve the provision of LTSS and to increase access to home and community based services (HCBS). This RFI creates an encouraging opportunity to assess the current system and to develop strategies that can promote person-centered, flexible, and cost-effective services and supports for individuals who require LTSS. Identifying ways to improve the delivery of LTSS is of utmost importance due to the aging of our nation resulting in a significant increase in individuals who will likely require these supports. In 2004, there were approximately 36 million individuals over the age of 65. By 2014, that number had increased by 10 million people to over 46 million.[1] This growth is expected to continue and accelerate. In fact, over a period from 2010-2029, approximately 10,000 individuals will turn 65 every single day.[2]

[1] http://www.aoa.acl.gov/aging_statistics/Profile/2015/2.aspx
[2] http://www.pewresearch.org/daily-number/baby-boomers-retire/

Our response to this RFI will address each of the discrete questions posed by CMS; however, we would note that the upcoming Administration and Congress will soon be examining and debating the role and structure of publicly funded health-care programs, including Medicare, Medicaid, and the Affordable Care Act's tax credits. Since Medicaid is the predominant payer of LTSS in this country, this forthcoming evaluation could allow for a rethinking of the way that LTSS are structured. We hope that the comments received through this RFI will be used to inform and support Congress and the new Administration as they embark on the process to restructure the health care system.

A restructuring of Medicaid policy can potentially lead to a removal of outdated legacy policies that result in the institutional bias of the program. NASUAD believes that the ideal Medicaid LTSS structure should include the following components:

- Eliminating the institutional bias through parity in financial and clinical eligibility between HCBS and institutional services, removing the requirement that institutional services are the Medicaid entitlement, and eliminating the constraint forcing states to secure a waiver to provide HCBS;
- Establishing eligibility criteria and service designs that promote early intervention and diversion strategies and that enable states to tailor benefits packages that respond different levels of assessed participant need;
- Creating and supporting meaningful choices in residences that suit individual preferences and support needs, ranging from Nursing Homes, Assisted Living Facilities, Group Homes, Shared/Supported Living, and private homes, apartments, and similar residences;
- Establishing strong options counseling supports that provide clear information about and assistance with accessing available services, supports, residences, and other programs for individuals currently enrolled in Medicaid as well as those who are at risk of entering Medicaid-funded LTSS in the near future;
- Incorporating person-centered planning practices that assist beneficiaries control their lives and create service and support plans which reflect the needs and preferences of each individual; and
- Strong protections that establish safeguards against abuse, neglect, and exploitation while simultaneously reducing the risk of fraud, waste, and abuse in the system.

We recognize that many of these policies and practices have already been incorporated into some Federal and state programs; however, the move to this type of coordinated, balanced, and supportive system has been fragmented and wrought with challenges due to statutory inconsistences, outdated and deprecated policies, and rigid requirements that reduce the flexibility of state agencies to implement innovative practices. As CMS assesses the opportunities to improve LTSS and advance the provision of HCBS, we encourage you to think broadly about the flexibilities that currently exist in statute as well as the legislative changes that could be made in order to promote the vision articulated above.

Our comment letter will now address each specific section and question posed by CMS, recognizing that there are specific actions that can be taken to address these issues and improve the provision of LTSS outside of a complete statutory overhaul of the program.

A. What are the additional reforms that CMS can take to accelerate the progress of access to HCBS and achieve an appropriate balance of HCBS and institutional services in the Medicaid LTSS system to meet the needs and preferences of beneficiaries?

1. Potential interpretation of current law regarding Nursing Facilities and the potential for states to offer the mandatory nursing facility benefit only to individuals eligible for nursing facility coverage whose assessed need cannot be met by HCBS.

Despite being developed with the best of intentions, this provision creates significant challenges for state program administration. One of the primary issues is how this provision would interface with the assessment of individuals who are already in a nursing facility at the time of Medicaid eligibility. As you know, many people do not become eligible for Medicaid LTSS until after they have already been in an institution. In many cases their institutional residence has lasted for a considerable period prior to becoming Medicaid eligible. This could include individuals who enter a nursing home as private-pay and spend down to Medicaid eligibility as well as Medicare beneficiaries who receive post-acute and rehabilitative care in a skilled nursing facility. Forcing some kind of HCBS placement for these individuals prior to Medicaid-funded institutional care could be disruptive and detrimental to their care and quality of life.

Additionally, many of these individuals may not have a community residence where they can return as their home or apartment may have been sold or otherwise relinquished during their institutional stay. Without a stable community-based residence available for the individual, such a transition to the community would be challenging and potentially harmful.

The other challenge that this interpretation presents is the issue of person centered healthcare and planning. Though HCBS settings have been found to be strongly and widely preferred by those who receive LTSS, individuals receiving Medicaid should still have the opportunity for meaningful choices regarding their residence and setting of care. NASUAD completely agrees that steps should be taken to eliminate the institutional bias in Medicaid and to place HCBS on an equal and level field; however, we are concerned that the elimination of opportunities for people to freely select a nursing home as their place of residence undermines central tenets of choice and self-determination.

In contrast, we believe that CMS should leverage flexibilities within the statute as well as waiver authority to continue promoting the availability of HCBS as well as the parity between institutional and community-based LTSS. Waivers under section 1115A could offer some intriguing possibilities, especially if the waiver could be extended to cover services provided by both Medicaid and Medicare. This would be particularly useful for addressing some of the challenges related to hospital discharges and institutionalization. If an 1115A waiver allows Medicare post-acute care to be provided in an intensive, holistic, and community-based fashion,

beyond what is currently available through Medicare home health, it could provide greater opportunities to serve individuals in the community and prevent long-term institutionalization. This would require a waiver to convert the Medicare post-acute benefit into an array of HCBS that meets the varied needs of individuals in the community. Any demonstrations or projects under this proposal would also need strong links between the existing aging and disability networks, as well as coordination to ensure that there is no duplication with Medicaid-funded HCBS.

Additionally, NASUAD believes that there is value in pursuing expanded nursing home diversion initiatives for individuals who are not yet eligible for Medicaid but who are likely to require Medicaid-funded LTSS in the future, including those who are considering entering an institution on private pay. These diversions can be coordinated through Medicaid at-risk programs and/or Medicare diversions.

Lastly, we note that major grant programs supporting deinstitutionalization have expired. Rebalancing efforts have been supported in the past by a number of Federal grants, including Real Choice Systems Change grants, Money follows the Person (MFP), and the Balancing Incentives Payment Program. We recognize that the creation of these programs and appropriation of funding is largely the responsibility of Congress; however, we encourage CMS and the Administration to coordinate with is partners in the Legislature to extend the MFP program and to create additional grants that support state efforts to increase rebalancing and community integration.

2. Are there particular flexibilities around Medicaid requirements for LTSS that states would be interested in using 1115 authority to support? How could 1115 authority be structured to streamline the provision of LTSS across authorities, while adhering to budget neutrality requirements?

1115 waivers can streamline the provision of LTSS in a number of ways. States and beneficiaries could benefit from the creation of a consolidated menu of services and supports that are allocated based upon assessed need rather than diagnosis or eligibility category. This consolidation could also reduce administrative burden by reducing the number of waiver renewals that States and CMS must process. The positive outcomes of this approach is evident through state experiences with the 1915(k) benefit, as well as through prior demonstrations.

We support the concept of expanded flexibility and authority to use 1115 waivers to develop innovative HCBS programs. We believe that this process should include expedited approval (aka the CMS "Fast Track" approval[3]) for renewal applications if HCBS policies have been successfully implemented. Similarly, if a HCBS proposal has been approved in multiple other states then there should be opportunities for expedited Federal review when a new state seeks to implement a change through an 1115 demonstration.

[3] https://www.medicaid.gov/federal-policy-guidance/downloads/cib07242015-fast-track.pdf

1115s also provide some interesting and innovative opportunities to expand person and family-centered supports. Some potential examples include models already being implemented such as the Vermont Choices for Care; TennCare CHOICES; and the Washington State Global Transformation waivers. Each of these waivers contains unique eligibility and service components that target the needs of individuals in a less rigid fashion.

We believe that waivers can also be used to promote holistic family-centered models of care. If an 1115 would allow states to expand the unit of care to include family caregivers, it could provide demonstrable savings. Approximately 80% of LTSS is unpaid and delivered by family and friends; thus, Medicaid services that promote and extend the availability of these natural supports is a value-added proposition. Services that enable these informal caregivers to adequately take care of the individuals, such as training, respite, telemedicine, and other supports will prevent caregiver burnout and ultimately reduce the number of individuals who enter paid LTSS in institutional settings.

Lastly, NASUAD believes that budget neutrality for these waivers should continue to be calculated via the "with waiver/without waiver" methodology that allows for modifications due to enrollment growth or service cost inflation. HCBS continues to be a less expensive alternative to institutional and facility based care, and the budget neutrality calculations should acknowledge this financial benefit – thereby allowing creativity and flexibility with the service packages provided. Since the general standard for budget neutrality is that approval would not cost the Federal government more than it would spend without the waiver, cost savings to Medicare should also be considered.

3. What types of eligibility flexibility and controls, including level of care and utilization, could be used to encourage access to HCBS?

As previously mentioned, many of the individuals who enter Medicaid-funded LTSS are already in institutional settings upon eligibility determination. Attempts to implement pre-eligibility diversions and coordination with Medicare hospital discharges and post-acute benefits could begin to address this problem but would likely require modifications to eligibility criteria. Such eligibility flexibilities could include the establishment of an "at-risk" group for LTSS, as well as an option to capture individuals with a chronic condition in Medicare-funded hospital or nursing facility services.

Flexibilities with level of care (LOC) could also provide some value towards rebalancing. CMS has offered states the opportunity to create separate LOC for HCBS and for institutional care via 1115s as well as the statutory option available via 1915(i) services. Allowing the creation of differentiated benefit packages based upon the assessed level of need would be an option for developing a system of care that promotes individualized, person-centered models of care. By allocating more comprehensive services to those with the greatest needs, while simultaneously implementing targeted but limited benefits to individuals with a lower assessed level of care, state Medicaid programs could provide a type of "preventive" LTSS benefit that focuses on

retaining individuals in the community. A diagram of what this type of system could look like is contained in Figure 1.

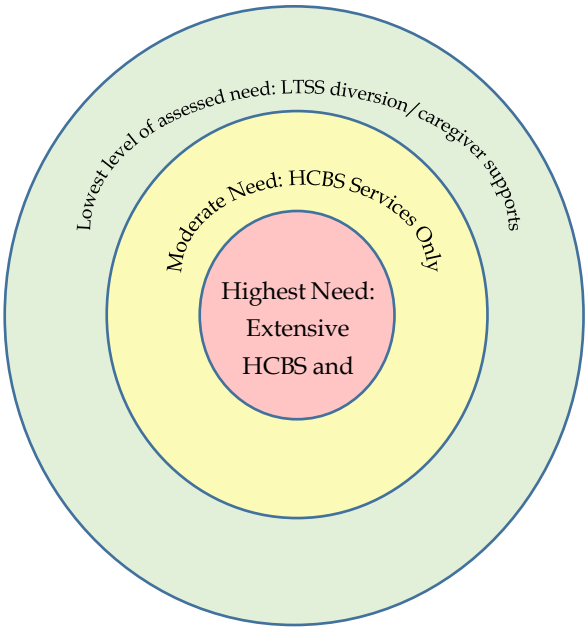

Figure 1: tiered LTSS system allocated based upon need

However, these proposals do create some challenges as many individuals living in institutional settings do not have a home-based setting available. Lowering the LOC for HCBS and/or increasing the institutional LOC and forcing these individuals to enter HCBS could create unintended consequences where affordable housing is unavailable. Such changes should be accompanied by a "grandfather" clause for those currently in institutional settings as well as a concerted effort to improve housing availability. Additionally, implementing a system such as this would require diversion and early intervention strategies that enable individuals to access supports prior to institutionalization as well as policies that preserve an eligible person's rights to enter a nursing facility or similar institution if they so choose.

4. What types of benefit redesign (such as a package of benefits) would improve the provision of LTSS?

Any efforts to increase rebalancing between institutional and HCBS must be accompanied by strong options counseling resources. Individuals' lives are greatly impacted by the decisions regarding the services they receive, the providers that they use, and their location of care. Sufficient supports are absolutely essential in order to assist people understand the ramification of their choices and facilitate meaningful selections from the wide array of services available to them.

These "options counseling services" extend beyond traditional case management or information and referral services and are often needed prior to the formal determination of eligibility and, in many cases, may result in an individual refraining from enrolling in Medicaid. As such, flexibility with the provision of Medicaid-funded options counseling supports, including services to participants who are not Medicaid eligible, would greatly improve the provision of LTSS. The Aging and Disability Resource Centers, authorized by the Older Americans Act, could be used as a model to deliver these supports. Many ADRCs have experience with providing options counseling to Medicaid beneficiaries as well as the broader community. CMS and its Federal partners should invest in the expansion of robust options counseling services nationally in order to assist individuals make informed decisions about LTSS and access services that allow them to remain in the community.

In addition to options counseling, stronger supports between Medicaid and housing are required to improve the provision of HCBS. Medicaid will cover the costs of room and board for individuals residing in an institutional setting, yet it explicitly bans reimbursement for similar expenses in an HCBS setting. Given that many older adults do not enter Medicaid until after they have spent down their assets in an institution, a process which can take months or even years, a substantial number of these people do not have a community residence that would facilitate the transition from a facility. The individual's Social Security benefits are often insufficient to cover rising rent costs and the lack of assets prevents any property purchases. We appreciate the work that CMS has done to articulate the housing supports available through Medicaid. We encourage CMS to continue exploring Medicaid's ability to provide support for housing-related issues, both financially as well as through coordination. 1115 and 1115a waiver authority as well as grants and other flexible sources of funding should be considered. The Administration should also work with Congress to identify additional ways to promote affordable, accessible housing for older adults and people with disabilities.

5. What resource needs, including differences between urban and rural areas, and variations in providing services to different HCBS populations, would need to be taken into account to ensure access to HCBS?

Assuring appropriate access to HCBS represents a different challenge than in other areas of healthcare services. Many measures of access include time and distance standards for groups of providers; however, the individualized nature of LTSS and HCBS mean that broad analyses of provider types are largely inappropriate for these populations. Therefore, assessing adequate access to services should be driven by the person-centered plans rather than by standardized metrics of provider groups.

The difference between rural and urban areas is significant when evaluating proper access to care. In some cases, rural areas may not have sufficient population to support congregate living arrangements and issues related to proximity of providers, access to care, and provider availability should therefore be evaluated in a different manner. Flexible and innovative services, such as telemedicine for HCBS, should be allowed wherever possible. Additionally, CMS should recognize the distinction between cultural norms in rural and urban areas when considering the determination of community-integration for purposes of the HCBS settings requirements established in January 2014.

B. What actions can CMS take, independently, or in partnership with states and stakeholders, to ensure quality of HCBS and beneficiary health and safety?

1. What is the appropriate role for CMS versus the states in ensuring quality of care for Medicaid beneficiaries receiving HCBS? How could CMS and states best monitor quality and beneficiary safety? What actions should CMS take when HCBS are not being delivered according to federal requirements? What evidence would be required to determine when CMS takes these actions?

Quality and safety are core functions of state Medicaid and operating agency responsibility. CMS does not have the capacity to adequately monitor the health and safety of all HCBS participants and should instead provide leadership, policy, and funding that supports state efforts in this area. It is important to remember that State agencies have an equally vested interest in ensuring that participants receive quality HCBS services that safeguard the health and welfare of participants, and CMS should address identified issues in a collaborative and coordinated fashion.

Monitoring safety remains a priority area for states. The development of critical incident reporting and monitoring programs is an important and ongoing effort. We appreciate the work that CMS has done with states to articulate promising practices and to establish a framework of expectations around these types of programs. Similarly, the Administration for Community Living's efforts to establish a national database and consensus guidelines for Adult Protective Services represents a strong step forward for identifying and disseminating best practices, as well as for determining the prevalence of abuse, neglect and exploitation. We encourage CMS to work closely with ACL around these provisions and to identify and expand opportunities for Medicaid LTSS to coordinate and collaborate with APS systems. Yet we note that there is no dedicated source of Federal funding for APS services, creating challenges when states attempt to adhere to the aspirational standards within ACL's guidelines. APS should be strengthened via both policy and financing nationally.

Adequate information technology is also a crucial component of identifying and monitoring trends of safety concerns. Ongoing investment in IT systems that enables states to collect, track, and analyze issues in their system, as well as to ensure that individuals and providers who have a history of creating unsafe environments or engaging in illegal activities are excluded from providing services. CMS should support ongoing efforts to develop and expand IT systems that identify and track critical incidents within the HCBS system. Making enhanced Medicaid matching funds explicitly available for this purpose would go a long way toward improving these systems.

Law enforcement is another critical, but frequently overlooked, partner in these efforts. NASUAD supports the Elder Abuse Prevention and Prosecution Act, which was introduced in the Senate in 2016, and included provisions to increase the Department of Justice's ability to respond to issues related to elder abuse, neglect, and exploitation. We encourage the Administration to work with Congress in order to pass laws that strengthen protections for older adults and people with disabilities, and that also increase the ability to coordinate with partners in the justice community.

Lastly, NASUAD believes that the current structure of developing corrective action plans and collaboratively working with states to address and ameliorate identified issues is the best process to use when HCBS services do not meet Federal guidelines. Other actions that have been proposed, including a suspension of Federal funding or a freeze on waiver enrollment, are unnecessarily punitive measures that negatively impact beneficiaries without addressing the underlying problems.

2. Should there be an oversight structure with conditions of participation in HCBS similar to that of institutions and home health agencies, in which state surveyors report survey findings directly to CMS?

The existing institutional survey and certification processes make sense given the brick and mortar construction of these buildings, but would be challenging to implement for HCBS services. We agree that a federally operated and financed certification process for HCBS could assist with efforts to improve quality management and monitor providers in certain arenas, but are concerned about the challenges it would present for many other HCBS services. Such a process could potentially be effective in facility-based HCBS settings, such as assisted living, provider-operated group homes, memory care facilities, and adult day centers. However, these providers have been established and facilities were constructed based upon existing state regulatory frameworks, safety codes, and licensure reviews. We caution CMS that, if they seek to implement such a program, the requirements should be sensitive to existing state standards in order to minimize the burden and capital costs that these providers have to incur in order to become compliant with the new requirements. We also recognize that many provider groups may oppose such a provision and raise concerns about the intersection between such a requirement and their ability to remain solvent based upon Medicaid provider payment rates; however, we believe that these concerns could be mitigated through proper and thoughtful development of the protocol.

There would also be some challenges associated with requiring all HCBS providers to participate in such a program. Key questions should be addressed before approaching this type of framework. For example:

- How would such requirements apply to providers operating in self-direction models of HCBS?
    - Would the requirement be placed upon independent individuals who are hired by the participant?
- How would this provision relate to entities and providers that are not associated with brick and mortar facilities or with large companies?
- How would this type of requirement be applied to other providers of services that do not involve direct-care, such as home modifications or home delivered meals?

These types of requirements could also place significant burden on small, independent personal care providers, supported employment programs, and other specialized services. As CMS acknowledges in this RFI, the LTSS system is already struggling to attract a sufficient workforce in order to provide services to all individuals who require care. Creating onerous and potentially expensive processes such as a survey and certification review would likely further diminish the provider pool.

Based on these issues, we recommend that if CMS seeks to implement such a program, it should be financed fully with federal funding, and CMS should identify specific HCBS provider groups subject to the review. This type of oversight should not apply to all HCBS providers.

3. What can CMS do to support standardized performance measures for HCBS, including in Medicaid waivers and state plans?

Quality of care is largely a state-operated issue and should remain as such. In other parts of the Medicaid system, CMS has had collaborative involvement in the development of quality metrics, including the Child and Adult core quality measures. However, these provisions are optional for states. We do not believe that it is appropriate to create national, mandatory quality measures for HCBS given the optional nature of CMS metrics for state plan services. However, states are keenly interested in a consistent framework within which they can select vetted and valid quality measures. There are not nearly enough HCBS measures in that group. Because Medicaid is the primary payer for HCBS services, there is no drive from the commercial marketplace to invest the resources necessary to develop and test HCBS measures, such as has happened with HEDIS measures. CMS is the only entity which has the resources to invest in development and testing, as they did with the HCBS CAHPS tool.

CMS should use the HCBS quality framework put forward by the National Quality Forum (NQF) as a guide for quality measurement requirements. This framework suggests a balance between system, provider and individual measures that can be equally applied in fee-for-service as well as managed care delivery systems. This framework also sets forth the critical domains that contribute to quality HCBS. We believe that states should have the flexibility to select valid and reliable measures in any of those domains. States would be pleased to work with CMS towards the development of a menu of quality measures using the NQF rubric, but do not support the imposition of federally mandated-data points or indicators. LTSS and HCBS are uniquely flexible and person-centered services as they often represent the intersection of both health and social supports. The desired outcomes for LTSS generally include medical and health related improvements, but can also include personalized outcomes such as engagement in community or religious activities; employment; or other nontraditional goals. CMS should work with states to develop relevant measures that could be adopted across multiple programs throughout the country, but should allow states to retain flexibility to select measures – within a standardized framework – that work for their programs.

4. What other quality measurement activities could CMS undertake to strengthen the provision of HCBS across any Medicaid authority? What data, reporting and system resources would be necessary to support those activities?

States have long been measuring consumer quality of life for individuals with intellectual and developmental disabilities using the National Core Indicators consumer survey, and have more recently begun doing the same for seniors and adults with disabilities using the National Core Indicators – Aging and Disabilities. While consumer experience is a fundamental aspect of HCBS quality, we suggest that CMS provide the funding to independent measure developers to focus on domains other than those that rely on person-reported outcomes – that is, measures that use administrative data – so as to make effective quality measurement more achievable and cost-effective. Continuing to provide opportunities for technical assistance and access to promises practices – such as is available through the Medicaid Innovation Accelerator Program

– should also continue to be a focus for CMS. Finally, information infrastructure to support quality measurement and reporting is sadly lacking in many states. Like safety reporting, making enhanced Medicaid funding available to states will have the greatest impact on this need. .

5. What other quality measurement activities should CMS require or do to support states and other stakeholders to strengthen the provision of quality HCBS across any Medicaid authorities?

In a recent survey of state aging and disability agencies, NASUAD found that states desire integrated systems that include information across multiple programs such as Medicaid, Medicare, and the Older Americans Act in order to understand the services provided to participants outside of funding silos. States specifically cited the need to include additional information within the agency's database, including data regarding service authorizations, assessments, eligibility, claims data, and participation in other HHS programs. Such coordination and integration would require investment in expanded information technology and reporting criteria. This investment should be supported by state and Federal policymakers, and include broad stakeholder engagement that solicits innovative ideas and secures buy-in from partners, providers, and beneficiaries regarding the steps that must be taken to improve outcomes measurement and reporting.

C. What program integrity safeguards should states have in place to ensure beneficiary safety and reduce fraud, waste, and abuse in HCBS?

1. What are the benefits and consequences of implementing standard federal requirements for personal care workers in agency-directed and/or self-directed models of care?

Standardized Federal requirements could further complicate efforts to expand the available provider workforce. Federal conditions of participation for providers tend to be strongly based upon the benefit provided. However, the variation in personal care models, including the tasks that are performed, the acuity of program participants, and the skill level required by providers, is quite different across the states. Such standard requirements will likely undermine some of the existing workforce and further exacerbate provider shortage issues.

We also note that there are different models of care with varying levels of support provided and training required. Family members and friends who provide limited care, or who are selected by an individual in a self-direction model, may not require the same level of professional experience as other providers. Similarly, one of the tenets of self-direction is the ability of participants to deliver personalized training to their care worker. Depending on the training standard(s) in place, it may be appropriate to provide an exemption from the standard for these types of providers.

Other types of providers may require specialized training beyond minimum qualification standards. This could be particularly relevant if the beneficiaries they work with have conditions that require extra support and training, such as dementia or behavioral issues.

However, these types of specialized training requirements should be left to state discretion since the training would likely be driven by state specific eligibility and service requirements.

Similarly, imposition of national standards for training and certification may not comport with existing state licensure and certification requirements. Such changes could require significant amount of new training for providers in some states. Funding for these activities could be challenging, and it risks providers seeking employment elsewhere.

2. What role could state-administered home care worker registries play in facilitating access to HCBS? What issues should be addressed in the creation of home care worker registries?

Home care worker registries have the potential to be a powerful force in marketing to and recruiting potential providers and assisting beneficiaries to find qualified providers who are well matched to their needs. Strategies to leverage this potential include embedding job matching services within the registry and linking supports for both the beneficiary employer and providers into the registry platforms. It is essential that issues of beneficiary confidentiality and protection of protected health information be considered in determining what information will be stored in the system and who will have access to the system. Home care worker registries could be supported in this by providing matching funds for marketing and recruitment and incentives for other workforce development efforts (such as those funded by the Workforce Innovation and Opportunity Act) to partner with the registries.

Ensuring that Registry workers have access to training to include work force development, recruitment and retention strategies, as well as person centered practices would better prepare the registries for effective provider and beneficiary/employer recruitment. Additionally, the establishment of minimum data requirements for matching service applications (including matching elements, security protocols, direct service support options, and ease of user access) would support quality matches.

It is important that registries are developed and operated in a manner that is beneficiary-centric and this could be supported through use of consumer advisory/stakeholder boards.

3. What issues should be considered in requiring criminal background checks? In the states that are utilizing fingerprinting and background checks already, what lessons can be learned from implementation and experience with these approaches?

States using criminal history and fingerprinting indicated that the processes were marginally beneficial. There are some benefits to this approach, yet there are also some challenges with implementing such a program as well. There are some specific unanswered questions regarding this type of initiative. For example:

- Under a proposal that requires the checks, what entity would be responsible for funding these types of investigations?

- There have been challenges in states where background checks lapse or incidents occur after the period under investigation, so would there be processes that could be established to keep the information current?
- In the event that CMS establishes national mandates for these type of services, what would happen if a provider continued to deliver care in an instance where a certification is lapsed or circumstances change unbeknownst to the state agency?
    - Would the state be liable for an FFP disallowance?

4. Should states be required to enroll or register all PCS attendants and assign them unique numbers for purposes of tracking claims? What is the feasibility for state Medicaid programs of including home care worker identity on claims submitted for Medicaid reimbursement?

NASUAD is concerned about the unintended consequences and administrative burden associated with PCS worker registries and unique identification. A unique identifier for each home care agency employee would create additional complexities for home care agencies when they bill for services and additional administrative burden and expense to assign and manage unique identifiers. How would this provision work with self-directed models where certain providers may not deliver services to anyone except the self-directing participant?

5. What other program integrity safeguards should be put in place, either as an alternative to, or in addition to, the controls recommended by OIG, for agency-directed PCS? For self-directed PCS?

We note that the recently passed 21st Century Cures bill included some significant requirements for LTSS that will likely address some of the OIG requirements. For example, the use of Electronic Visit Verification (EVV) for personal care services will improve the ability of states to verify that services are being provided in the time and place that providers are reporting. As such, we recommend focusing on successful implementation of the EVV rather than creating additional and disparate requirements for personal care services.

6. Are the program integrity safeguards that are appropriate for agency-directed personal care services also appropriate for self-directed personal care services?

It is reasonable to expect more documentation and oversight of larger providers who deliver care to multiple participants. These provider agencies have administrative and supervisory functions that far exceed the ability of individuals. Additionally, one of the core components of many self-directed models is the ability of program participants to hire, train, manage, and fire participants. These individuals must follow the programmatic rules and cannot be complicit in efforts to defraud Medicaid, and we believe that post-delivery audit and reviews are necessary components of such programs. However, we do not believe that it is appropriate to impose significant additional burdens in a system that is already struggling to secure sufficient workforce.

7. How can program integrity safeguards be developed and implemented to support key HCBS programmatic objectives such as choice and self-direction?

Differentiated requirements between agency-directed models and self-directed models will continue to be necessary. In states with self-direction models, CMS and State agencies can leverage financial management system providers (FMS) as partners in anti-fraud and program integrity reviews. These entities have incentives to ensure that claims are paid in an appropriate and accurate manner. FMS vendors have served as a front-line defense against issues of fraud and abuse. We encourage CMS and OIG to support FMS providers with training, technical assistance, and information on software that supports best practices in data analytics, pre and post payment reviews, and other methods for ensuring program integrity.

D. What specific steps could CMS take to strengthen the HCBS home care workforce?

1. What if any actions could CMS take to better ensure adequate beneficiary access to safe HCBS services provided by qualified individuals, across both urban and rural locations and across disparate populations?

We believe that CMS can work with states to identify funding sources, available technology, and promising practices that support the development of worker registries. We also believe that CMS and other Federal agencies, such as the Department of Labor, can work to focus on career ladders, training, and other efforts that support the provider workforce. CMS and states can continue to leverage self-direction models that allow program participants to recruit and hire their workers, potentially expanding the available pool of providers. Lastly, efforts to support family caregivers and other unpaid workers could prevent caregiver burnout and promote the ongoing availability of this source of care for longer than currently exists.

2. Should CMS expand its rate-setting approval authority to support provider infrastructure and the HCBS workforce?

NASUAD is not certain that increased CMS rate-setting requirements and oversight will assist with the issues of provider shortages. States have experimented with increasing rates to entice additional providers into the workforce, and experience has demonstrated that rate increases do not necessarily lead to increased pools of providers. Wages and benefits are an important part of the conversation, but so are training, support, and feelings of value and significance. In another, non-LTSS area, the Affordable Care Act required states to increase payments for primary care services delivered by eligible providers. During an analysis of the policy, MACPAC interviewed eight states. Those states reported that "the payment increase had little effect on recruiting Medicaid primary care providers, as few providers who participated in the increase were new to Medicaid."[4] Perhaps an increased rate could assist with the retention of some providers currently providing Medicaid services, but it is unlikely to entice significant numbers of new home care workers to this field.

[4] https://www.macpac.gov/wp-content/uploads/2015/03/An-Update-on-the-Medicaid-Primary-Care-Payment-Increase.pdf

3. What effect would an increase in payment rates necessitated by a CMS rate review process that focuses on home care worker wages have on funded slots or services, particularly given budget limitations and cost neutrality requirements inherent in many Medicaid authorities?

CMS actions have never focused on specific minimum rate requirements. The CMS access rule from 2015 included reviews of Medicaid payment rates compared to other health insurance programs (such as Medicare, private health insurance, the VA, etc), but specifically did not require states to set minimum reimbursement rates. Extending minimum reimbursement levels to HCBS while excluding other services from this requirement would be contrary to the basic operating protocol and state-Federal relationships within the Medicaid program.

As the experience of the Department of Labor (DOL) home care rule has demonstrated, mandating payment increases for LTSS programs has inherent drawbacks. State agencies must operate within their legislatively authorized funding levels, which are constrained by State legislatures, state balanced budget requirements, and state general fund revenue. The DOL rule led to reductions in hours allotted to providers in order to prevent overtime accrual. Similar unfunded Federal mandates regarding worker pay will likely result in longer waiting lists for services, a reduction in authorized hours of care, and/or reductions in other parts of the Medicaid program.

4. How could CMS determine whether an increase in home care worker wages results in an increase in the quality of services provided and an increase in the size of the workforce such that it will be more likely to meet future industry needs?

Reimbursement rates are a component, but not the sole determining factor, of the number of home care workers in LTSS. Formal and informal surveys of home care workers cited the emotional and physical demands of caregiving as a deterrent to ongoing employment, as well as opportunities in the retail and service sectors. We encourage CMS to identify other innovative ways to work with states in order to support caregivers and identify, recruit, and retain home care workers.

5. What other actions could CMS consider to strengthen the home care workforce such as assessing training needs, developing career ladders, etc.?

We agree that identifying training needs, providing support for education, and promoting career advancement of providers are ways to help strengthen the workforce. Limiting provider burnout and improving retention could have significant positive impacts on the overall availability of care. NASUAD also recommends that CMS develop policies and provisions that assist with promoting and improve opportunities for self-direction as well as supporting unpaid caregivers.

Conclusion

We appreciate the opportunity to comment on the wide range of issues discussed in this RFI. Our nation's population is aging, individuals are living longer, and new technology and medical advances are allowing individuals with disabilities to live longer and more fulfilling lives in the community. Similarly, cultural norms are shifting and participants are rightfully demanding services and supports that are individualized based on each person's needs and preferences. These shifts will force policymakers to seek innovations that allow us to deliver LTSS in a cost-effective, person-centered, and flexible manner. NASUAD and our membership remain committed as partners in designing, improving, and sustaining state systems delivering home and community based services and supports for people who are older or have a disability, and their caregivers. We look forward to engaging with CMS as you review the responses to this RFI and develop strategies to enhance the provision of LTSS for all individuals who require these supports.

If you have any questions, please feel free to contact Damon Terzaghi of my staff at (202) 898-2578 or dterzaghi@nasuad.org.

Sincerely,

Martha A. Roherty
Executive Director
NASUAD