Instructions for Using This Template

Please use this template to help you in drafting written comments to CMS on its proposed *Ensuring Access to Medicaid Services* rule.

Writing Comments

The highlighted text provides opportunities for you to frame your thoughts and comments to CMS. While there is no one correct way to write comments, additional consideration is given to comments which are personalized and reflect the impact of the rule on individual organization. *If you are able, please replace the highlighted text with thoughts and data on the impact the rule will have on your organization.*

Submitting Comments

Before you submit your comments, please double check the following:

- Have you removed this instructions page?
- Have you removed all the highlighted text from the document?
- Have you added the date and your signature?
- Have you saved the document as a PDF?

When you are ready to submit:

- Visit https://www.federalregister.gov/documents/2023/05/03/2023-08959/medicaid-program-ensuring-access-to-medicaid-services
- Click the green button that says "Submit a Formal Comment." This will open the Comment Form.
- Complete the required text fields:
    - In the Comment field, enter "See attached."
    - In the Upload File(s) field, upload your completed comments.
    - In the "Tell us about yourself! I am..." field, select An Organization.
        - For Organization Type, select Organization.
        - For Organization Name, add your organization's name.
    - Check the box corresponding with "I read and understand the statement above."
- Once these tasks are completed, the Submit Comment button will turn green and you will have the ability to submit.

Help ANCOR Understand Your Impact

- After you click the green Submit Comment button, follow this link to send us a quick email letting us know.
- Need additional information about the rule? Visit our Access Rule Resource Center for additional resources or reach out to Lydia Dawson, Director of Policy, Regulatory & Legal Analysis.

[Date]

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 to regulations.gov

Dear Administrator Brooks-LaSure:

On behalf of [Organization Name] thank you for the opportunity to provide feedback to the Centers for Medicare & Medicaid Services (CMS) on proposed rule *Ensuring Access to Medicaid Services*. We appreciate and 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. While much of what was proposed in the rule underscores and supports access, we have concerns that the HCBS Payment Adequacy provision as proposed in § 441.302(k)(3)(i) does not effectively address the underlying issue of payment inadequacy and has the potential to reduce access in an already fragile system of services.

[Insert information about your organization]

[Organization Name] offers the following comments, questions, and requests to the pending rule.

Direct Support Workforce Crisis

We appreciate CMS' recognition of the direct support workforce crisis and the impact it has on access and quality of care. We agree that providers must be able to attract and retain qualified workers in order for beneficiaries to access services they need. We further agree with CMS that the resulting insufficient supply of HCBS providers can prevent individuals from transitioning from institutions to home and community-based settings and at increased risk of hospitalization or institutionalization.

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 hourly wage positions, such as fast food restaurants or retail and convenience stores. This crisis is one of the greatest barriers to accessing community-based supports and services. According to *The State of America's Direct Support Workforce Crisis 2022*, 63% of community-based providers nationally have already been forced to close programs as a direct consequence of the workforce crisis. This represents a staggering 85.3% increase in service closures since the beginning of the COVID-19 pandemic.

[In your own words, add information about how the direct support workforce crisis has impacted your ability to provide services. In this section, you may consider the following questions to help prompt your thinking and personalize your comments:

- Is your organization having difficulty continuing certain services due to the high rates of turnover and vacancies? What does the mean for the future of community services?
- Is your organization having difficulty connecting families with services due to lack of available providers? What is the impact for families waiting for services?]

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, which would mandate that 80% of all payments go toward direct care worker compensation, could have the unintended consequence of decreasing access to services. We urge CMS to remove the payment adequacy provision from the proposed rule and consider proposals that address the root cause of the workforce crisis: stagnant and insufficient Medicaid payment rates that do not include adequate funding for competitive wages.

Without additional funding to meet the mandate, providers could be forced to cut funding from other areas which also ensure access, such as training or supervision, and reduce investments in programming including technology and regulatory compliance. In worst case scenarios, smaller providers unable to shoulder the additional expense, could be forced to close—a result that would undermine the proposed rule's intent to ensure greater access to services.

[In your own words, add information describing concerns you have for ensuring 80% of reimbursements are spent on compensation and/or only having 20% of reimbursements to cover all other necessary expenses. In this section, you may consider the following questions to prompt your thinking and personalize your comments:

- What program expenses are necessary to deliver services at your organization (e.g., supervision, quality assurance, clinical oversight, training, transportation, reporting, overtime, capital costs such as housing, vehicles, home maintenance, etc.)?
- What general and administrative expenses are necessary to deliver services at your organization (e.g., finance and billing, regulatory compliance, workers compensation, administrative costs of quality assurance and reporting, capital costs, etc.)?
- Are you able to cover all the costs above with 20% of the rate? What will you be forced to cut if you do not? Will you have to close any programs, reject referrals, reduce current service offerings?
- What expenses does your organization additionally shoulder or subsidize that support health equity and are not covered by Medicaid payments (e.g., rent, food, life enhancement activities [events, holidays, vacations], unfunded items or activities to support individual needs, vacancies, home and facility maintenance, technology, innovation, etc.)? Be clear that Medicaid payments are not being used for these expenses.
- If you are a small business, in a rural area, or serving beneficiaries with complex needs, will this 80/20 proposal impact your ability to provide services if forced to make cuts?]

For all the reasons stated above, we urge CMS to remove the HCBS Payment Adequacy provision as currently drafted from the proposed rule.

Payment Rates

We appreciate the efforts CMS has made within this proposed 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 stagnant payment rates. Further, we support the proposed requirements that create accountability for attempts to restructure or reduce rates against significant access concerns from beneficiaries, providers, and other interested parties.

While these proposed requirements are a positive step forward in ensuring transparency, the rule does not go far enough to require regular review and update to payment rates. The source of the direct support workforce crisis is payment rates left unadjusted for rising costs, inflation, and increased service expectations for decades at a time. CMS should consider proposals to address stagnant and insufficient Medicaid payment rates that do not include adequate funding for competitive wages. Regular review of payment rates which adjust for inflation and include a competitive wage within the underlying payment rate model would better effectuate the rule's intent to address the direct care workforce crisis and increase access to HCBS.

[In your own words, add information describing whether rates in your state have kept up with rising costs. In this section, you may consider the following questions to prompt your thinking and personalize your comments:

- Have rates in your state kept up with inflation and increased regulatory and program expectations?
- Have you had to make any cuts or reductions to your services because rates did not keep up with rising costs?
- If rates were sufficient to meet the costs of delivering high quality services, would you expand your service offerings?
- How important is stakeholder engagement and advisory functions to ensuring adequate rates?]

Waiting Lists

We support CMS' proposal to require annual reporting on state waiting list metrics including how the state maintains a list of individuals who are waiting to enroll in the waiver program, the number of people 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, which will demonstrate the need to develop standardized processes from states to better quantify accessibility of services.

We urge CMS to include additional measures that make clear the criteria in which states determine who is eligible to be on a waiting list, how states determine priority for who comes off of the waiting lists, and whether states maintain separate waiting lists or registries for people who are eligible for HCBS, but have been determined by the state to not have a prioritized "need."

[In your own words, add information describing your understanding of your state's waiting list(s). In this section, you may consider the following questions to prompt your thinking and personalize your comments:

- Does your state have a waiting list, and do you know how many people are on it?
- Does your state's waiting list accurately count every person with an unmet need?
- If your state does not have a waiting list, does that mean every person in your state has their needs met?
- In addition to a waiting list your state may maintain, are there people waiting for services because providers are unable to accept new referrals?]

HCBS Quality Measure Set

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. Providers and beneficiaries of HCBS will benefit from the proposed rule's inclusion as part of the advisory group that informs the composition of the Home and Community Based Services Quality Measure Set. However, it is crucial that in defining the HCBS Quality Measure Set there is adequate opportunity for public input to prevent unnecessary administrative barriers.

[In your own words, add information describing any support or concerns you have for the creation of an HCBS quality measure set. In this section, you may consider the following questions to prompt your thinking and personalize your comments:

- What are your thoughts about the creation of a mandatory HCBS Quality Measure Set that CMS can change every other year through a process that allows for public input and comment?
- Have you had an opportunity to review the current HCBS Quality Measure Set? Are there any measures you feel strongly should or should not be included?]

Critical Incident Systems

We appreciate CMS' inclusion of measures which standardize critical incident reporting and requires 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 responses. It will also ensure timely oversight responses to incidents which risk the health and safety of people receiving services.

While we support the inclusion of these assurances, we urge recognition that compliance will require necessary time and funding for each state to respond and adjust their systems accordingly. Many providers may be required to adopt a new system of reporting, which will necessitate additional training and administrative reporting. In significant system transitions, 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.

[In your own words, add information describing any support or concerns you have for the creation of standardized critical incident reporting systems. In this section, you may consider the following questions to prompt your thinking and personalize your comments:

- Is the proposed definition of critical incident sufficient, too broad, or too narrow (i.e., abuse, neglect, exploitation, misuse or unauthorized use of restrictive interventions or seclusion, medication errors resulting in communication with poison control, an ER visit, urgent care visit, hospitalization, or death, or unexplained or unanticipated death)?
- Do you think your state's current system of incident management will need to be updated to meet the new electronic critical incident data collection requirements?
- Will your organization's system of reporting need to be updated?
- Do you anticipate your organization will need additional funding to meet these new requirements? Is three years sufficient time to make a successful transition in your state?]

Additional Protections for Beneficiaries

Beneficiaries of home and community-based services and their families will similarly benefit from the clear processes that allow for the filing of grievances, the requirements to reassess person-centered plans every year, and the transparency about critical incidents and quality measure set reporting to the state's website. Beneficiaries will also benefit from increased oversight through the creation of a Medicaid Advisory Committee (MAC) with a dedicated Beneficiary Advisory Group (BAG). These protections strengthen the infrastructure of HCBS by creating more transparency and opportunity for stakeholder engagement and response.

[In your own words, add information describing any support or concerns you have for these additional protections for beneficiaries. In this section, you may consider the following questions to prompt your thinking and personalize your comments:

- Does your state already have a system for assuring annual review and updates to person-centered planning? If not, are there additional costs to providing this level of review and documentation?
- Does your state already have a system for addressing grievances? Does it work well to address beneficiary concerns about their services?
- Are you familiar with your state's medical care advisory committee? Does replacing the committee with a Medicaid Advisory Committee strengthen the voice of stakeholders?]

Thank you for your work and the opportunity to share this feedback with you.

Sincerely,

[Insert signature]
[Your full name]
[Your title]
[Your organization]
[Your city and state]

STOP! BEFORE YOU SUBMIT, PLEASE ENSURE YOU HAVE REMOVED THE INSTRUCTIONS ON P. 1 AND THAT YOU HAVE REPLACED OR REMOVED ALL HIGHLIGHTED TEXT!