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Comments on Discussion Draft
Home and Community-Based Services Access Act (HAA)
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The Ohio Health Care Association (OHCA) is Ohio's largest organization representing long-term services and supports (LTSS) providers. We have a unique perspective because we represent assisted living communities, ICFs/IID, ID/DD waiver providers, hospices, home health agencies, skilled nursing facilities, and waiver providers serving older Ohioans. This enables us to have a balanced viewpoint that takes into consideration all of these different providers and the people they serve – or could serve if access is expanded.

We support the HAA and its goal of enhancing access to home and community-based services (HCBS) for aging and disabled Americans. We believe all Americans should have access to the services they need in the setting of their choice. As part of our support, we would like to make a number of suggestions for improvement, which are detailed below. We have two over-arching themes, both of which are tied to workforce – the area left blank in the discussion draft. Workforce, coupled with a shortage of providers, is by far the greatest impediment to the HAA's success.

1. **Don't let the HAA be an empty promise.** Americans do not have adequate access to existing HCBS programs, as evidenced by waiting lists, and they do not even capture all of the people unable to get services. The primary reason is lack of available providers because of inadequate reimbursement. Inadequate reimbursement (among other factors) keeps providers from entering the business, attracting the necessary workforce, and expanding the number of Medicaid recipients they serve.

   The HAA's cornerstone is expanding access to HCBS by making it an entitlement, lowering the required level of care, and providing a 100% Federal Medical Assistance Percentage (FMAP). To prevent the HAA from being an empty promise to hundreds of thousands of Americans, the legislation must make use of the enhanced FMAP and five-year transition period to mandate that states fully serve the populations eligible for their existing services (that is, eliminate waiting lists) before expanding eligibility further. States would accomplish this benchmark by using the 100% FMAP and grants during the transition period to improve reimbursement in existing HCBS programs and to develop initiatives to augment workforce.

2. **Do no harm to people who choose facility-based services.** As it should, 100% FMAP will encourage states to increase reimbursement to HCBS providers, which in turn will allow them to offer higher wages and benefits to their workforce. This is a clear intent of the HAA. With the longstanding workforce shortage in all LTSS, grievously exacerbated by COVID-19, higher wages in HCBS will pull workers from facility-based services, putting individuals who choose to receive services in facilities at grave risk of reduced quality and, potentially, lack of access. We recommend that the HAA expand 100% FMAP to require states to deliver additional funding to facility-based Medicaid LTSS providers so they too can attract the workforce needed for all seniors and people with disabilities to receive quality services and supports regardless of where they choose to receive their care.

We now will turn to a more detailed discussion of the HAA's provisions.

<u>Entitlement/Mandatory Benefit/100% FMAP</u>

- We support HCBS becoming an entitlement as long as the choice to receive services in a facility also remains an entitlement. The HAA should not restrict choice at the same time as it seeks to enhance choice.

- 100% FMAP could really help make HCBS available to people who need them and help create a living wage for the staff who provide HCBS. We remained concerned, however, that states may not set reimbursement at the level needed to ensure access to services for all eligible individuals, now or in the future. Also, we have a concern that states may reduce funding for facility-based LTSS to lower overall state financial responsibility for Medicaid coverage. We recommend language that requires states, beginning during the transition, to improve HCBS reimbursement sufficiently to allow access for all who are currently eligible for and choose HCBS and also to improve facility-based reimbursement sufficiently to allow facility-based providers to attract the workforce needed to serve people who choose those services.

- We agree with removing the state requirement to apply repeatedly for waivers. It would save administrative expenses and allow more funds to flow to services.

<u>Choice</u>

- Choice needs to be the center of any conversation. The HAA must strongly protect personal choice from among the array of Medicaid services so seniors and people with disabilities can select what they feel best meets their needs. While many Americans would like to be served in their own homes, there are care needs, physical plant limitations, and financial constraints that make facility settings the better choice for others. We should strive to increase access to services and supports in whichever setting is most beneficial to the person and their loved ones. OHCA suggest clarifying a few points in the language to ensure recipients continue to have the choice of where they receive services.

- Under the section on ensuring coverage of HCBS for all Medicaid-eligible individuals, (ii)(III) uses the wording, "elects to receive such services" – this is key! It seems buried, and further clarification elsewhere in the language is needed to secure choice of services and settings.

Covered services

- We question the need for an advisory panel to expand the already extensive list of covered HCBS, especially when its recommendations essentially would be mandatory. Instead we recommend requiring CMS to publish a notice in the Federal Register every two years announcing a public comment period on the list of services. CMS then could determine, based on the comments, whether changes to the list are needed.

- If an advisory panel is retained, how do we ensure providers are adequately represented? There are many groups listed in (bb), along with a requirement to include equal numbers of participants from (aa) and (bb), which makes us concerned that providers may be under-represented on the panel.

- The draft language needs to clarify distinctions between how state plan and waivers will be used. Would states have the ability to choose which services become state plan services? Would states have the ability to expand services that are currently for a specific population to other populations? It would seem that when the transition period ends, the concept of HCBS waivers would go away and the specified HCBS would become an entitlement under the state plan. Is that the case?

- We also feel that facilities play an integral part in supporting the HCBS population, as well as family caregivers. We suggest that as part of support for family caregivers, covered services include a required benefit for respite stays in SNFs or ICFs. This will help family caregivers by giving them a break and providing alternative options for people to have stays away from their loved ones. Ultimately, it will help keep those in most need in their homes longer.

- It would appear from the HAA's reference to 1915(c) waivers and the state plan personal care benefit, through which Medicaid funding for assisted living services typically flows, that assisted living would be covered as part of HCBS. We strongly support retaining assisted living as HCBS, as it is a desired choice of many individuals. Access to Medicaid-funded assisted living currently is limited by restrictive policies and insufficient reimbursement in many states.

Eligibility criteria

- We support the lower level of care (LOC) for HCBS when the entitlement takes effect. In the meantime, the HAA needs to ensure states maintain current eligibility levels based on current level of care definitions. Moreover, because the HAA will lower the LOC to include many people who are not currently eligible, the law must require states first to meet the needs of

the hundreds of thousands of Americans currently waiting for services under the existing LOC criteria before adding an expanded eligibility group.

In the HAA, eligibility for services is based on a functional impairment expected to last at least 90 days, with functional impairment meaning assistance with 2 or more instrumental activities of daily living (IADLs). We are extremely concerned that without an adequate transition plan, this expansion will exacerbate current access issues and will result in widespread frustration. Wait lists exist in many states for community individuals who have higher needs than just 2 IADLs. This is due, primarily, to lack of adequate reimbursement for waiver services, which results in lack of available workforce. We strongly recommend the HAA include a provision requiring a state first to eliminate the wait list for existing services before expanding eligibility for additional services.

- Relative to the individualized assessment, (A)(iv) references 1915(i)(1)(F)(ii-v), which includes a face-to-face evaluation. One of the learnings from the pandemic is that some people are better able to participate in their assessments through telehealth, so we suggest allowing face-to-face to include videoconference.

- The presumption in (B)(i) that everyone can be served in their own home is a great philosophy, but in reality sometimes just isn't possible because of the physical layout of the home, homelessness, lack of staffing, or the costs associated with providing 24-hour services in a non-group setting. In operation, this presumption could interfere with informed choice. People need and deserve an objective, unbiased explanation of the services and supports available to address their assessed needs. For individuals who meet only the expanded LOC proposed in the HAA, the choice would be limited to HCBS because they would not meet the LOC for facility-based services. For those with a higher LOC, however, facility-based services may be the option they would choose as best meeting their needs, so a broad presumption is inappropriate. We recommend removing the presumption and adding language to recognize choice explicitly and to specify that barriers to services in a person's home need to be addressed during the individualized assessment.

- We also suggest a tiered level of Medicaid financial eligibility for HCBS services similar to what exists now with, for example, Qualified Medicare Beneficiaries. This approach would enhance access to HCBS by enabling recipients to retain a higher level of income/resources that would allow them to pay living expenses that are not covered as HCBS and would not be incurred in facility-based care.

<u>Reimbursement</u>

As mentioned previously, current Medicaid waiver rates typically are not adequate to support wages necessary to attract and retain the workforce to provide services. As a strategy for meeting our suggested requirement to serve all currently eligible individuals during the transition period, states should be mandated to address reimbursement inadequacy using the available 100%

FMAP. We recommend allowing states flexibility in doing this, subject to the requirement that they specify how they will improve reimbursement in their transition plans. We also have some ideas that could be included as guidance or examples to states in developing their plans.

- Provide funding for benefits, as many workers are on public benefits that they would lose if wages are raised, and funding for paid time off, which many employers are currently unable to offer because of low reimbursement rates.

- Provide funding for ongoing training and other non-billable time – especially if workers will need to travel from one person's home to another during the day (both staff travel time and reimbursement for transportation) – including time to document services and to meet other regulatory requirements.

- Provide appropriate reimbursement if workers are asked to furnish transportation for the person they are serving in their personal vehicles.

- Ensure reimbursement solutions avoid salary compression for staff other than direct care workers (DCWs) who are essential to providing HCBS. The reimbursement approach would need to allow increased compensation for supervisory and management staff to avoid salary compression and to attract quality candidates into these positions. This is critical given the nature of HCBS is typically one-on-one with individuals in their homes. Without the assistance of co-workers on-site or other support personnel, supervisory staff are essential to ensuring quality delivery of services. In addition, the reimbursement approach would need to account for all levels of staff who provide the various services within HCBS (DCWs, LPNs, RNs, CNAs, social workers, employment specialists, behavioral specialists, etc.).

- Using past cost data for rate-setting purposes would not be beneficial, as those data reflect inadequate wages. Increasing the reimbursement rate only by the increase in wages to the DCW also would not alleviate this issue, as waiver services often are provided at a loss. This leads to providers limiting the number of Medicaid beneficiaries they serve. A full cost analysis should be executed comparing competitor wage rates (such as grocery store chains, as well as health care personnel) combined with cost data from current waiver providers.

- We also suffer from a lack of providers in rural settings. These areas are more difficult for attracting workforce and also require increased travel costs for HCBS services. A rural add-on component should be included as part of the rate-setting methodology to alleviate these issues.

- Address reimbursement for agencies that only serve Medicaid clients, commonly providers serving people with developmental disabilities, as there is no other coverage for these services to help cover workforce and other costs. Medicaid can no longer pay rates that are

below what it realistically costs to provide the services that are being asked of the providers. Providers need to be able to attract and to retain qualified personnel to provide these services. Rates need to be flexible to adjust to the job market in a particular area and need to be adjusted regularly to allow for wage increases for cost of living, longevity, and performance. Rates need to be updated at least annually if not more often to keep up with the changing job market.

Workforce

- Moving the needle on workforce is critical to the HAA's success. Changing the structure of the Medicaid program with the goal of expanding access to HCBS will be an empty promise without sufficient workforce to deliver services to what will be a much larger group of beneficiaries. We know from experience that one-on-one services or even smaller group settings require 2-10 times the number of workers currently in our HCBS systems. That is why we recommend establishing requirements in the HAA for states to develop the workforce for their currently eligible and underserved populations as a prerequisite to expanding eligibility. Higher reimbursement, of course, is an important component of securing the necessary workers because it allows higher wages and better benefits, but reimbursement alone is insufficient.

  Workforce shortages are caused not only by wage issues, but also by the risk associated with caring for individuals in their home. We urge you to consider, if you were an hourly employee and had a choice between working a customer service job from your home with no exposure to emerging infectious disease for $15 an hour or working as a personal care attendant in multiple homes with considerable risk exposure for $13 an hour, which would you choose?

  We recommend that the HAA require states, as part of their transition plans, to create workforce development initiatives targeted at services and supports for seniors and people with disabilities. As these initiatives would not be Medicaid services eligible for the 100% FMAP, we suggest the legislation specifically provide that states could use the transition grants provided by the HAA as a funding source. As with approaches to reimbursement, we believe the HAA should not mandate specific initiatives because states are all so different. What is important is the outcome: fixing existing HCBS access problems by increasing the number of hands available to do the work. Again, we offer some considerations for states in developing their plans.

  - In addition to wage increases to attract workforce, grant opportunities or other funds for education, certification, and other assistance to workers.

  - Training and education needed to recruit people into these positions. Could there be loan forgiveness for nurses, social workers, and other degreed professionals? Can nationwide programs be created to provide DCWs with the basic training needed to perform the services they will be providing?

- Paths to higher-paying jobs, for example through nursing school grants for personal care attendants. This is a powerful motivator for retention and workforce development. It does not have to be limited to clinical certifications, but also could apply to administrative workforce, such as coding certification grants, bereavement counseling training, and health care administration higher education and continuing education credits.

- Advertising campaigns to educate the general public of this opportunity for employment.

- Coordination with other agencies that help with job employment to educate job seekers of this opportunity for employment.

- Coordination with technical schools, community colleges, and other accredited universities/colleges to identify programs currently available and gaps where programs are needed to educate and to train all levels of staff who will be providing HCBS.

- For states to support family caregivers and independent providers, as well as provider agencies, states first should establish a communication system that includes email and phone outreach to unregistered providers. Additionally, states could provide a team of dedicated professionals who supply resources and training, as well as information on available respite programs and providers, for family caregivers.

- As vital as expanding the HCBS workforce is, it cannot be done at the expense of people who choose facility-based care because they believe it best meets their needs. These individuals deserve access to quality services as much as people who choose HCBS. Workforce is a crisis today in facility settings just as it is in community-based settings. As added funding through 100% FMAP flows to HCBS providers, they will be able to offer higher wages and better benefits. Without a balanced approach to workforce, the higher wages in HCBS will draw workers away from facility-based settings that do not have the funding to offer the higher wages, jeopardizing the services the facilities provide. As we have stated repeatedly, OHCA strongly supports individual choice of where and how to receive Medicaid-funded LTSS. We believe that is the intent of the HAA as well. A choice is not meaningful if one of the options is starved of resources – workforce – necessary to deliver quality services.

  Our recommended solution to this problem is expanding availability of the HHA's 100% FMAP to cover additional funding to facility-based Medicaid settings that will allow them to compensate workers at a level commensurate with HCBS. States should be required to include these reimbursement measures in their transition plans and should have the flexibility to design them, as long as they meet the outcome of improved wages and benefits for facility-based workers.

Oversight

- It is critical for protection of individuals receiving HCBS that the HAA require states to improve their quality oversight of HCBS during the transition period. This should be a requirement to receive 100% FMAP for current and expanded HCBS, with a reasonable implementation timetable (e.g, two years). The transition plan should specify the state's process and timetable for ensuring oversight of service quality. This would not mean federal regulation of HCBS, but a requirement for meaningful state oversight.

- Other stakeholders beside AHRQ and State Medicaid Directors need to be involved in developing quality metrics for HCBS, not just through a public process (which typically means public comment after the fact) but through involvement in creating the metrics. Any metrics developed need to reflect the differences in the many types of HCBS and expected outcomes, as well as the variety of populations who may use those services. As currently drafted, the language does not require process or outcome-based measures of service quality, but appears to focus solely on access. Access is not adequate if it is to substandard services.

- The current requirement for electronic visit verification (EVV) should be eliminated for Medicaid HCBS. EVV requirements add both financial and administrative burdens to HCBS providers. Staff have to take 5-10 minutes out of each shift to complete EVV, and even then, many times additional administrative time is needed afterward to fix minor issues. Additionally, EVV systems rely heavily on internet service working properly. In many areas of the nation, internet is sporadic at best and sometimes non-existent or very unreliable. As more people need HCBS, EVV use will increase, and the struggles providers and staff are facing now will become more prevalent. The challenges with EVV already have caused some providers to stop accepting Medicaid patients. This could cause even more access issues in the future as demand for HCBS increases.

Structural Issues

- In respect to states that offer HCBS through managed care arrangements, we recommend that the HAA ensure individual choice of provider within that structure. Managed care organizations (MCOs) often limit their networks to a few providers based on quality or other performance measures set internally. We recommend the HAA require states mandate that their Medicaid MCOs allow open provider panels or set a required minimum number of providers available to individuals in a region or county, regardless of the MCO's pre-set standards. Instead of excluding providers they feel are underperforming from the network, MCOs should provide additional support and education. An exception to the minimum number of providers may be granted if there are no available providers in the area.

- Relative to the HCBS Implementation Grant Program, the HAA should require states to engage stakeholders in the process of developing the implementation plan. Also, (c)(4) refers to incorporating disability agencies into the new unified provisions. The legislation should

ensure this will not remove the presence of developmental disability agencies/offices in state government across the country. Many states have only gotten to where they are now by elevating disability services to high levels of government. That focus on DD services needs to continue.