July 3, 2023

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services, Department of Health and Human Services
Attention: CMS–2442–P
P.O. Box 8016
Baltimore, MD 21244–1850

Dear Administrator Brooks-LaSure,

On behalf of ADvancing States, I am writing to you in response to the *Ensuring Access to Medicaid Services Notice of Proposed Rulemaking [CMS-2442-P]* (proposed rule). ADvancing States is a nonpartisan association of state government agencies that represents the nation's 56 state and territorial agencies on aging and disabilities and long-term services and supports directors. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services (HCBS) for older adults and persons with disabilities. Our members administer services and supports for older adults and people with disabilities, including overseeing a wide range of Medicaid HCBS programs. Together with our members, we work to design, improve, and sustain state systems delivering long-term services and supports (LTSS) for people who are older or have a disability and their caregivers.

The goals in the proposed rule reflect important priorities for Medicaid, which is the principal public payer of these services for over four million older adults and people with disabilities nationwide. Medicaid HCBS continues to become a more predominant proportion of Medicaid LTSS expenditures. Reflecting "rebalancing" of the proportion of spending on HCBS versus institutional care, HCBS represented 58.6% of Medicaid long-term services and supports (LTSS) spending in FY 2019. As HCBS programs and service delivery systems continue to grow, it is imperative to ensure beneficiaries have access to high-quality service delivery that supports them to live and thrive in their communities.

ADvancing States strongly supports the intent of the proposed rule to take a comprehensive approach to improving access to care, quality and health outcomes, and to better address health equity issues across Medicaid HCBS delivery systems through initiatives which increase transparency and accountability, standardize data and monitoring, and promote beneficiary engagement. Further, we believe the focus areas addressed in the proposed rule — increasing support for direct care workers (DCWs), improving quality measurement and reporting, ensuring systems are in place for beneficiaries to express grievances, standardizing requirements for investigation of critical incidents to ensure health and safety, and tracking and improving timeliness of access to services — are the most important areas of focus for strengthening HCBS delivery systems.

In order to successfully implement these requirements and achieve the intended outcomes for Medicaid HCBS beneficiaries, state Medicaid and operating agencies will need sufficient time for planning, implementation, and evaluation, as well as extensive guidance and technical assistance from CMS. We encourage CMS to consider the need for flexibility for state Medicaid and operating agencies to implement these requirements in a meaningful way that best fits their unique program structures and processes. We expect states will encounter significant obstacles to implementation due to timeframes, cost, and operational burden.

Implementation Timeframes, Cost Impacts, and Operational Burden

While state Medicaid and operating agencies support the overarching goals and objectives of the proposed rule, they overwhelmingly voiced concerns that the level of operational and systems change required for successful implementation would result in a substantial increase in workload and costs that states are not currently equipped to handle. The HCBS provisions of the proposed rule will require states to implement at least five major systems initiatives: (1) enabling mechanisms for fee-for-service grievance systems, (2) new incident management systems, (3) operationalization of the minimum compensation percentage for direct care workers (DCWs), (4) website transparency, and (5) modification of systems to support tracking and reporting on quality measures and rates. To effectively meet the desired outcomes and intent of the proposed rules, states must undertake these projects alongside already obligated (e.g., Electronic Visit Verification (EVV) and ongoing work to complete HCBS Settings Rule corrective action plans) and upcoming (e.g., continuous eligibility for children) projects.

State Medicaid and operating agencies emphasized that the estimated costs to states included in the proposed rule significantly underestimate the actual costs they will incur while implementing these requirements. To successfully implement the proposed requirements, state agencies will likely need to request funding from their legislatures, which is a multi-year process, particularly in states whose legislatures meet biennially; for these states, budgets are likely already set for FY 2025 and new budget development is likely already beginning for fiscal years (FY) 2026 and 2027. In addition to requesting legislative appropriations, state procurement processes are complex, arduous, and time intensive. After securing funding, the process to procure vendor(s) could take a year or longer, after which the state and their selected vendor(s) would require a readiness period before implementation begins. Reflecting on state experience of the HCBS Settings Rule, which made similarly foundational changes to the HCBS system and required more implementation time than initially envisioned, **we recommend CMS extend the implementation timeframes for the HCBS provisions of the proposed rule. For several of the proposed provisions, we suggest CMS base implementation timeframes on the issuance of sub-regulatory guidance.**

In additional to allowing states much-needed time to request funding, this would help accommodate several significant constraints state currently face:

- Data collection and analysis: States are at a very early stage of readiness for collection and stratification of data that will help to illuminate disparities of HCBS access, experience and outcomes for populations including minorities and LGBTQIA+ people.
- Culture change for providers: Many aspects of the proposed rule, including collection and reporting of quality and cost data, will require culture change for HCBS providers. Just one

example of this is the proposed new requirement for home care agencies to document and report on pass-through of a minimum percentage of Medicaid payments to DCWs. This will be a new process for those often small and less administratively sophisticated entities.

- Need for guidance and technical assistance: While CMS has generally signaled both its goals and an array of new policy proposals, state Medicaid and operating agencies will need considerably more detail in the form of sub-regulatory guidance to understand and implement the proposed provisions. In making this observation, we are influenced by the serious challenges states faced in meeting the requirements of the HCBS Settings Rule.

HOME AND COMMUNITY-BASED SERVICES PROVISIONS

Person-Centered Service Plans

Proposed 42 CFR §§ 42 CFR 441.301(c), 441.450(c), 441.540(c), and 441.725(c)

CMS proposes to require annual person-centered service plan reassessment and reporting. ADvancing States recognizes the centrality of person-centered planning to the provision of high quality HCBS and supports efforts to ensure states implement timely and adequate person-centered planning processes. **We request CMS provide clarification on application of this proposed requirement to specific assessments**, to ensure effective implementation.

CMS Request for Comment: CMS invites comment on the proposals to require states to conduct an annual reassessment of functional need for at least 90 percent of individuals continuously enrolled in an HCBS program and to require states to annually review and update the person-centered service plan based on the reassessment for at least 90 percent of individuals continuously enrolled in an HCBS program.

ADvancing States supports the annual reassessment of functional need for at least 90 percent of individuals continuously enrolled in an HCBS program, as well as the requirement that states review and update person-centered service plans annually. Several states have already implemented similar thresholds for reassessment, and many reassess functional needs at more frequent intervals. **However, we request clarification regarding whether 90 percent is considered an acceptable margin of error and if states will be expected to remediate if this threshold is not met.**

States use a variety of terminology to describe assessment processes. We understand person-centered service plan reassessment in the proposed rule to mean reassessment of a beneficiary's goals and/or service needs, rather than an assessment to determine the beneficiary's eligibility for HCBS. Because full eligibility/level of care assessments can be involved, medically complex, rigorous processes, and can be considered intrusive by beneficiaries, we recommend CMS only require a full functional level of care reassessment process when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary.

CMS Request for Comment: CMS invites comments on whether there are other specific compliance metrics related to person-centered planning that they should require states to report, either in place of or in addition to the metrics they proposed.

ADvancing States recommends CMS not add or change compliance metrics on which states are required to report for person-centered planning.

CMS Request for Comment: CMS requests comment on whether we should establish similar person-centered planning and service plan requirements for section 1905(a) State plan personal care, home health, and case management services.

ADvancing States recommends that CMS not establish similar person-centered planning and service plan requirements for section 1905(a) state plan services. Given the wide variety of state HCBS program structures, the expansion of these requirements to state plan benefits would pose additional challenges and burdens to the states. Many state agencies operate Medicaid state plan services through different branches or divisions of the agency. For these states, implementation could prove challenging and costly, and may not have the desired impact given the mechanisms and requirements that are already in place to ensure access and quality for state plan benefits. State Medicaid and operating agencies should be encouraged to implement the proposed provisions where applicable, but at this time we recommend that the decision to implement similar person-centered service planning processes in 1905(a) state plan services be left to each state.

CMS Request for Comment: CMS requests comment on the application of these provisions to section 1915(i), (j), and (k) authorities.

ADvancing States supports the intent to align the HCBS program authorities and apply the proposed rule provisions where the regulatory program parameters align. We support the application of this provision to section 1915(i), (j), and (k) authorities. This will ensure state programs provide a service delivery framework that provides consistent approach in access, equity, quality, and reporting.

CMS Request for Comment: CMS invites comments on the timeframe for states to report on the person-centered planning, whether we should require reporting less frequently (every 2 years), and if an alternate timeframe is recommended, the rationale for the alternate timeframe.

ADvancing States supports the proposed annual reporting frequency. State Medicaid and operating agencies indicate that this frequency of reporting is feasible.

CMS Request for Comment: CMS invites comments on whether this timeframe is sufficient, whether we should require a shorter timeframe (2 years) or longer timeframe (4 years) to implement these provisions, and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

CMS proposed a 3-year timeframe for implementation of person-centered planning provisions. Given the variation in state systems, states may need more time to implement all proposed provisions. **ADvancing States recommends CMS allow states 4 years to implement this requirement,** to allow states adequate time to implement all person-centered planning system changes.

Grievance System

Proposed 42 CFR §§ 441.301(c)(7), 441.464(d)(2)(v), 441.555(b)(2)(iv), and 441.745(a)(1)(iii)

CMS proposes to require states to establish a procedure under which a beneficiary can file a grievance related to the state's or a provider's compliance with the HCBS settings requirements and person-centered planning and service planning requirements. 'Grievance' is defined as an expression of dissatisfaction or complaint, regardless of whether the beneficiary requests remedial action be taken to address the area of dissatisfaction or complaint.

ADvancing States applauds efforts to empower beneficiaries in driving their own person-centered service plans and service delivery. We recognize that providing an additional formal outlet to raise concerns and address grievances is an important component in supporting this empowerment.

We also support changes to address disparities between Fee for Service (FFS) and Medicaid managed care delivery systems and recognize that, currently, managed care systems provide grievance opportunities that are unavailable for beneficiaries receiving services through FFS models.

We recommend CMS extend implementation timeframes and increase projected state costs. Implementing a statewide grievance system on its own would require substantial funding and state resources, particularly in FFS states that do not currently have established grievance systems. State Medicaid and operating agencies report that state statutory amendments would also be needed to implement this requirement. Accomplishing this while undergoing systems change efforts proposed in other parts of the proposed rule will be a significant undertaking. We believe allowing additional time to accomplish the proposed changes will lead to more successful implementation, to the benefit of HCBS beneficiaries.

CMS Request for Comment: CMS proposes that states must establish a procedure under which a beneficiary can file a grievance related to the state's or a provider's compliance with the person-centered planning and service plan requirements and the HCBS settings requirements… To avoid duplication with the grievance requirements at part 438, subpart F, CMS is not proposing to apply this requirement to establish a grievance procedure to managed care delivery systems. The proposals in this section are similar to requirements for managed care grievance requirements… CMS requests comment on any additional changes they should consider in this section.

ADvancing States supports the intent to provide beneficiaries with an opportunity to file grievances regardless of service delivery system, but we raise several concerns from state Medicaid and operating agencies regarding the system structure and timeframe for implementation.

We believe implementing a grievance process in FFS systems will be more complex and nuanced than implementing grievance processes in managed care systems. Implementing a uniform, consistent grievance system within one Medicaid managed care organization (MCO) is a reasonable and feasible expectation, as all services are delivered under one organization. In FFS delivery systems, multiple state agencies or agency divisions may operate various waiver programs and services. Operationalizing a standardized grievance system would require clarification and guidance about which agency or department is responsible for oversight of the system and coordination within varying state departments. **We recommend CMS allow states flexibility to design grievance system(s) and**

process(es) to fit their unique program and systems structures. For example, in a state where multiple agencies or divisions responsible for overseeing various HCBS programs and services, the state could choose to implement multiple grievance systems or processes tailored to their programs. **We also recommend CMS allow states the flexibility to delegate operation of the grievance procedures to a vendor or other contracted entity.**

State Medicaid and operating agencies have expressed concerns about the volume of grievances that will be filed and staff capacity necessary to respond to these grievances within an expedited timeframe of 14 calendar days. We support requiring states to resolve and provide notice of resolution related to each grievance in a timely manner but believe there should be only a standard resolution and notice timeline of 90 calendar days. Grievances are typically related to issues with provider rudeness, timeliness of transportation, quality of care, and other complaints not related to the beneficiary's health and safety. There are also separate channels to address health and safety concerns. **We recommend CMS remove the requirement for expedited resolution.** We note that there is not a corresponding expedited grievance process in Medicaid managed care, which seems appropriate given that grievances are an expression of dissatisfaction with services. Therefore, limiting the grievance resolution to one standardized 90-day timeframe is consistent with grievance processes in managed care and will allow states the time necessary to respond appropriately to all grievances that require a response. **If an expedited grievance resolution timeline is included in the final rule, we recommend CMS extend the timeframe from 14 calendar days to 30 calendar days.**

We recognize that the intention of limiting the proposed grievance system to grievances related to a state or provider's compliance with person-centered planning, service plan requirements, and HCBS settings requirements is to avoid duplication with existing fair hearing requirements. However, we believe the distinction will be challenging to operationalize, and we anticipate that there will be confusion about when and where a beneficiary or their representative should go to file a grievance. State Medicaid and operating agencies will need adequate timeframes in which to share information and education with beneficiaries about this new process. Upon implementation, significant time and effort will be required to provide guidance to beneficiaries on an individual basis to determine the most appropriate path to file a grievance or appeal, as well as to ensure all grievances and appeals are filed with the appropriate entity.

We recommend CMS narrow the scope of allowable grievances and provide additional clarification about the responsibilities of providers versus the responsibilities of state Medicaid and operating agencies in responding to a beneficiary's grievance. Although the proposed rule limits the grievance system to person-centered planning, service plan requirements, and HCBS settings requirements, these requirements are still very broad and would allow a beneficiary to file a grievance on nearly every aspect of their HCBS experience, creating the potential for an unreasonably high volume of grievances to which states will be required to respond.

Many states require providers to have policies and procedures in place related to service-delivery complaints and recommend that beneficiaries exhaust these processes at the provider level before a complaint is escalated to the state agency for investigation or intervention. In states where these provider-level processes are required, we believe these processes are an appropriate first step toward resolution of grievances related to person-centered planning requirements and HCBS settings requirements. **We request CMS provide clarification, either in the final rule or sub-regulatory**

guidance, regarding the incorporation of the proposed grievance process into existing provider-level complaint and grievance processes. Additional guidance is needed to help all stakeholders understand when beneficiaries should file a grievance with their provider and when they should file with the state.

We also request CMS specify the instances for which responses to grievances are expected and necessary, and the type of response appropriate for different types of grievances. This may include providing a definition or detailed description of the term "resolution" that clarifies instances where the state must take action and when acknowledgement of the grievance is sufficient. For example, given the current direct care workforce crisis, we anticipate many grievances filed in today's environment would be related to provider shortages. State Medicaid and operating agencies recognize that this is a real problem and support taking steps to address the crisis. Collecting data about grievances filed related to this topic may help to identify and/or confirm gaps that exist within the HCBS system, but responding to each grievance filed on this topic is unlikely to address the problem. Further, state Medicaid and operating agencies are limited in their ability to provide a solution that would offer satisfactory resolution to the beneficiary. Collecting and recording information about each grievance will require significantly less time than responding to grievances, and clarification about an adequate state response will help state Medicaid and operating agencies to develop an adequate grievance system.

CMS Request for Comment: CMS invites comment on whether part 438, subpart F, should be amended to include the proposed requirements for expedited resolution and notice.

ADvancing States recommends part 438, subpart F not be amended to include the proposed requirements for expedited resolution and notice. When creating the appeal and grievance process in Part 438, Part F, CMS could have implemented an expedited grievance process, but did not, recognizing that very few expressions of dissatisfaction require expedited resolution. They typically include rudeness of provider, timeliness of transportation, quality of care, and other complaints not related to the beneficiary's health and safety. There are also separate channels to address health and safety concerns in a timely manner. As an intention of this proposed requirement is to better align grievance opportunities between Medicaid-managed care and FFS programs, we recommend both systems require standard resolution of grievances occur within 90 calendar days of receipt of the grievance. **An expedited resolution timeline should not be applied to either managed care or FFS systems.**

CMS Request for Comment: CMS requests comments on the overall burden for states to meet the requirements for this section, whether this timeframe is sufficient, whether we should require a shorter timeframe (1 year to 18 months) or longer timeframe (3 to 4 years) to implement these provisions, and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

CMS proposes a two-year implementation timeframe. State Medicaid and operating agencies expressed concern that this timeframe is not feasible for completing the extensive work that will be necessary to implement this proposed requirement. Implementing this provision would require: 1) funding requests to state legislature; 2) potential legislative changes; 3) administrative rulemaking; 4) system design and development, which may include vendor procurement); 5) collaboration with other state agencies or agency divisions, 6) partnering with providers for implementation; and 7) ongoing monitoring and support. To accommodate these complex and time-intensive implementation activities, **we recommend CMS allow a timeframe of at least 4 years to ensure successful implementation.**

States without a managed care delivery system may not currently have a grievance process in place, and in these states, building a statewide grievance process from the ground up will require time and significant resources, particularly given the broad nature of items about which beneficiaries can file a grievance. In many states, especially those with a biennial legislative calendar, budgets are likely already set for FY 2025 and new budget development is likely already beginning for fiscal years (FY) 2026 and 2027. We anticipate many states will need additional staff resources to establish a dedicated team available to receive and respond to grievances, and requesting these appropriations, filling the positions, and conducting necessary onboarding and training is likely to take more than two years.

Additionally, states will need time to evaluate how this process will interface with other systems and processes currently in place, such as client ombudsman processes and incident management systems, and may need to update state statute or regulations. State Medicaid and operating agencies will also need time to develop a process for collecting and tracking information. Given the reporting requirements in other components of the proposed rule, states would benefit from additional time to evaluate existing operational systems and implement new systems that can effectively and efficiently collect all necessary information.

CMS Request for Comment: CMS requests comment on the application of the grievance system provisions to section 1915(i), (j), and (k) authorities.

We support the intent to align the different HCBS program authorities and apply these proposed grievance system provisions where the regulatory program parameters align. **We support the proposal to apply the grievance system provisions to section 1915(i), (j) and (k) authorities.** This will ensure all Medicaid managed care and FFS state programs use a consistent approach in access, equity, quality, and reporting. We would highlight that there may be nuances to implementing this requirement in self-direction models, and additional time may be needed for states to successfully implement this requirement for self-direction.

CMS Request for Comment: CMS requests comment on whether they should establish grievance requirements for section 1905(a) state plan personal care, home health, and case management services.

The expansion of these requirements to state plan benefits would pose additional challenges to state Medicaid and operating agencies. Many states deliver Medicaid State Plan services through different agencies or agency divisions. For these states, implementation could prove challenging and costly, and may not have the desired impact given the mechanism and requirements that are already in place to ensure access and quality for state plan benefits. In addition, because the HCBS settings requirements and person-centered planning requirements do not apply to 1905(a) state plan services, it would be impractical to establish grievance processes specific to these requirements. **We recommend CMS not establish grievance requirements for section 1905(a) state plan personal care, home health and case management services at this time.**

States should be encouraged, but not required, to implement the proposed rule provisions to their 1905(a) state plan services. For instance, at least one state uses the same authorization and reporting processes for state plan personal care services and for HCBS delivered under other authorities. In this

state, it may be appropriate to implement the grievance provision for their 1905(a) services. However, that determination should be left to the state's discretion.

Incident Management System

Proposed 42 CFR §§ 441.302(a)(6), 441.464(e), 441.570(e), and 441.745(a)(1)(v))

CMS proposes to establish a minimum definition of critical incident. A provider must report a critical incident that occurs during service delivery or because of failure to deliver services as authorized in the person-centered service plan.

Critical Incident Definition

CMS Request for Comment: We request comment on whether there are types of events or instances of serious harm to 1915(c) waiver participants, such as identity theft or fraud, that would not be captured by the proposed definition and that should be included, and whether the inclusion of any specific types of events or instances of harm in the proposed definition would lead to the overidentification of critical incidents.

ADvancing States supports the establishment of a minimum definition of a critical incident as a mechanism to help standardize practices across states and HCBS programs.

We recommend CMS not expand the minimum definition of critical incident further. State Medicaid and operating agencies emphasize that, based on the specific population and services provided under a state's HCBS programs, additional criteria may or may not be applicable. State Medicaid and operating agencies need flexibility to expand their critical incident definition(s) to fit the HCBS program and/or targeted population served. Expansion of the federal definition beyond the current proposal would create an additional burden on states to implement, as state statute and agency regulation amendments would likely be required. Finally, we specifically recommend CMS not expand the definition to include identify theft or fraud, as this would create duplication of existing investigative and reporting processes.

Critical Incident Reporting

The proposed rule would require that providers report on critical incidents that occur during service delivery *or the failure to deliver services* authorized in the person-centered service plan.

We recommend CMS remove the requirement for reporting on the failure to deliver services. While many states already have robust mechanisms to collect and report on critical incidents when the incident occurs during the provision of HCBS, state Medicaid and operating agencies reported concerns with the proposed requirement to report incidents that occur because of a failure to deliver services, as this criterion is too broad for states to operationalize effectively and consistently. It is unclear how providers and state agencies would objectively correlate a failure to deliver services with a critical incident. Claims data alone does not provide sufficient information to determine causation for incident reporting. Further, there are sometimes significant delays between service delivery and billing, thus limiting effective reporting, investigation, and intervention based on service gaps. In addition, many provider entities do not have access to the full scope of services authorized and delivered in the plan of

care to fully assess and determine whether the incident was the result of a gap in service delivery. This requirement would place the burden for determining causation and reporting on state agencies. The end result may be more time spent determining causation between a critical incident and failure to deliver services than implementation of effective incident reporting, investigation, and remediation strategies.

If the requirement to report on critical incidents that result from a failure to deliver services is included in the final rule, we request CMS provide detailed sub-regulatory guidance and technical assistance to states on how to identify critical incidents that occur as a result of a failure to deliver services identified in the person-centered service plan.

Electronic Critical Incident System

CMS proposes to require states to maintain and operate an incident management system that identifies, investigates, resolves, tracks, and trends critical incidents.

ADvancing States supports efforts to develop management systems that track, monitor, and respond to critical incidents in order to ensure beneficiary health and welfare. State Medicaid and operating agencies support efforts to establish and strengthen electronic incident management systems and understand the value of operating and maintaining an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.

Inter-Agency Collaboration

State Medicaid and operating agencies have expressed significant concern regarding proposed requirements that would dictate the type and extent of collaboration with other state agencies. These proposed requirements would create complexity and operational burdens that could undermine a state's ability to effectively implement and oversee their critical incident management system(s). Further, they could cause duplicative investigations that might threaten the integrity of all systems.

The following proposed requirements are of the most significant concern:

- Use of claims data, Medicaid fraud control unit data, and data from other state agencies to the extent permissible under applicable state law, to identify critical incidents that are unreported by providers;
- Ensure information sharing on the status and resolution of investigations if the state refers critical incidents to other entities for investigation; and
- Separately investigate incidents if the agency fails to report the resolution within state-specified timeframes.

Collaboration between state Medicaid and operating agencies and Adult Protective Services (APS) agencies or divisions would be especially challenging. Many state Medicaid and operating agencies indicate that state statutes prohibit disclosure of certain information from the APS investigation process. Implementation of this requirement would require statutory changes and would likely require fundamental shifts in the culture of information sharing and privacy between APS and Medicaid agencies. Further, implementation would require significant process and IT system integration between

agencies to facilitate the identification, investigation, and resolution of critical incidents; this is especially true for the requirement that the Medicaid agency separately investigate incidents.

State Medicaid and operating agencies have expressed concern that the requirement for the Medicaid agency to separately investigate incidents could be burdensome for beneficiaries and may inadvertently cause trauma. The initial investigation process may be stressful for the beneficiary, and that stress would be exacerbated by a follow-up investigation which would likely include repetitive and invasive personal questions. This separate investigation process is also likely to complicate existing state processes, inhibit the goodwill that is essential to creating successful interagency partnerships, and either duplicate or elongate investigations. The duplicative investigation could also potentially jeopardize criminal investigations. **We recommend CMS remove the requirement for Medicaid agencies to independently investigate and respond if an agency with primary responsibility for doing so fails to report resolution within state-specified timeframes.**

90 Percent Performance Measure Threshold

ADvancing States believes there is great value in establishing minimum performance levels for HCBS program operation and supports the use of critical incident data for performance measures. **We support the increased performance measure threshold of 90 percent for states to initiate investigation, complete and determine a resolution of the investigation, and ensure corrective action has been completed within state-specified timeframes.** Finally, we appreciate that the proposed rule includes the identification of "state-specific timeframes" because many states use differing timelines. We support the decision to allow the state to establish appropriate timeframes for critical incident management and believe this will yield more valuable reporting measures for state entities.

Related to minimum performance measures, we note that the proposed regulation does not specify whether the performance measure is a statewide performance measure or specific to each HCBS program. States operate multiple HCBS programs, and some states have multiple 1915(c) waivers. State Medicaid and operating agencies have expressed concern that statewide reporting would prove problematic, as they often operate multiple waivers that each use different management systems to capture and report data on performance measures. States have waivers that differ dramatically in size. Within a single state, one waiver program for a specialized population may serve fewer than 100 beneficiaries while another program serves tens of thousands of beneficiaries. **We recommend that states have flexibility to track and report critical incident performance measures at the program level rather than at a state level.** The reporting of data at an aggregate, state-wide level will not only prove operationally challenging, but it will also limit the ability to identify and address program-specific issues.

Implementation Timeframe

State Medicaid and operating agencies overwhelmingly expressed concern regarding the proposed three-year implementation timeframe, as it will likely not be feasible to complete the operational changes, including vendor procurement, necessary to implement this requirement within that time. System procurement and implementation are incredibly complex processes at the state level. In addition to establishing funding authority, which may require legislative approval, state procurement

processes can be arduous and extensive. We note that states are receiving no new resources to implement these provisions, and technology projects are the most complex to manage. **We recommend CMS extend the implementation timeframe for this requirement to at least five years after CMS's issuance of explanatory sub-regulatory guidance.**

We also recommend that sub-regulatory guidance address: systems requirements; tools to operationalize cross-agency and program collaboration (e.g., data use agreements, contracts); and intersection of these requirements with requirements for APS, which will require collaboration with the Administration for Community Living (ACL).

It is important that state Medicaid and operating agencies have an opportunity to design a program-specific incident management system. We believe CMS has underestimated the number of HCBS programs that would require a new critical incident management system. The cost estimates for this provision assumes that only nine states would need to implement new electronic incident management systems; however, state Medicaid and operating agencies have communicated that, while they may currently operate one incident management system for certain program(s), they would likely implement new systems for their other waivers or require substantial updates to their current systems to accommodate varying program needs. The cost and time for this work is not adequately captured in the proposed rule. Further, these costs and timeline challenges will be exacerbated if the 1915(i), 1915(j) and 1915(k) authorities are included in the final rule.

We recommend CMS remove the following provisions:

- Use of claims data, Medicaid fraud control unit data, and data from other state agencies, to identify critical incidents that are unreported by providers;
- Ensure there is information sharing on the status and resolution of investigations if the state refers critical incidents to other entities for investigation; and
- Separately investigate incidents if the agency fails to report the resolution within state-specified timeframes.

As an alternative to these provisions, we propose that the critical incident management system requirement focus solely on the development and procurement of a critical incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. We also propose that CMS work jointly with ACL to identify coordination expectations and regulations across APS and Medicaid, which in turn will facilitate streamlined, efficient, and non-duplicative work.

CMS Request for Comment: We request comment on the burden associated with requiring states to have electronic critical incident systems and whether there is specific functionality, such as unique identifiers, that should be required or encouraged for such systems.

State Medicaid and operating agencies report that the burden to implement an incident management system will be significant. The main burdens are:

- Cost, both for funding of new staff resources and IT system funding;

- Impact of system reporting change on the entire service delivery system, from member and worker level to provider and case management level; and
- Burden of integrating multiple systems, which is particularly elevated with the expectation that multiple state systems communicate in order to manage and track critical incidents.

Without sufficient time and resources for implementation, these burdens may undermine the effectiveness of the state's incident management system. As noted above, we recommend removing certain elements of the proposed rule to ensure this requirement is feasible for states to implement.

We recommend against requiring states to include additional specific functionalities, including unique identifiers.

CMS Request for Comment: We request comment on whether states should be required to use these data sources [APS, CPS, MFCU] to identify unreported critical instances, and whether there are other specific data sources that states should be required to use to identify unreported critical incidents.

As previously mentioned, the requirement to use data sources from other state agencies, such as APS, CPS, and MFCU, will be extremely challenging for states to implement in a systematic and efficient manner. State Medicaid and operating agencies highlight the following challenges with implementing this type of requirement:

- Claims data review for potential unreported critical incidents is not an exact science and proves problematic for many reasons, such as the delays between service delivery and billing, and inability to determine causation of the incident. For example, while hospitalization and death data can be obtained through database cross-reference, neither data element captures an unreported critical incident without additional examination. The expectation that 90 percent of critical incident reports in the FFS would be captured through claims identification and other sources is not reasonable.
- Many states have already initiated substantial work to "peel back the layers" of incident investigation under HCBS authorities. This work is time-intensive, tedious, and does not always achieve the anticipated outcome(s). Many states have encountered challenges securing inter-agency agreements – particularly with APS agencies. With no corresponding Federal directives to APS agencies to cooperate in sharing the outcomes of their investigations of Medicaid-referred cases, states are faced with resistance as well as state statutory prohibitions on data-sharing.
- The data sharing and separate investigation requirements could result in duplication of effort, particularly when states refer cases to other entities for investigation. The requirement to investigate critical incidents if they are not resolved within the Medicaid agency's timeframe further increases the likelihood for duplication of effort across systems, as other investigative entities (e.g., law enforcement) may operate under different timeframes. They would also place new and significant burden on the state workforce, where vacancies are at an all-time high. States report increased challenges to manage and operate existing systems.

- The requirements for data sharing and reporting outlined in this proposed rule will place increased work and burdens on multiple state systems (not just within Medicaid) and these systems are not equipped to handle the demand at this time.
- The term "investigation" poses many challenges when it comes to operationalizing a critical incident system. This operational challenge is exacerbated with the requirement to investigate incidents that are being investigated by another entity.

ADvancing States supports the intent of inter-agency data sharing. However, based on the wide range of experiences and challenges that state Medicaid and operating agencies have already experienced operationalizing similar processes, **we recommend excluding it from the requirements for the incident management system.** We propose that CMS encourage, but not require, inter-agency coordination and collaboration within states to report and capture information as appropriate and feasible within the state structures and authorities.

CMS Request for Comment: We invite comments on whether this timeframe is sufficient, whether we should require a shorter timeframe (2 years) or longer timeframe (4 years) to implement these provisions, and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

Given the operational complexity and significant cost of implementing an incident management system as described in the proposed rule, state Medicaid and operating agencies overwhelmingly agree that three years is not a feasible implementation timeframe. In addition to needing new state funding, states would likely need legislative direction or approval to pursue new/updated system procurement and would need to make substantive policy changes, including amending definitions of the terms "critical incident" and "investigation" across program authorities.

State Medicaid and operating agencies emphasized the need for sub-regulatory guidance prior to beginning implementation activities, to ensure their incident management systems align with CMS's expectations. It is imperative that states receive this guidance before starting work to implement these systems, because once states begin implementation activities – particularly those tied to funding requests to their legislatures — it would be challenging, if not impossible, to change course and still complete implementation within the required timeframe. **We recommend that the timeframe for implementation be based on the provision of sub-regulatory guidance, rather than the effective date of the rule, to ensure effective and efficient program design and implementation. Further, we recommend CMS allow states 4-5 years for implementation following issuance of sub-regulatory guidance.** Many states will need state legislative appropriations and/or legislature approval to begin the procurement process; for states whose legislatures meet biennially, this adds up to two years to the implementation timeframe before they can begin procurement.

If the timeframe for implementation is not based on the issuance of sub-regulatory guidance, we recommend an implementation timeframe of 5-7 years. This request will provide states with time to receive the technical assistance support identified in the proposed rule and ensure system adequacy in procurement and operation.

CMS Request for Comment: We request comment on whether we should establish similar health and welfare requirements for section 1905(a) state plan personal care, home health, and case management services.

The expansion of these requirements to state plan benefits would pose additional challenges and burdens to the states. Many state agencies operate Medicaid state plan services through different branches of the state agency. For these states, implementation could prove challenging and costly, and may not have the desired impact given the mechanism and requirements that are already in place to ensure access and quality for state plan benefits. **We recommend against expanding the requirement to section 1905(a) state plan services at this time.** States should be encouraged to implement critical incident reporting, where applicable, but this decision should be left up to each state.

CMS Request for Comment: We request comment on the application of these provisions across section 1915(i), (j), and (k) authorities.

ADvancing States supports the intent to align the different HCBS program authorities and apply the critical incident management system to additional HCBS authorities. We support the application to the 1915(i), (j) and (k) authorities.

However, we believe there will be additional, nuanced challenges to implementing this requirement in self-direction. Therefore, we recommend CMS allow additional time for states to implement this requirement in the 1915(j) authority and for self-directed services delivered under other HCBS authorities.

CMS Request for Comment: CMS requests comment on the accuracy of our cost estimate.

State Medicaid and operating agencies indicate the projected costs for a critical incident management system severely underestimate the true cost and burden to states.

First, the estimate assumes only 39 states would need to update existing electronic incident systems and 9 states would need to implement new incident management system. As stated previously, we expect many states will implement electronic systems that are program specific and will not have one centralized electronic system across all programs. As a result, the CMS estimate underrepresents the number of state systems necessary to come into compliance with the regulation.

In addition, the overall time estimates and cost for requirements/tasks do not include state staff time to triage, review, investigate, and consult with providers and case managers on critical incidents. Most state incident management systems operate with state staff working in partnership with provider entities and case managers. The proposed changes will increase overall incident reporting and, as such, will increase state staff time to assist with management and oversight of these cases. We do not see these costs accounted for in CMS's one-time and ongoing cost estimates for the system.

Compliance Report Requirements

CMS Request for Comment: We invite comments on whether the timeframe for states to report on the results of the incident management system assessment is sufficient or if we should require reporting more frequently (every year) or less frequently (every 3 years).

ADvancing States supports the proposed reporting frequency for states to report on the results of the incident management system assessment. State Medicaid and operating agencies have not expressed concerns about this timeframe.

CMS Request for Comment: We also invite comment on whether we should require reporting more frequently (every 3 or 4 years) for states that are determined to have an incident management system that meets the requirements at § 441.302(a)(6). If an alternate timeframe is recommended, we request that commenters provide the rationale for that alternate timeframe.

ADvancing States supports the proposed reporting frequency for states that are determined to have an incident management system that meets the requirements at §441.302(a)(6). State Medicaid and operating agencies have not expressed concerns about this timeframe.

CMS Request for Comment: We invite comments on the timeframe for states to report on the critical incidents, whether we should require reporting less frequently (every 2 years) and, if an alternate timeframe is recommended, the rationale for the alternate timeframe.

ADvancing States supports the proposed reporting frequency. State Medicaid and operating agencies have not expressed concerns about this timeframe.

Impact to Self-Direction

ADvancing States supports reporting of critical incidents for all HCBS beneficiaries, including those participating in self-direction. However, reporting of critical incidents should be evaluated at the program level to ensure requirements for state-level system management and reporting are not contradictory to self-directed service delivery and pre-existing reporting to partner agencies (such as APS, CPS, MFCU, etc.). States reported concerns that implementation of the proposed rule requirement for reporting on self-directed beneficiaries and their workers (providers) could infringe on beneficiaries' privacy. Several state Medicaid and operating agencies also expressed concerns that they do not have authority under state statute to mandate and manage this level of critical incident reporting for self-direction.

ADvancing States recommends CMS provide a definition of the term "provider" for purposes of critical incident reporting in self-directed service models, as well as guidance on the reporting process for self-direction. As the beneficiary or a family member is often the employer of record and responsible for overseeing their service providers, it is unclear whether the self-directed employee should be responsible for critical incident reporting or if that responsibility would fall to the beneficiary. State agencies expressed concern that requiring a beneficiary to self-report critical incidents could be operationally difficult and may create the unintended consequence of infringing on the beneficiary's privacy, dignity and choice. For example, a beneficiary may feel shame or embarrassment if required to

report an instance in which they made an error when taking their medication and were hospitalized as a result.

HCBS Payment Adequacy

Proposed 42 CFR §§ 441.302(a)(6)(k)-(i)

CMS proposes to require that at least 80 percent of all Medicaid payments for homemaker, home health aide, and personal care services go to compensation for DCWs. States must report to CMS annually on the percent of payments that are spent on compensation for direct care workers. States must report separately for each service and, within each service, must separately report services that are self-directed.

ADvancing States strongly supports the intent to improve recruitment, retention, and economic security of the direct care workforce. This workforce is essential for ensuring delivery of HCBS across Medicaid programs. State Medicaid and operating agencies consistently identify the DCW shortage as a fundamental challenge to strengthening HCBS, and overwhelmingly agree with the need to increase support for DCWs.

Recommendation to Consider Alternative Strategies

While some states support the use of an identified minimum percentage threshold as a means of addressing broader workforce needs, ensuring transparency in rate distribution, and promoting consistency, opinions vary widely regarding whether the proposed, uniform standard of 80 percent is the correct threshold and whether a threshold would address the workforce challenges.

There does not appear to be sufficient data available to determine the most appropriate threshold to apply across states, or to confirm that setting a uniform threshold is the most appropriate strategy to address the workforce crisis. In addition, many state Medicaid and operating agencies have expressed concern about solely relying on the methodology used by the few states that have been early adopters of this strategy and would prefer the opportunity to establish their own evidence base. While timely and intentional interventions to address the DCW workforce shortage are necessary, implementing a rate threshold without sufficient data to understand its immediate and long-term impact on state Medicaid and operating agencies, providers, and HCBS beneficiaries risks undermining the intent of the approach and unintentionally exacerbating the workforce crisis.

Many state Medicaid and operating agencies have expressed concern that setting a uniform percent threshold will disfavor 1) small and new providers as compared to larger, more established providers; 2) minority-owned provider agencies; and 3) rural and frontier providers. Small providers often have fewer options to optimize administrative costs and experience higher costs for recruiting and maintaining staff, as well as covering travel time to get DCWs to beneficiaries. Setting a uniform threshold could also disincentivize providers from delivering services to targeted populations for whom service delivery requires additional training, supervision, and administrative support. Of specific concern is that a uniform standard may unintentionally disfavor or crowd out small and minority-owned provider agencies and exacerbate the degree to which large agencies with proportionately lower administrative costs continue to be the primary HCBS providers. The application of this provision to specific service types may also incentivize providers to shift away from delivering these services, in favor of delivering

other HCBS services without a minimum percentage threshold for DCW compensation. This could reduce provider pools and limit beneficiary access to the services subject to this requirement.

Implementation of a minimum percentage threshold could also limit states' ability to offer value-based payments or other financial quality incentives for the affected services. Based on these concerns, **ADvancing States believes establishing a percentage threshold for DCW compensation without further analysis will likely not achieve the intended outcomes. We recommend that CMS consider alternative approaches; we offer alternatives below.**

- **Expand proposed rate transparency requirements to collect meaningful data on the DCW workforce over a 3-5 year period to inform further interventions.** In collaboration with state Medicaid and operating agencies and other stakeholders, evaluate this data to identify and consider options to support/increase DCW compensation. If the data indicate a percentage threshold is appropriate, states will collectively be in a better place to determine that figure as a starting point. This approach would help ensure CMS and states have the necessary evidence to establish interventions that are feasible for states and providers to implement and that will have meaningful positive impact on the workforce.
    - Data collection requirements could apply to services beyond personal care services, homemaker, and home health aide services (e.g., habilitation, adult day services, and residential services).
    - Required data elements could include: percentage of Medicaid service rates that providers direct toward DCW compensation; provider administrative costs; provider transportation and training costs; outcome-based payments; and state rate-setting methodology.
    - The Staff Stability Survey (recently renamed the State of the Workforce survey) administered by the National Association of State Directors of Developmental Disabilities (NASDDDS) and ADvancing States can gather critical data elements such as DCW turnover and retention rates, benefit availability, and average hourly rate.
    - In alignment with proposed requirements for state transparency and stakeholder engagement, CMS should consult with state Medicaid and operating agencies, rate-setting experts, DCWs, and HCBS beneficiaries throughout the process of data review and development of any subsequent requirements for states.
- **Adopt a framework/process for states to propose a rate-setting strategy for CMS review and approval to address workforce issues.** This would allow states more flexibility in their rate-setting process while still ensuring transparency and CMS oversight to ensure payment adequacy. This could function similarly to the statewide transition plan process for the HCBS Settings Rule, where a state would submit to CMS their proposed rate-setting process and rate amounts, to be implemented within a CMS-determined timeframe. This process could also be incorporated into the rate transparency requirements included in other sections of the proposed rule.
- **Allow states to elect their own minimum percentage pass-through amount**, based on state-specific data, experience, and provider/stakeholder engagement.

- **Add to the minimum percentage threshold requirement an exemption for states with a minimum hourly base wage of $15 per hour or higher for DCWs who deliver the affected services.** Many states have established a minimum base wage amount to ensure payment adequacy for DCWs, and setting a base wage that is high enough to adequately reflect cost of living in the state would likely be more effective than requiring a minimum percentage threshold (i.e., a base wage of $15 per hour provides greater compensation to DCWs than a wage of $10 per hour where the $10 equates to a certain percentage of total service costs).

In addition, Medicaid and operating agencies reinforce that solving the workforce challenge will require implementation of additional strategies beyond addressing DCW compensation, including building out meaningful career ladders and providing training and support. CMS should continue to actively partner with the ACL and other sister federal agencies to promote a comprehensive, integrated campaign that addresses the multiple facets of the direct workforce crisis (promotion of and improvement of social valuation of this work, workforce pipelines, immigration policy, wages, benefits, training, vehicles for retirement savings, etc.).

80 Percent Requirement

CMS Request for Comment: We request comment on the following options for the minimum percentage of payments that must be spent on compensation to direct care workers: (1) 75 percent; (2) 85 percent; and (3) 90 percent. If an alternate minimum percentage is recommended, we request that commenters provide rationale.

As noted above, we urge CMS to consider alternative approaches to setting a minimum percentage for DCW compensation. However, if a percentage threshold requirement is included in the final rule, ADvancing States recommends requiring a minimum percentage of **no more than 70 percent** of payments be spent on compensation to direct care workers.

CMS noted in its rationale for the 80 percent threshold the fact that a handful of states mandated a rate increase pass-through to DCWs for the time-limited wage increases they implemented under their American Rescue Plan Act (ARPA) spending plans. ADvancing States would offer that these mandates only affected a small portion of total DCW wages and most often were structured as one-time bonus or retention payments, whereas this proposal would affect all wages and, as noted below, potentially hamper agencies' ability to remain in business.

Many states have expressed concern that setting a uniform percent threshold will disfavor 1) small and new providers as compared to larger/established providers; 2) minority-owned and operated provider agencies; and 3) rural and frontier providers. Small providers often have fewer options to optimize administrative costs and experience higher costs for recruiting and maintaining staff, as well as covering travel/windshield time to get workers to recipients. Setting a uniform threshold could also disincentivize providers from delivering services to targeted populations for whom service delivery requires additional training, supervision, and administrative support. Of specific concern is that a uniform standard may unintentionally disfavor or crowd out small provider agencies and exacerbate the degree to which large agencies with proportionately lower administrative costs continue to be the primary HCBS providers. Small local providers, many serving underserved Medicaid beneficiaries, are not able to distribute administrative costs across larger Medicaid populations. In one state, 75 percent of enrolled HCBS

providers serve fewer than three beneficiaries at a time. The small service pool in relation to the administrative costs for these providers would make meeting a targeted wage threshold impossible. Implementation of a minimum percentage for DCW compensation could inadvertently create inequity in provider availability and HCBS service access, especially in rural communities and communities serving people of color and tribal nations.

Finally, if a minimum percentage threshold is included in the final regulation, it is important to broaden the definition of compensation to include the full array of worker training, supervision, oversight, quality support, and supplies that many states have incorporated into their direct service rates. This would level the playing field for the varying range of service models that states deploy to deliver personal care services across state HCBS program authorities. Key components of a rate model often include direct care compensation (wage cost, employment-related expenditures and supervision costs), billing adjustments to direct care compensation costs (productivity of direct service staff, absences), program support expenses (staff training and development, activities, expenses for devices and technology, supplies, transportation, and other service related to quality of care), and administrative expenses (payroll, non-payroll and facility and administrative costs). The wage cost is often a small portion of overall worker support and retention in HCBS direct care service work. Administrative costs should be limited to payroll, non-payroll, and facility and administrative costs to ensure provider agencies are not penalized for offering robust training and quality initiatives to support their workers.

Affected Services & Authorities

CMS Request for Comment: We request comment on whether the requirements should apply to other services at §440.180(b) -- adult day health, habilitation, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness.

As noted above, we recommend CMS consider alternative approaches to setting a minimum percentage for direct care worker compensation. However, if a percentage threshold requirement is included in the final rule, ADvancing States recommends a lower threshold, that CMS limit which services are included, and does not expand the requirement to additional services.

We recommend CMS limit the requirement to personal care services only and remove homemaker and home health aide services. Homemaker services do not cover activity of daily living (ADL) tasks as typically associated with direct care to HCBS recipients. Since CMS's rationale in this provision does not address this aspect of the services, homemaker services do not appear appropriate to include. Limiting the requirement to personal care services would allow CMS and states to concentrate on the most utilized service and would make the requirement more operationally feasible for states. It would reduce the burden on states to define and identify affected services and, further, allow states to build from policy and operational work already completed for implementation of EVV as required by the 21st Century Cures Act. For the purposes of EVV, states have already defined and identified personal care services, in most cases to include habilitation services that have a personal care component. By operating from the same definition for purposes of implementing this requirement, states would likely capture habilitation services delivered to individuals with intellectual and developmental disabilities.

CMS Request for Comment: We also request that commenters respond separately on the minimum percentage of payments for facility-based residential services and other facility-based round-the-clock services that have other indirect costs and facility costs that would be paid for at least in part by room and board payments that Medicaid does not cover. If a minimum percentage is recommended for any services, we request that commenters provide the rationale for that minimum percentage.

As noted above, we recommend CMS consider alternative approaches to setting a minimum percentage for DCW compensation. However, if a percentage threshold requirement is included in the final rule, we recommend that it not be applied at this time to facility-based residential services or other facility-based, round-the-clock services. If CMS finalizes the proposal to implement a minimum percentage for personal care services, home health aide, and homemaker services, the requirement should be limited in scope to allow time for CMS and states to evaluate the effectiveness of this strategy in addressing the direct care workforce shortage and any necessary changes to the requirement before expanding to additional services.

CMS Request for Comment: We request comment on the application of payment adequacy provisions across section 1915(i), (j), and (k) authorities.

As noted above, we urge CMS to consider alternative approaches to setting a minimum percentage for direct care worker compensation. However, if a percentage threshold requirement is included in the final rule, ADvancing States supports the application to 1915(i), (j) and (k) authorities.

We would highlight that there may be nuances to implementing this requirement in self-direction models, and additional time may be needed for states to successfully implement.

CMS Request for Comment: We request comment on whether we should apply these requirements to section 1905(a) State plan personal care and home health services.

As noted above, we urge CMS to consider alternative approaches to setting a minimum percentage for direct care worker compensation. However, if a percentage threshold requirement is included in the final rule, ADvancing States recommends that CMS not apply these requirements to section 1905(a) state plan personal care and home health services. As described in the preamble to the proposed rule, states do not have as extensive data collection and reporting processes in place for 1905(a) state plan personal care services as they do for other HCBS authorities.

CMS Request for Comment: We request comment on whether we should exempt services delivered using any self-directed service delivery model under any Medicaid authority.

We urge CMS to consider alternative approaches to setting a minimum percentage for direct care worker compensation. However, if a percentage threshold requirement is included in the final rule, ADvancing States recommends CMS allow states additional time for implementation and outline reporting metrics specific/tailored to self-directed services.

In particular, CMS should consider the following operational challenges when finalizing reporting requirements for self-directed services:

- There are various self-directed service models, including fiscal vendor models and/or individual budget-authority models, in which implementing and overseeing adherence to a minimum

percentage threshold would be challenging, if not impossible. Rates for self-directed services may or may not include oversight components, including support brokerage and fiscal management services.

- States are concerned that the enforcement of a minimum percentage threshold, as well as detailed reporting, would force the state to interfere in a beneficiary's employment relationship with the direct care worker. This risks positioning the state agency in the role of employer for purposes of Department of Labor employer responsibility considerations. This could infringe on the beneficiary's choice and control over their services. For example, in self-direction programs that offer individual-directed goods and services, this requirement could prevent a beneficiary from using their self-direction budget to make purchases, because their budget would necessarily be dedicated to DCW compensation.
- This requirement could place additional burden on beneficiaries who self-direct their services by requiring them to document and report rate and wage information, which could disincentivize beneficiaries from choosing to self-direct their services.

State Medicaid and operating agencies agree that DCWs who deliver services in self-direction options and programs must be included in interventions to support the direct care workforce. Given the nuances of self-direction models across states, we encourage CMS to consider how best to capture meaningful data specific to that service delivery model to ensure what is being captured and reported is comparable to the agency-based service side. We also encourage CMS to consider other workforce incentives in self-directed services delivery. These could include support for pre-employment costs, such as covering self-directed training and background checks, which are currently limiting the worker pool for self-directed participants.

We suggest that self-direction rates and compensation be included in the rate and wage data collection that ADvancing States proposes as an alternative to establishing a minimum percentage threshold. We also suggest that self-direction rates and compensation could be an area of specific focus in those data collection and evaluation efforts. Reviewing and evaluating self-directed rate data as part of this process would allow CMS, in collaboration with states and other stakeholders, to identify specific approaches for self-direction appropriate for that service delivery model. Further, it may also be valuable to review the percent of the beneficiary's self-direction budget spent versus authorized to gauge access for self-directed services. To ensure effective and meaningful reporting, we encourage CMS to allow an extended timeframe for implementation of this requirement in self-direction.

Definition of Compensation

CMS Request for Comment: We request comment on whether the definition of compensation should include other specific financial and non-financial forms of compensation for direct care workers.

DCW training and travel costs are all too real to state Medicaid and operating agencies that employ DCWs and should be factored into the equation when establishing requirements for HCBS direct care rates and spending.

As noted above, we urge CMS to consider alternative approaches to setting a minimum percentage for direct care worker compensation. If CMS pursues an alternative strategy, it may not be feasible or

valuable to include training and travel costs in the definition of compensation; however, we encourage CMS to account for these costs in the implementation of an alternative strategy.

If a minimum percentage threshold is included in the final rule, we recommend CMS expand the definition of compensation to include the full array of worker training, supervision, oversight, quality support, and supplies that many states have incorporated into their direct service rates. This would level the playing field for the varying range of service models that states deploy to deliver personal care services across HCBS programs. Key components of a rate model often include direct care compensation (wage cost, employment-related expenditures and supervision costs), billing adjustments to direct care compensation costs (productivity of direct service staff, absences), program support expenses (staff training and development, activities, expenses for devices and technology, supplies, transportation, and other service related to quality of care), and administrative expenses (payroll, non-payroll and facility and administrative costs). The wage cost is often a small portion of overall worker support and retention in HCBS direct care service work. Administrative costs should be limited to payroll, non-payroll, and facility and administrative costs to ensure provider agencies are not penalized for offering robust training and quality initiatives to support their workers.

Definition of Direct Care Worker

CMS Request for Comment: We request comment on whether there are other specific types of direct care workers that should be included in the definition, and whether any of the types of workers listed should be excluded from the definition of direct care worker.

State Medicaid and operating agencies generally support the broad, functionally-based definition of DCW that CMS proposes. We recommend CMS specify, in the final rule or in sub-regulatory guidance, which employees are *excluded* from the definition for ease of provider education.

It is important to note that typical definitions of DCWs have focused on unlicensed, non-clinical providers of personal care services and have not typically included nurses. We understand this to be an intentional expansion, but some Medicaid agencies note that, by including nurses in the definition of DCWs, services that are reliant on nursing will have an easier time meeting the 80 percent requirement due to the higher levels of compensation for nurses. We recommend excluding nurses from the definition of DCW, as they are excluded from the National Core Indicators® Staff Stability survey data collection on DCWs.

Definition of Personal Care Services

We request CMS provide a federal definition or more detailed description of the term "personal care services." States would benefit from more specific detail on the definition of this term, particularly as that may implicate constituent parts of other services (e.g., residential habilitation). It is notable that while CMS's definition of "direct care worker" (DCW) specifically includes reference to job roles that provide services for individuals with intellectual and developmental disabilities, the definition of personal care substantially excludes the habilitative services on which those people rely. If CMS does not provide a federal definition, the resulting data will be difficult – if not impossible – to generalize nationally based on the differences in state definitions.

Implementation Timeframe

CMS Request for Comment: We invite comments on the overall burden associated with implementing this section, whether this timeframe is sufficient, whether we should require a shorter timeframe (such as 3 years) or longer timeframe (such as 5 years) and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

CMS proposes a four-year implementation timeline. **Due to the volume of work states would be required to complete to implement this requirement, we recommend CMS allow states at least six years for implementation.** State Medicaid and operating agencies overwhelmingly report concerns about the feasibility of this timeline. Implementation of this requirement will be complex and time intensive and will require extensive collaboration with and education and training for provider entities. Steps to successful implementation would likely include: 1) funding requests to state legislature; 2) potential legislative changes; 3) administrative rulemaking; 4) system design and development; 5) education, training, and oversight of provider implementation and reporting; and 7) ongoing monitoring and support.

Reporting

CMS proposes new annual reporting requirements on the aggregate percent of payments for homemaker, home health aide, and personal care services that is spent on compensation for direct care workers, separately by each of the three services and for self-directed services.

ADvancing States supports this proposal as a positive strategy to improve transparency and facilitate meaningful comparisons across programs. However, collecting provider-level data is time consuming and can require significant follow-up to ensure all providers have submitted data.

As noted above, we urge CMS to consider alternative approaches to setting a minimum percentage for direct care worker compensation. If CMS pursues the proposed alternative strategy to collect rate and compensation data before determining further interventions, we support the proposed reporting requirement timeframe and would support expansion of reporting requirements to additional services (e.g., residential habilitation services, day habilitation services, and home-based habilitation services).

However, if a percentage threshold requirement is included in the final rule, ADvancing States recommends **CMS amend the reporting frequency to biennial to allow states sufficient time to collect data, conduct necessary follow-up activities, and publish data while simultaneously working to implement the minimum percentage requirement.**

State Medicaid and operating agencies report:

- An optional self-attestation process would be helpful to Medicaid programs, although some Medicaid agencies note that they would need to collect at least some provider-level data to ensure compliance;
- Aggregate reporting is preferable to a more granular approach (e.g., reporting on the percent of payments for certain HCBS that are spent on compensation for direct care workers at the delivery system, HCBS waiver program, or population level; reporting on median hourly wage and on compensation by category);

- It would be useful and appropriate to permit state Medicaid and operating agencies to exclude from their reporting to CMS payments to providers of agency-directed services that have low Medicaid revenues or serve a small number of beneficiaries; and
- Focusing this reporting requirement on HCBS delivered through 1915 or 1115 authorities, as opposed to 1905(a) authorities, is appropriate.

Overall Burden

Related to operational impacts of implementing the payment adequacy provisions, state Medicaid and operating agencies report significant concerns about the cost and effort of implementing, monitoring, and ensuring ongoing compliance with this requirement. States also request:

- Clarity and specificity in definition of terms; and
- Uniform, federally-produced enabling tools including sub-regulatory guidance and an HCBS cost report template.

Due to the volume of work states would be required to complete to implement this requirement, we recommend CMS allow states at least six years for implementation. State Medicaid and operating agencies overwhelmingly report concerns about the feasibility of this timeline. Implementation of this requirement will be complex and time intensive and will require extensive collaboration with and education and training for provider entities. Steps to successful implementation would likely include: 1) funding requests to state legislature; 2) potential legislative changes; 3) administrative rulemaking; 4) system design and development; 5) education, training, and oversight of provider implementation and reporting; and 7) ongoing monitoring and support.

Access Reporting

Proposed 42 CFR § 441.311(d)

Timeliness of Access

CMS proposes to require states to report annually on timeliness of access to personal care, homemaker, and home health aide services. The report must include:

- The average amount of time from initial service authorization to the initiation of services (i.e., Service initiation timeliness measure); and
- The percent of authorized service hours actually provided in the past 12 months, for individuals newly approved to receive services in that time (i.e., gaps in care measure).

ADvancing States strongly supports the intent to improve and expedite a beneficiary's access to services. State Medicaid and operating agencies agree that the collection and evaluation of data regarding timeliness of access is a promising practice to help states better achieve this goal. However, state agencies have identified several complicating factors that would reduce the value of the proposed data reporting and collection. For the service initiation timeliness measure, there may be instances where a beneficiary is receiving another service that meets their needs prior to initiation of personal care, homemaker, or home health aide services. In addition, some states have delegated service authorization

activities to HCBS case managers, and therefore do not have systematic ways to collect and report on that data.

For the gaps in care measure, the proposed data collection and reporting would not reflect individual circumstances that may contribute to differences in services authorized and services delivered. These circumstances could include instances where an individual is hospitalized, changes providers, is traveling or unavailable for service delivery, or otherwise refuses services. Medicaid churn could also be a complicating factor. These circumstances should not be considered gaps in care. Without capturing additional circumstantial information, there may appear to be more gaps in care than really exist. This proposed requirement could also have the effect of unintentionally incentivizing the state to under-authorize services to meet reporting requirements, in order to avoid the appearance of under-utilization of services or gaps in care.

CMS Request for Comment: CMS invites comments on whether there are other specific metrics related to individuals' use of authorized homemaker services, home health aide services, or personal care services that they should require states to report, either in place of or in addition to the metric they proposed.

ADvancing States recommends CMS allow a state the option to choose one of the proposed criteria on which to report, or for the state to propose a different metric on which to report. This would permit flexibility in reporting on and context for data related to timeliness of initiation of person-centered service plans that reflects the reality of inhibiting circumstances beyond the state agency's control (e.g., hospitalization, refusal by member; unavailability of or change in provider) as well as the potential that while all authorized services have not been initiated, the beneficiary is receiving another service that effectively meets their immediate needs. Because HCBS programs and services operate so differently among states, and often even within a single state, the results of the proposed metrics will vary greatly from state to state and program to program. However, we would offer that it is still valuable to collect and review state-specific and program-specific data to pinpoint specific areas for intervention within each state. State flexibility to determine the most appropriate metrics for their programs is essential to ensuring meaningful data collection and evaluation, and subsequent action steps.

CMS could use this as the first stage in a phased approach, similar to the implementation of EVV. This would allow states flexibility to begin data collection and reporting tailored to their programs, and expand to include additional, more standardized metrics in the future.

Allowing a state the option to choose their reporting metric(s) would make this requirement operationally feasible, as states would have the opportunity to tailor their reporting to their programs and existing system capabilities and would result in more meaningful data collection. One state has included a 'missed visits' measure in its MLTSS program that is quite similar to the one proposed in this rule. That state emphasized the significant amount of time it took to identify legitimate reasons for services to not have been provided and build the system mechanisms to capture that data. They shared that it is primarily a case management record retrieval process, as there are not electronic systems to capture services not provided. It took this small state almost three years to gather complete and accurate data; we expect that larger states would need a much longer runway for implementation.

CMS Request for Comment: CMS requests comment on whether this requirement to report on timeliness of access to personal care, homemaker, and home health aide services should apply to additional services authorized under section 1915(c) of the Act.

ADvancing States recommends this requirement not be applied to additional services authorized under section 1915(c).

Further, we recommend narrowing the scope of this requirement to personal care services only and removing homemaker and home health aide services from the requirement. Homemaker services do not cover ADLs, as typically associated with direct care to HCBS beneficiaries. Since CMS's rationale in this provision does not address this aspect of the services, homemaker services do not appear appropriate to include. Home health aide services are typically offered under the Medicaid State Plan rather than a 1915(c) waiver. Limiting the requirement to personal care services would allow CMS and states to concentrate on the most utilized service and would make the requirement more operationally feasible for states. It would reduce the burden on states to define and identify affected services and, further, allow states to build from policy and operational work already completed for implementation of EVV as required by the 21st Century Cures Act. For the purposes of EVV, states have already defined and identified personal care services, in most cases to include habilitation services that have a personal care component. By operating from the same definition for purposes of implementing this requirement, states would likely capture habilitation services delivered to individuals with intellectual and developmental disabilities.

CMS could use this as the first stage in a phased approach, similar to the implementation of EVV. This would allow states flexibility to begin data collection and reporting for personal care services and expand to include additional services in the future.

CMS Request for Comment: CMS invites comment on the timeframe for states to report on the metrics for homemaker, home health aide, and personal care services, whether they should require reporting less frequently (every 2 or 3 years) and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

ADvancing States recommends CMS extend the proposed reporting from annual to biennial, to reduce administrative burden to states Medicaid and operating agencies.

CMS Request for Comment: CMS requests comment on the application of these timeliness of access provisions across section 1915(i), (j), and (k) authorities.

ADvancing States supports the application of these requirements across 1915(i), (j) and (k) authorities. We would highlight that there may be nuances to implementing this requirement in self-direction models, and additional time may be needed for states to successfully implement this requirement for self-direction.

CMS Request for Comment: CMS requests comments on whether they should establish similar reporting requirements for section 1905(a) "medical assistance" state plan personal care, home health, and case management services.

ADvancing States recommends CMS not expand the requirement to 1905(a) state plan services at this time.

Implications for Self-Direction

We believe there is value in understanding how different service delivery models (i.e., agency-based and self-direction) ensure service access. However, there are nuances to self-direction that could create challenges for meaningful aggregate reporting within states, as well as across states for national comparisons.

The proposed timeliness metrics may not accurately reflect access to self-directed services, given the level of choice and control the beneficiary has over their service delivery. The nuances of self-direction and wide variations in self-directed programs and models across states, including vendor/fiscal models and the spectrum of individual budget authority, increase the difficulty of drawing accurate and meaningful conclusions from timeliness metrics.

Examples of potential challenges to meaningful data collection include:

- *Reporting timeliness from service authorization to service delivery:* There is large variation across states and programs in the operational process for beneficiary enrollment in a self-direction program or option and hiring/onboarding of the beneficiary's direct care workers. Unlike agency-based services, the beneficiary is responsible for selecting, hiring, and training their workers. In many states, self-directed workers are also required to complete provider enrollment steps, which could include screening and background checks along with enrollment in the provider system. These processes often result in longer wait times between authorization of services and the start of service delivery; however, these lengthier timeframes do not necessarily represent a gap in care or failure on the part of the state, financial management services (FMS) provider, direct care worker, or beneficiary to complete the necessary service initiation steps in a timely manner.
- *Reporting timeliness in annual service utilization:*
    - Because self-direction participants have control over the schedule for their service delivery, there are more likely to be instances where services are not delivered as authorized based on the beneficiary's choice regarding scheduling or decision to refuse services.
    - In self-direction models that offer budget authority, the beneficiary has the ability to negotiate the rate of pay for workers and move budget dollars between services as needed throughout the budget year. If individual-directed goods and services purchases are permitted, the beneficiary may choose to purchase an item that supports their well-being in place of having in-person services delivered. For example, the beneficiary may purchase a microwave that allows them to heat their own meals, reducing the need for a direct care worker to provide support for this activity.

For these reasons, we recommend data elements collected and reporting processes for self-direction be tailored to that service delivery model. This will provide clearer results to better inform any necessary interventions to increase access. Further, it will allow more accurate comparison to timeliness of access to agency model services.

Waiting List Reporting

ADvancing States strongly supports the intent to improve and expedite a beneficiary's enrollment and access to waiver services. State agencies agree the collection and evaluation of data regarding time individuals spend on a waiting list is valuable for helping states understand and evaluate the need for waiver services in their state and develop interventions to support timely access to services. However, state agencies emphasize that access to waiver services is limited by the amount of state funding available to support waiver slots; in the absence of additional funding, it is not possible for states to expedite waiting list times by creating additional waiver slots.

Waiting list definitions and processes vary widely among states and even among individual state programs. This makes it challenging to draw meaningful conclusions about the time individuals spend on the waiting list. Some states operate an interest list or similar-named list, rather than a waiting list. In these cases, anyone can sign up to express interest in a waiver program. Interested individuals may not be assessed for eligibility at the time they join the interest list and thus may not be considered "waiting to enroll" as described in the proposed rule, as they are waiting to be determined eligible to enroll. It is unclear whether the proposed requirement applies to interest lists and similarly structured lists and enrollment processes. If the requirement does apply, states that use an interest list approach would have to make significant changes to their processes to meet the waiting list reporting requirement.

CMS Request for Comment: CMS invites comments on whether there are other specific metrics or reporting requirements related to waiting lists that they should require states to report, either in place of or in addition to the requirements they proposed.

ADvancing States recommends CMS not add any other specific metrics or reporting requirements related to waiting lists.

CMS Request for Comment: CMS requests comment on the application of the waiting list reporting provisions across section 1915(i), (j), and (k) authorities.

ADvancing States assumes this requirement would necessarily be limited to the 1915(c) authority and to the 1915(j) authority, where it is used as the state's authority for self-direction in a 1915(c) waiver. We recommend limiting this requirement to these authorities.

CMS Request for Comment: CMS invites comments on the timeframe for states to report on their waiting lists, whether they should require reporting less frequently (every 2 or 3 years), and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

ADvancing States supports the proposed requirement for states to report annually on their waiting lists. State agencies indicate that this reporting timeframe is feasible.

However, state Medicaid and operating agencies have also highlighted that waiting list volumes may vary at certain times of year or from year to year, depending on how states structure the release of new waiver slots and the timing of the state legislative sessions where new funding for waiver slots may be approved. It is important to take these factors into account when considering reporting frequency and when evaluating reported data from year to year.

HCBS Quality Measure Set

Proposed 42 CFR §§ 441.312, 441.474(c), 441.585(d), and 441.745(b)(1)(v)

CMS proposes to require states to implement the HCBS Quality Measure Set, introduced in State Medicaid Director (SMD) Letter #22-003: Home and Community Based Services Quality Measure Set (issued July 21, 2022). This would replace current requirements described in "Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers" (issued March 12, 2014).

ADvancing States supports the comprehensive approach to monitoring HCBS service delivery and ensuring HCBS delivery systems utilize consumer feedback and experience in their quality strategies. The proposed rule includes measures that are relevant, useful, and actionable, and it is evident that CMS incorporated states' feedback and collaboration in development of this requirement. As measure stewards of the National Core Indicators – Aging and Disabilities (NCI-AD™), ADvancing States appreciates the inclusion of NCI-AD™ measures in the HCBS quality measure set, as states have used these measures for quality improvement since 2015. NCI-AD™'s primary aim is to collect and maintain valid and reliable data that give states a broad view of how Medicaid HCBS impact the quality of life and outcomes for beneficiaries.

Further, ADvancing States appreciates and strongly supports CMS's commitment to "Ensure that all measures included in the Home and Community-Based Services Quality Measure Set reflect an evidence-based process including testing, validation, and consensus among interested parties; are meaningful for states; are feasible for state-level, program-level, or provider-level reporting as appropriate." These are the correct standards. We also appreciate that CMS emphasizes consultation with state Medicaid and operating agencies in this process.

Reporting on the HCBS Quality Measure Set

CMS Request for Comment: CMS invites comments on whether the timeframe for states to report on measures in the HCBS Quality Measure Set is sufficient, whether they should require reporting more frequently (every year) or less frequently (every 3 years), and if an alternative timeframe is recommended, the rationale for that alternative timeframe.

ADvancing States appreciates the flexibility inherent in the proposed requirement and the consideration CMS has afforded for implementation of the HCBS Quality Measure Set. State Medicaid and operating agencies generally support the proposed biennial reporting timeframe. Several states noted that implementing biennial reporting, rather than annual reporting, would be preferable and beneficial in terms of workload and cost.

We recommend CMS offer states additional flexibility in reporting periods, such as (1) allowing states to choose the cadence of their biennial reporting (e.g., choosing to report on odd-numbered years or even-numbered years, or to alternate reporting years for the state's various waiver programs); and (2) allowing additional time if necessary for states to initiate reporting. CMS may also consider allowing states to phase in the implementation of the new reporting requirements. This additional flexibility would be especially helpful for the many states that would need to adopt one or more of the consumer

surveys cited in the HCBS Quality Measure Set (NCI®-IDD, NCI-AD™, HCBS CAHPS®, or POM®). In order to launch a consumer survey, states will need to complete implementation steps, including: securing state legislative approval; identifying and approving funding allocations; executing procurement with survey vendors; and migrating current performance measures or survey outcomes into crosswalks with the new Measure Set. Further, in our experience, states often require a year or more of technical assistance and project management planning prior to implementing the NCI-AD™ survey. Extending this timeline to allow for sufficient change management planning would better position states for successful implementation and meaningful data collection.

Several states currently participate in one or more of the consumer surveys cited in the HCBS Quality Measure Set (NCI®-IDD, NCI-AD™, or HCBS CAHPS®). Since 2015, approximately 30 states have participated in NCI-AD™, with 24 states expected to participate in the 2023-2024 survey cycle.

States that do not currently deploy one of CMS's recommended consumer experience surveys would also face burdens in analyzing the cost and benefits of the different consumer surveys tools available, obtaining authority and funding to implement or change their tools, and would require ample time to successfully implement the tool. States may have different agencies, divisions, or bureaus that operate their various waiver programs, and time for coordination at the state level should be observed and allowed.

CMS Request for Comment: CMS welcomes comments on whether there should be a threshold of compliance that would exempt the state from developing improvement strategies, and if so, what that threshold should be.

State Medicaid and operating agencies overwhelmingly support a high threshold of compliance as "there is always room for improvement." In short, states agree with the intent to raise minimum thresholds and requirements for quality service delivery. However, there was not consensus identifying a replacement threshold that would exempt states from developing and implementing improvement strategies.

States voiced curiosity and concern about the rationale for establishing a specific percentage threshold of compliance and had many lingering questions about what this minimum threshold would replace. We request CMS clarify and record their intention of establishing a minimum threshold and specify what the threshold would replace.

CMS notes that the new requirements would replace the 2014 "Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers" guidance. However, this is a guidance document that modifies previous guidance on §1915(c) waivers. We request CMS clarify whether the requirements outlined in the proposed rule replace the original requirements or modified guidance, or both. State Medicaid and operating agencies indicated support for the replacement of the current 1915(c) waiver performance measures structures with the HCBS Quality Measure Set. States do not support a hybrid approach that retains elements of the current 1915(c) waiver assurance process while adding these new quality measure reporting requirements.

One state Medicaid agency shared their experience of overhauling performance measures within the last five years, noting that they encountered significant administrative challenges when implementing

evidentiary reporting for different measures on a different cadence of three years. States fear they would have the same or similar experience implementing the proposed requirement, as evidentiary requirements appear to remain in place and different reporting points/measures will be required in different timeframes.

CMS Request for Comment: CMS also invites comments on any additional changes they should consider in HCBS Quality Measure Set Reporting.

ADvancing States requests CMS reconsider allowing states flexibility to (1) choose the measures that would be most meaningful to implement of those outlined in the HCBS Quality Measure Set, and (2) determine how to apply measures to their various HCBS populations and authorities.

Further, state Medicaid and operating agencies will face significant costs – both one-time for initial implementation and ongoing – to implement and operationalize consumer experience surveys and analyze findings for meaningful quality improvement and policy change. We request CMS explore the maximum flexibility permitted by statute and regulation to apply the enhanced FMAP for quality activities conducted by external quality review organizations (EQRO) to states that operate a FFS delivery system. The inherent inequities across states are problematic, given the broad applicability of these provisions.

CMS Request for Comment: CMS requests comment on the application of the reporting provisions across section 1915(i), (j), and (k) authorities.

Operationalizing these reporting provisions across HCBS authorities will pose challenges for state Medicaid and operating agencies. Some states collect data and report on only certain populations at intervals such as five years, while others collect and report annually or biennially. Currently, the application of quality measure data collection and reporting for HCBS authorities is mixed among states; therefore, the level of operational burden to implement across section 1915(i), (j) and (k) authorities would vary across states.

Several state Medicaid and operating agencies requested exemption for 1915(i) authorities, and explained in consensus that the burden would outweigh the potential benefit of implementing the HCBS Quality Measure Set for this authority. The states noted that the service array for 1915(i) programs is more limited than in 1915(c) or other authorities and emphasized that the burden of gathering information on this population could be overwhelming. Some states voiced concern about the Measure Set stratification requirements in a smaller HCBS population. For instance, would a small sample size be able to bear multiple stratification requirements?

CMS Request for Comment: CMS requests comment on whether they should establish similar reporting requirements for section 1905(a) "medical assistance" state plan personal care, home health, and case management services.

State Medicaid and operating agencies expressed concern that implementing this or similar reporting requirements would be a considerable burden for 1905(a) "medical assistance" state plan personal care,

home health, and case management services. **We recommend CMS not establish similar reporting requirements for 1905(a) services in the final rule.**

States that currently implement a consumer survey, and therefore would be years ahead of implementation compared to states who do not, expressed concern at the volume and cost of representing 1905(a) beneficiaries in future reporting. Multiple states reported that, at minimum, they would have to double their sample population sizes to meet this requirement and expressed great concern at the associated burden of doing so (e.g., contract costs, staff needed for administration, ability to analyze findings, and other reporting requirements). States would require a significant amount of time and additional resources to implement the Measure Set.

Beyond the weight of potential implementation, states raised questions and concerns on the application of the current outcomes identified in the HCBS Quality Measure Set for use with the populations that utilize 1905(a) services, as these populations were not included in outcome measure development, testing, and refinement.

CMS Request for Comment: CMS invites comments on whether this timeframe is sufficient, whether they should require a shorter timeframe (2 years) or longer timeframe (4 years) to implement these provisions, and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

In isolation – detached from the other new requirements in the proposed rule – state Medicaid and operating agencies agreed that the proposed timeframe of three years would be feasible. However, states voiced significant concern about implementing this requirement in tandem with other proposed requirements, given limited capacity (state staff resources, funding, contract fees, etc. identified throughout these comments). **We recommend CMS extend the implementation timeframe for this requirement to at least three years after CMS's issuance of explanatory sub-regulatory guidance.**

CMS may also consider requiring states to begin reporting on the Measure Set no later than three years after the year the state first deploys its consumer survey.

States will be required to complete a number of complex, time-intensive implementation steps, including: securing state legislative approval; identifying and approving funding allocations; executing procurement with survey vendors; and migrating current performance measures or survey outcomes into crosswalks with the new Measure Set. Legislative sessions and budgets are often developed several years prior and anachronistically to the current program or calendar year. In addition, state agencies are subject to their state procurement and contracting requirements, which may add considerable time to implement a consumer survey as required by the Measure Set. In our experience, states often require a year or more of technical assistance and project management planning prior to implementing the NCI-AD™ survey. Extending this timeframe to allow for sufficient change management planning would better position states for successful implementation and meaningful data collection.

States that do not currently deploy one of CMS' recommended consumer experience surveys would also face burdens in analyzing the cost and benefits of the different consumer surveys tools available, obtaining authority and funding to implement or change their tools, and would require ample time to successfully implement the tool. States may have different agencies, divisions, or bureaus that operate their various waiver programs, and time for coordination at the state level should be observed and

allowed. Extending the implementation timeframe would allow states that are newly undertaking a consumer survey the necessary ramp-up time to prepare for and field the survey, and then report results to CMS.

Reporting of Stratified Data

CMS Request for Comment: CMS solicits comments on the proposed schedule for phasing in reporting of HCBS Quality Measure Set data.

ADvancing States supports a staggered implementation of quality reporting requirements. However, within the totality of the proposed rule, even the staggered implementation timeframe is likely unattainable for states either already utilizing consumer surveys, or those that will need to adopt them. We recommend CMS allow additional time and flexibility for states to phase in reporting of the HCBS Quality Measure Set data.

As discussed immediately above, states often work within the confines of state legislative approval and budgeting, in addition to state procurement and contracting requirements. State Medicaid and operating agencies request additional flexibility to implement based on the needs of their legislature and operational agencies. To successfully implement the Measure Set, states need additional time to plan internal coordination and administration.

Adopting different measures would require state Medicaid and operating agencies to reevaluate and modify quality systems infrastructures. These changes will likely cost significantly more than CMS' estimate in both time and funds. To ensure successful implementation, CMS should provide states additional funding and flexibility on phase-in.

Of note, several state agencies raised questions about the definitions used within the proposed rule and Measure Set regarding stratification. Some states expressed concern that areas required in the proposed rule are based on self-identification, self-designation, or are voluntary disclosures by participants and consumers (such as race or tribal affiliation). State Medicaid and operating agencies that currently participate in consumer experience surveys highlighted challenges they have experienced with data stratification, even when stratification is by more singular factors such as MCO or region. These agencies expressed concern with the size of the sample that would be required for multi-factor stratification, the costs incurred with these sample sizes, and the burden participants would feel, leading to survey-fatigue and lower participation over time.

State Medicaid and operating agencies questioned the basis of definitions around stratification areas and explained that definitions would need to be included and consistent across program stratification (for example – what is "disability" for purpose of stratification?). Without consistent definitions, states would likely use differing definitions and sources that would make meaningful comparisons across states and programs challenging, if not impossible. We request CMS provide sub-regulatory guidance to define key terms and further describe expectations for data stratification.

One state Medicaid agency shared their experience in attempting to comply with the HCBS Quality Measure Set as written. This state utilizes NCI-AD™. Despite multiple technical assistance meetings with measure stewards, state staff, and survey vendors, the state was unable to follow the stratification

requirements as laid out in SMD #22-003 due to the sample size of the programs. The state also had difficulties in determining what definitions applied to stratification classes such as "disability," "gender," "urbanicity," and others. Despite best efforts of all parties involved, the state was unable to follow the guidance as written.

HCBS Quality Measure Set

CMS Request for Comment: CMS invites comments on whether the timeframes for updating the measures in the HCBS Quality Measure Set and conducting the process for developing and updating the HCBS Quality Measure Set is sufficient, whether they should conduct these activities more frequently (every year) or less frequently (every 3 years), and if an alternate timeframe is recommended, the rationale for that alternate timeframe.

CMS proposes to update the measure set in a biennial cadence. State Medicaid and operating agencies voiced significant concern about the frequency of changing measures and the ability to track meaningful change over time. Several states questioned the usefulness of the measures if they change as frequently as every other year. When considered with the totality of reporting, phasing in of stratification, and other areas of the proposed rule, states felt that too many variables were changing in a short period of time and recommended against the proposed cadence for updating the measures. We recommend CMS update the measures less frequently, and suggest a revision frequency of up to 5 years.

There was consensus among state Medicaid and operating agencies that the proposed biennial cadence does not allow time for real world implementation and testing to determine if a measure yields useful results. While recognizing that CMS could potentially elect to implement no changes or measure updates at any given biennial interval, establishing these timeframes would create expectations among stakeholders and uncertainty among states. This is especially true as the process for updating appears to include re-identifying the specific measures for which reporting is mandatory and for which stratification is required. Additional time would be needed to account for unusual events (such as a pandemic, managed care expansion, etc.), and did not want to make wrong decisions because of a singular unrepresentative data point.

We urge CMS to develop a measures assessment and revision process that includes measurement experts as well as thought leaders in the HCBS field. We note that the current Medicaid and CHIP Core Measure Set workgroup – while lamenting the lack of HCBS measures – does not contain either survey measurement expertise nor significant HCBS knowledge and experience. We encourage CMS to take a different approach for developing and updating the measure set.

Further, ADvancing States would support CMS funding to determine the extent to which psychometric data are available with respect to the ability of measures to be used in a longitudinal manner (i.e., evidence exists with respect to measures being sensitive to change in outcomes across time). This characteristic is essential if measures are to be used as part of quality improvement efforts. NCI measures have implemented revisions processes on a five (5) year cycle that involves state, participant, and stakeholder feedback. To date, CMS has left this practice to measure stewards to define and implement.

CMS Request for Comment: CMS requests comment on the application of these provisions across sections 1915(i), (j), and (k) authorities.

As noted above, state Medicaid and operating agencies expressed concerns about the applicability of measures and stratification throughout all authorities. Of note, states felt uneasy about the application of measures and stratification requirements when the service array was limited and the population of recipients was small.

Estimated Burden for Reporting on the HCBS Quality Measure Set

State Medicaid and operating agencies overwhelmingly voiced that the cost estimates were much lower than experienced costs and time. Several states agreed that if surveys were to be conducted by a vendor rather than the state (which is necessary, given the staff workload required and increased burdens of larger samples), the costs would be much higher than what CMS predicts. Some cost savings may be realized when surveys are conducted via telephone rather than in person, lowering the cost per survey; however, this could incentivize states to provide fewer person-centered options for surveying.

States further expressed concern that they may need to refrain from engaging in other quality assurance activities to implement the HCBS Quality Measure Set. For example, one state noted that implementing the entirety of the rule would impact quality of service delivery. The state shared that they would need to end value-based payment initiatives in order to provide capacity needed to implement the proposed rule.

Payment Rate Transparency

Proposed 42 CFR §§ 447.203(b)(1)-(6)

FFS Rate Publication

CMS proposes to require states to publish all Medicaid FFS rates on their website. Rates must be organized in a way beneficiaries can easily understand.

- If rates vary, the state must separately identify rates by population, provider type, and geographical location, as applicable.
- Publication must include the date that rates were last updated. Updates to the published rates must be made no later than one month following the date of rate amount or methodology change.

CMS Request for Comment: We are seeking public comment on the proposed requirement for States to publish their Medicaid FFS payment rates for all services, the proposed structure for Medicaid FFS payment rate transparency publication on the State's website, and the timing of the publication of and updates to the State's Medicaid FFS payment rates for the proposed payment rate transparency requirements in §447.203(b)(1).

ADvancing States supports the proposed requirement for states to publish their Medicaid FFS payment rates for all services. We believe this is a positive strategy to improve transparency and facilitate meaningful comparisons across programs.

To help clarify the structure of reporting, we recommend CMS provide more detailed guidance and/or definitions of the categories that must be identified in reporting: population, provider type, and geographic location. For example, it would be helpful to provide clarity on questions such as: Does the "population" category refer to beneficiary demographics or waiver/program population? If the former, which demographic criteria must be included?

Given the significant data collection and operational changes states will need to make to comply with rate requirements and other provisions in the proposed rule, **we request CMS extend the initial publication date to January 1, 2027, to provide states at least 3 years from the possible effective date of the final rule.** We recommend CMS propose an alternative date if the final rule effective date does not allow states 3 years between the effective date and Jan. 1, 2027.

FFS Rate Disclosure

CMS proposes to require states to publish a rate disclosure for personal care, home health aide, and homemaker services. The disclosure must be updated every two years, and must include:

- Average hourly payment rates, separated by agency and self-directed options, and stratified by population, provider type, and location;
- Number of Medicaid-paid claims; and
- Number beneficiaries who received a service within a calendar year.

CMS Request for Comment: We are seeking public comment on personal care, home health aide, and homemaker services provided by individual providers and providers employed by an agency as the proposed categories of services subject to the payment rate disclosure requirements in proposed § 447.203(b)(2)(iv).

As proposed above, we urge CMS to consider alternative approaches to setting a minimum percentage for DCW compensation – one of these alternatives is to expand the rate disclosure requirements for additional analysis. If CMS pursues this alternative strategy, we support the inclusion of the personal care, home health aide, and homemaker services in this requirement and would support expansion of this requirement to additional services (e.g., residential habilitation services, day habilitation services, and home-based habilitation services).

If the minimum percentage threshold is included in the final rule, we recommend CMS limit this requirement to the services for which the minimum percentage threshold requirement applies. As noted above, we recommend that if CMS finalizes a minimum threshold requirement, it is limited to personal care services only.

CMS Request for Comment: We are seeking public comment on the proposed requirement for States to break out their payment rates for personal care, home health aide, and homemaker services separately for individual analyses of the payment rates for each category of service in the comparative payment rate analysis.

ADvancing States recommends CMS not require states to break out payment rates separately. The value of this breakout of data is unclear and given the significant work states would be required to undertake to meet all the proposed payment adequacy and rate transparency requirements, we believe state efforts should be concentrated on collecting and reporting only the most meaningful data elements.

CMS Request for Comment: We are seeking public comments on the proposed requirement for States to calculate the Medicaid average hourly payment rate made separately to individual providers and to agency employed providers, which accounts for variation in payment rates by population (pediatric and adult), provider type, and geographical location, as applicable, in the payment rate disclosure as discussed in this section.

ADvancing States recommends CMS remove the proposed requirement for states to calculate the average hourly payment rate. State calculation and reporting on this data would likely provide little value in drawing meaningful conclusions on direct care worker rates. Calculating an average rate amount would not account for variation in service definitions within state programs and across states, making evaluation and comparison across states challenging.

In addition, this information is already collected and reported on by ADvancing States and NASDDDS through the State of the Workforce Survey. We recommend leveraging existing data to reduce duplication and burden on state Medicaid and operating agencies.

To support meaningful data collection, we request that CMS provide a federal definition or description of the terms "provider type" and "geographic location."

CMS Request for Comment: We are seeking public comments on the proposed requirement for States to include the number of Medicaid-paid claims and number of Medicaid enrolled beneficiaries who received a service within a calendar year for which the Medicaid payment rate is published under paragraph (b)(3)(ii)(B), as specified in proposed §447.203(b)(3)(ii)(C).

ADvancing States recommends CMS remove this requirement. It is unclear what value this data would provide to states and CMS, as on its own it does not provide significant insights into beneficiaries' access to services. It would not capture instances in which a beneficiary transfers from one program or service to another or when a beneficiary declines service delivery, which are essential for drawing accurate conclusions regarding access to services.

CMS Request for Comment: We are seeking public comment on the proposed timeframe for the initial publication and biennial update requirements for the comparative payment rate analysis and payment rate disclosure.

As proposed above, we urge CMS to consider alternative approaches to setting a minimum percentage for direct care worker compensation. If CMS pursues the alternative strategy to collect rate and compensation data over a 3-5 year period, we recommend amending the timeframe for updates to annual in order to capture more data over the review period.

If the minimum percentage threshold is included in the final rule, **we recommend CMS extend the timeframe for the initial publication from 2 years to 3 years.** State Medicaid and operating agencies have indicated that a biennial timeline for updates is feasible**.**

CMS Request for Comment: We are seeking public comment on the proposed required location for States to publish their comparative payment rate analysis and payment rate disclosure.

ADvancing States supports the requirement for state Medicaid and operating agencies to publish their rate analysis and disclosure on the state website. Medicaid agencies have not expressed concern about the location of publication for states to publish their rate analysis and disclosure on the state website.

CMS Request for Comment: We are seeking public comment on the proposed method for ensuring compliance with the payment rate transparency and comparative payment rate analysis and payment rate disclosure requirements, as specified in proposed §447.203(b)(5).

ADvancing States supports the proposed method for ensuring compliance. State Medicaid and operating agencies have not expressed concerns about the compliance method.

Self-Direction

The proposed rule references the requirement in the Affordable Care Act for states to maximize beneficiary independence and self-direction. States are overwhelmingly concerned that the requirements in the proposed rule, as written, will have the opposite effect, creating challenges and barriers to self-direction. While states agree the proposed requirements should apply to self-direction, **we strongly encourage CMS to allow state Medicaid and operating agencies additional flexibility and time to implement the proposed requirements in their self-directed programs and services.**

Doing so would help ensure the requirements support/uphold the hallmarks of self-direction, including beneficiary decision-making authority that promotes control and choice over service delivery. In its current version, the implementation of specific requirements in the proposed rule could have a significant impact on how states operationalize their self-direction programs. Additional implementation time would also allow states more opportunity to collaborate with beneficiaries who self-direct their services, FMS entities, health plans, and other stakeholders to develop operational systems and processes that are feasible and do not add burden to beneficiaries who self-direct their services.

Specifically, we request additional consideration in the following aspects of the proposed rule:

- Incident management system;
- Payment adequacy and rate transparency; and
- Timeliness of access.

State Medicaid and operating agencies overwhelmingly expressed concern that implementation of the proposed rule will have unintended, negative consequences for self-direction, in addition to being operationally challenging to implement. They highlighted the many challenges they faced implementing EVV for self-directed personal care services and are concerned that implementation of the proposed

rule requirements would be equally challenging. States found that EVV implementation in self-direction took additional time and consideration to successfully achieve the balance between meeting federal requirements and upholding the philosophy of choice and control that is central to self-direction. Several states continue to take the federal medical assistance percentage (FMAP) penalty for noncompliance with the 21st Century Cures Act requirements to allow for additional time to successfully implement EVV. Without further consideration and tailored implementation to fit self-direction models, we expect the same may occur for provisions of the proposed rule.

To ensure data collection and reporting are consistent and able to be aggregated at state and national levels, extensive technical assistance will be necessary to guide states in implementing the proposed rule requirements in their self-direction programs. Sub-regulatory guidance should provide state Medicaid and operating agencies with operational guidance that addresses complexity of service delivery in self-direction, including variances across the spectrum of budget authority and differences in FMS contracting models. Without direction on how to address these differences and nuances across states and within individual state programs, data collection and reporting will vary significantly and will not provide meaningful or actionable information.

ADvancing States recommends CMS provide additional time for states to operationalize proposed rule requirements for self-direction. We offer the following alternatives for consideration:

- Set timeframes for implementation in self-direction based in relation to the issuance of CMS sub-regulatory guidance.
- Allow states to submit a transition plan to CMS for review and approval that outlines the state's timelines and milestones for implementing the proposed rule requirements in self-direction models. Similar to the statewide transition plan process for the HCBS Settings Rule, this would allow states the time and flexibility to successfully implement the requirements in a manner tailored to their self-directed services and programs. We recommend CMS allow states an overall implementation timeframe of a maximum of **8 years** in which to implement all of the affected proposed rule provisions for self-direction.

Final Thoughts

ADvancing States reiterates our support for the goals of ensuring timely access to and improved quality and outcomes from HCBS services, as well as increased transparency for HCBS beneficiaries. HCBS is an essential component of the continuum of LTSS and deserves continued attention and prioritization as a means of honoring individual's preferences, supporting caregivers, addressing disparities, and optimizing use of public funding.

State Medicaid and operating agencies agree that the goals of the proposed rule are worthwhile and meaningful, but note that implementation will require them to make sweeping systemic changes. The challenges to accomplishing these changes are likely to be exacerbated by state workforce challenges, including state staff vacancy rates as high as 30 percent. To support states in successfully implementing the proposed requirements to achieve the intended outcomes for beneficiaries, we emphasize the

request that CMS extended implementation timeframes and allow sufficient time for implementation following issuance of sub-regulatory guidance. This will help ensure state Medicaid and operating agencies have the time, resources, and direction to effectively implement each provision.

We appreciate the opportunity to provide comment on this proposed rule. We look forward to continued partnership with CMS and state and territorial agencies as we work collectively to improve outcomes and program integrity in Medicaid HCBS programs. If you have any questions regarding this letter, please feel free to contact Rachel Neely at rneely@advancingstates.org.

Sincerely,

Martha Roherty

Executive Director

ADvancing States