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Senator Maggie Hassan
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Washington, DC 20510

Senator Sherrod Brown
503 Hart Senate Office Building
Washington, DC 20510

Senator Bob Casey
393 Russel Senate Office Building
Washington, DC 20510

Representative Debbie Dingell
116 Cannon House Office Building
Washington, DC 20515

Dear Senators Hassan, Brown, Casey, and Representative Dingell,

On behalf of the nation's Medicaid Directors, NAMD is pleased to offer comments on the discussion draft of the Home and Community-Based Services Access Act. We appreciate the opportunity to provide principles and consideration for expanding the provision of home- and community-based services (HCBS) across the nation in a manner that is sustainable, person-centered, and administratively feasible for states. We strongly encourage lawmakers to ensure states retain flexibility to target HCBS programs to specific populations and have the resources to make long-term investments in developing the HCBS workforce and quality improvement infrastructure.

NAMD is a bipartisan, nonprofit association representing the Medicaid Directors leading programs across the 50 states, the District of Columbia, and the five U.S. territories. The Medicaid program is a critical component of the health care system, providing access to services and supports for millions of Americans, many of whom are the most vulnerable populations in the country. Medicaid is the primary payer of long-term services and supports (LTSS) in the nation.

Medicaid LTSS coverage is in both the mandatory nursing facility benefit and in HCBS through waiver and state plan options. States and the federal government have mutually prioritized rebalancing of Medicaid's LTSS benefits towards the community. HCBS is both cost-effective for the program and positively viewed by Medicaid members and their families. Since 2013, national Medicaid LTSS expenditures in HCBS has been above 50 percent.[1] However, more work can be done both to support states that are more institutionally oriented in their LTSS expenditures and to maintain and enhance the progress for more HCBS-oriented states.

Core Principles for Advancing HCBS

To achieve the ongoing goal of rebalancing, the following principles should be at the forefront of any Congressional action:

- **The Federal Role in LTSS:** While Medicaid is the de facto payer of LTSS in the nation, the program remains tied to the federal poverty level as well as an individual's level of care needs. In contrast, the Medicare program's provision of LTSS in both institutional and community

[1] Medicaid Long Term Services and Supports Annual Expenditures Report, FFY 2017 and 2018: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf

settings is limited, though this is poorly understood by the general public. Congress should consider how the federal government can enhance LTSS offerings to individuals and families, and ultimately ensure that the nation's LTSS delivery system does not rest on Medicaid alone or be conditioned on meeting Medicaid income eligibility requirements. A range of options could be considered in this area, such as:

  - Federally funded education and options counseling for individuals in need of LTSS so they fully understand available care programs, and requiring such expertise to be embedded within hospital inpatient discharge planning processes,
  - Creating a full-cost buy-in option for Medicaid HCBS for those who do not otherwise meet financial eligibility criteria,
  - Incorporating more robust LTSS benefits into Medicare, which could alleviate ongoing financing and operational challenges for serving dually eligible Medicare-Medicaid members.

- **Impacts on the LTSS Care Continuum:** Medicaid HCBS is currently an optional benefit, while institutional care in nursing facilities is a mandatory benefit. Should Congress look to adjust the mandatory benefit structure of Medicaid to further promote HCBS – and pair that change with federal resources necessary for states to meet this expectation – careful consideration should be given to the impact on workforce availability and care capacity in institutional LTSS settings. Certain individuals may have significant care needs that are best met in an institutional setting or may choose such a setting over HCBS options. As Congress supports states in the ongoing rebalancing journey, flexibility should remain for states to "right size" their institutional capacity as HCBS capacity and offerings expand.
- **Flexibility in Program Design and Use of HCBS Dollars:** To the extent that Medicaid remains a core component of national HCBS delivery, states must continue to have maximum flexibility in program design that matches their resource constraints, structural capacity, and specific populations in need of services. The HCBS population is diverse, and any changes to minimum service definitions must provide sufficient room for those services to match up with a specific member's needs as identified through a robust assessment and person-centered planning process. Further, as states look to expand HCBS and improve quality of HCBS services, they must have flexibility to invest HCBS dollars more broadly than has been allowed to date. Specific areas of need include paying for room and board in the community, direct reimbursement for HCBS provider training, and pre-Medicaid eligibility diversion activities that may delay an individual's need for full Medicaid benefits. States must also have the explicit ability to invest a portion of new HCBS dollars in state administrative capacity, data collection, and data analytics infrastructure. State administration must be supported in order to ensure quality and accountability for an expanded HCBS benefit, with tools that go beyond the current 50 percent federal match for existing state administrative costs.
- **Equity in Funding Opportunities Across States:** States are differently situated in their rebalancing work. New federal investments should be equitable across states regardless of where they are on the rebalancing spectrum. A state that is providing 90 percent of its Medicaid LTSS in HCBS should have the same opportunities for using this funding as a state that is at 30 percent.

- **Sustainability of HCBS Investments:** Expanding the availability of HCBS will take significant resources. Capacity constraints across the states, particularly among the HCBS workforce, must be addressed in both the short and long term. In order for states to have confidence that investments they make today in their HCBS systems will remain in place in the coming decades as demand for HCBS increases, Congress must ensure that federal support for these investments is durable and not subject to short-term appropriations. Federal policymaking should not create climates of uncertainty for states in either the resources available or the flexibilities afforded. Congress should avoid time-limited federal resources that create a "fiscal cliff" dynamic for states. Instead, permanent policy changes that provide ongoing stability for state planning and budgets should be favored.

Specific responses to stakeholder questions on the discussion draft follow.

HCBS as a Mandatory Medicaid Benefit

The institutional bias in the Medicaid program since its inception is a fundamental barrier inhibiting more widespread provision of HCBS. The mandatory nursing home benefit makes institutional care the default option in the program, even if an individual could be better served in their home or the community. In contrast, provision of HCBS requires states to leverage waivers or targeted state plan authority. These authorities introduce administrative burdens for states via periodic renewal processes cost neutrality demonstrations, and other requirements that are not present in the institutional benefit.

For these reasons, NAMD supports the principle of correcting the institutional bias in Medicaid statute and making HCBS a mandatory benefit in the program. Such a change would bring parity to Medicaid LTSS structures and clearly signal the federal government's commitment to advancing HCBS.

That said, realizing this mandatory benefit will require significant resource investments and years of work. States would need a significant implementation period to address HCBS infrastructure and workforce capacity challenges, all within the realities of balancing state budgets in each fiscal cycle. The federal government must provide states with a long-term and stable funding stream to implement and maintain this change, with specific resources to invest in state administrative staff for HCBS programs. Clear and streamlined authority pathways within the state plan or the state's preferred waiver mechanism should be available, with an explicit goal of minimizing the current administrative hurdles states must navigate to provide HCBS today.

Further, maintaining existing flexibilities in program design and benefits offered is critical to ensuring the long-term sustainability of the program. Benefits offered should remain explicitly tied to the outcomes of a functional assessment and a person-centered planning process that identifies a member's needs, goals, and preferences, discussed in more detail below.

The role of institutional care within a Medicaid LTSS benefit with mandatory HCBS should also be reconsidered. Potential approaches to ensure that institutional care is available to those who choose it could be modifications to the acuity levels required for an individual to be served in an institution, or potentially making the institutional benefit optional with significant flexibility for states to structure the

benefit. Congress could allow states to apply presumptive eligibility for HCBS, such that HCBS is the default LTSS option rather than institutional care.

Minimum HCBS Services, Standards, and Eligibility Pathways

As mentioned above, flexibility in HCBS program and benefit design is a critical component of long-term sustainability. States must retain their current ability to define functional eligibility for HCBS and have the tools to match services offered to the state's capacity to provide them. Required services must be cost-effective and based on need.

The degree of services envisioned in the discussion draft is overly expansive, and some services are open to broad interpretation, such as "services that enhance independence, inclusion, and full participation in the broader community." Further, the envisioned stakeholder council which will add new minimum services on an ongoing basis would create additional implementation challenges as the mandatory set of services continues to grow. The proposed eligibility threshold of needing supports for two Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs), rather than the current three, would also significantly increase the eligible HCBS population compared to current state approaches, which HCBS systems are not yet prepared to address. It may also have the unintended consequence of not being sensitive to individuals' cognitive, developmental, and behavioral health needs, which should be addressed in the eligibility determination process. These factors make it difficult for states to anticipate the impact on their HCBS caseload and per capita costs should such a permissive minimum service package and eligibility threshold be adopted.

Instead of an expansive set of federally identified services which all states must offer, Congress should consider a more targeted core set of HCBS and provide states with wide latitude to cover additional services identified in person-centered planning processes. States should also retain the ability to appropriately manage eligibility pathways for the benefit, taking into account ADLs, IADLs, developmental milestones, and other functional assessment factors that drive service needs. Taken together, these approaches would allow states to expand the benefit as resources and capacity permit, thereby ensuring the long-term viability of the benefit.

Congress should also allow states to more broadly expend HCBS dollars in the Medicaid program than what has been allowed to date. These dollars should explicitly support long-term investments in the program across an array of necessary areas, including but not limited to:

- Payment for room and board in the community, which states pay for under the institutional benefit but may not pay for under HCBS today. HCBS recipients being priced out of community housing is a major barrier to broader HCBS provision. Without the ability to address housing for the HCBS population, states will not be able to meet Congressional goals for a mandatory HCBS benefit.
- Increased state administrative capacity to support data collection and analysis of HCBS programs, members served, and workforce. This infrastructure is a critical element for professionalizing the HCBS workforce and advancing an HCBS quality agenda. These

expenditures should be matched at a higher rate than the base 50 percent for Medicaid administration available today.

- Direct payment for HCBS workforce training hours. Currently training can be incorporated into a rate for a service delivered to a Medicaid member, but may not be reimbursed directly. This creates a perverse financial incentive for provider agencies to not invest in workforce training, as these activities do not directly generate Medicaid revenue.
- Technology and telehealth, including broadband internet access and computer-based technologies for HCBS members to support remote monitoring.
- Broader family caregiver and guardian supports, including increased respite services, training resources, care planning resources, case management, housekeeping services, meal delivery, equipment and supplies, assistive technology, and peer supports. Flexibility should be provided to support family caregivers who choose to enter a paid employer/employee relationship with Medicaid-financed wages, while ensuring robust service offerings are available for family caregivers who choose to remain unpaid.

HCBS Workforce Development and Support: Career Pathways, Wages and Benefits, and Data

NAMD fully supports Congressional action to strengthen the HCBS workforce. Workforce capacity remains a major challenge for HCBS, both in terms of recruitment and retention. These challenges will only increase as aging demographics drive increased demand for HCBS.

We encourage Congress to take a holistic view of supports needed to address this workforce shortage. The discussion draft contemplates rate sufficiency analyses and other requirements that suggest Congress views rates, wages, and benefits as the primary driver of recruitment and retention. While these are important factors, they are not the only factors impacting the workforce. Indeed, states with robust wage and benefits structures in place today still struggle with HCBS worker retention. Short-term, time-limited wage increases may temporarily increase the workforce, but a career path that promotes professionalization and outlines clear opportunities for advancement will promote retention of those workers.

States must also have the resources to invest in a robust workforce data ecosystem that leverages partnerships between Medicaid, labor and training departments, and education providers to support an array of programs, supports, and systems changes.

Congress can support this multi-pronged effort in a variety of ways, including but not limited to:

- Investment in community college training opportunities and other similar community-based trainings to increase the professionalization of the HCBS workforce.
- Consideration of a National HCBS Curriculum modeled after the Centers for Medicare and Medicaid Services' Direct Service Worker Core Competencies developed in 2014. Ensure such training is competency-based with required demonstration of competencies. Completion of the training could be further incentivized by linking wage incentives for workers with value-based incentives to providers for employing higher qualified staff.

- Encourage through federal funding the development of continuing education programs and specialty training, with a specific focus on:
    - Trauma-informed care
    - Behavioral health (particularly critical for co-occurring behavioral health conditions and intellectual or developmental disabilities)
    - Alzheimer's and dementia care
    - Chronic disease management
- Direct reimbursement for training activities, as noted above and inclusive of tuition reimbursement, bonuses for completion of training programs, and similar financial incentives.
- Exempting any federally required wage, rate, or benefit increase from states' 1915(c) waiver cost neutrality calculations and 1115 demonstration waiver budget neutrality calculations. This exemption will ensure states retain the maximal use of these authorities in provision of HCBS.
- Require provider agencies to report annually on average rate of pay and benefits provided for their direct service workforce. States could use this data to develop additional strategies to support the HCBS workforce.
- Require provider agencies to pass through a given percentage of a rate increase directly to their HCBS workforce in the form of a wage and/or benefit increase. Some states with experience implementing this type of strategy note that successful implementation requires administrative work on the state's part to collect and analyze necessary data from provider agencies. Federal support for this administrative work should be provided.
- Consider a federally funded minimum childcare benefit for Certified Nurse Aides and below working in an HCBS setting. This could potentially be paired with a choice between the childcare benefit and an employer contribution to a portable retirement account to maintain parity across workers of different demographics.
- Ensure that direct care workers who currently receive public benefit programs, such as Temporary Assistance for Needy Families, do not lose access to these benefits (such as cash benefits, childcare, and transportation subsidies) until they have stabilized in their employment as a direct care worker. One approach to meet this objective could be to exempt a portion of pay from counting towards income limits for public assistance eligibility.
- Create reimbursement mechanisms and purchasing strategies to support independent contractors and small providers in securing liability insurance, health insurance, and other benefits. These small providers, particularly those serving high-risk populations, are often challenged to reach economies of scale for maximizing purchasing power and spreading risk across a larger risk pool. These purchasing strategies could potentially support training for these providers as well.
- Ensure states have federal resources ongoing to maintain training offerings, such as covering online training platform hosting costs, site maintenance, ongoing curriculum development, tracking of student completion, etc.
- Provide funding for investments to expand, enhance, or build data ecosystems within states. These ecosystems should match data sets, produce anonymized analysis and summaries, and inform future inform policy decisions, funding allocations, and targeted interventions.
- Improve the timeliness and granularity of workforce data gathered by the federal Bureau of Labor Statistics to provide states with information regarding direct care worker employment

figures, employment settings, demographics, hours of work, career pathways, projected shortages, and other critical labor market information. Federal investments in state-level collection of this information would also be valuable.

It is worth noting that if Congress seeks to make direct federal investments in HCBS worker wages and benefits, careful consideration should be given to the impact of such an increase on other sectors of the LTSS delivery system. The base skillset in both the institutional and HCBS sectors is broadly similar, and there is potential for a large gap in wages and benefits to favor one sector over another. States may be required to increase rates for institutional care workers to ensure sufficient institutional capacity remains in place as financial incentives to join the HCBS workforce expand, thereby increasing overall program costs.

Advancing Quality in HCBS

Medicaid Directors are committed to improving quality across all aspects of the program, including HCBS. However, the distinct characteristics of HCBS, diversity of services offered, and the variety in populations served create unique challenges that require ongoing attention. HCBS quality measurement is not as straightforward as quality measurement in other areas of the health care sector. It requires significant administrative work at the state and provider level. Federal investments in data collection and analysis infrastructure at the state level, combined with resources to ensure HCBS providers have administrative capacity to meet reporting requirements, is necessary, as is federal investment to support states in executing on their oversight responsibilities within the benefit.

Work is being done by several entities to develop validated and actionable HCBS quality measures that are outcomes oriented. This includes federally supported work within the National Quality Forum, as well as state-funded National Core Indicators that are in use today among state HCBS waiver programs. Looking ahead, Congress should aim to build on these existing efforts to further advance HCBS quality measurement, with a specific focus on member experience of care and outcomes.

Lastly, NAMD sees utility in some standardized HCBS measures that are stable and not changed over time. This core set of measures could facilitate longitudinal analysis of HCBS programs and support cross-state comparisons. These measures should not be based upon the current HCBS waiver quality assurances, which are largely process measures that do not generate meaningful information about waiver performance and member experiences.

Permanency for Money Follows the Person and HCBS Spousal Impoverishment Rules

NAMD strongly supports permanent authorization of the Money Follows the Person (MFP) program and the permanent application of Medicaid spousal impoverishment rules to HCBS.

MFP has consistently demonstrated the value of funding transition services to such a degree that such services should be allowed as a core element of HCBS. State plan and waiver authorities should be modified accordingly. Further, the length of stay requirements before initiating transition services should be dramatically reduced or outright eliminated. The longer an individual stays in an institutional

setting, the more likely their natural supports and housing will no longer be available, making a successful community transition exponentially more challenging and resource intensive.

We appreciate the opportunity to provide the perspective of Medicaid Directors on these critical questions. NAMD and our members look forward to continuing to work with Congress to improve the provision, quality, and sustainability of Medicaid HCBS going forward.

Sincerely,

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