

Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage. CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.

1. What are the specific ways that CMS can support states in achieving timely eligibility determination and timely enrollment for both modified adjusted gross income (MAGI) and non-MAGI-based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan, when applicable.

We recommend that CMS conduct surveys and structured interviews of groups of actual Medicaid beneficiaries and ask what barriers they face in eligibility determinations and revise the determination process to reflect the lessons from these survey groups. We can report anecdotally that for people with disabilities, especially disabilities with functional limitations, that applications, renewals, and other eligibility paperwork creates a huge burden on people with disabilities, their families, and support staff who often assist with these issues. All forms should be available online and in mobile-friendly formats given the disproportionate reliance on phone-based internet access by low-income families. All forms should be available in plain language, multiple languages, and in other accessible formats and augmentative and alternative communication (AAC) modalities. We believe CMS should directly test any improvements on actual beneficiaries to ensure that forms and language is truly accessible.

We also urge CMS to increase the frequency of reporting data on application processing time. This data is extremely important, as CMS has recognized by including it in the Medicaid and CHIP Scorecard, but it lags by over a year. This delay prevents advocates from using this data in real-time to raise issues with states and CMS. We would urge efforts to increase the timeliness of this data.

2. What additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?

We recommend that CMS provide guidance and technical assistance aimed at identifying and increasing the use of emerging promising practices states should use to manage and ensure that HCBS waiver lists are effectively managed, triaged, and reduced at a reasonable pace. At a minimum we believe CMS should require States to make the following kind of information on waiting lists transparent: the number of people on the list; the criteria for eligibility for the list and for prioritization once on the list; and any other criteria the state uses to determine placement

and movement within the list. This information should be updated at least quarterly. The guidance also should establish a baseline set of standards that CMS expects all waiting lists to meet. We strongly urge CMS to maintain a publicly available database of beneficiaries on waiting lists across the U.S. While protecting individual privacy, this database should be disaggregated by demographic and disability specific information since it is currently impossible to monitor or assess the equity impact of certain waiting list structures. There is no reason not to make such data widely available on a quarterly basis. Doing so would provide greater insights and accountability with regard to the extent to which states and CMS are making reasonably paced progress in “reach(ing all) *people who are eligible and who can benefit from such coverage.*”

To the extent that access to Medicaid in various waivers is predicated on establishing a level of care or functional assessment, the processes for these assessments can be incredibly opaque, especially when they are conducted by Medicaid Managed Care entities. CMS should require transparency with regards to these assessments, making the criteria, processes, and other details publicly available. We would also urge CMS to study best practices with regards to functional assessments and issue guidance to states.

3. In what ways can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups, which include, but are not limited to: people living in urban or rural regions; people who are experiencing homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); people with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?

CMS must also do all it can to reinforce the rights of people with disabilities, people with limited English proficiency (LEP), people who require AAC, people with limited literacy, and older adults in the eligibility and redetermination processes. Too often, applicants and beneficiaries in these groups lose eligibility because states do not provide the necessary assistance in what can be complicated application and redetermination processes. Complicated eligibility systems, insufficient notices, reliance on technology, and complicated workflow processes can mean eligibility workers are rarely able to fully and helpfully answer an applicant or beneficiary’s questions. This violates the requirement that a State provide application assistance and ensure the accessibility of their eligibility processes. However, most states fail to fulfill their assistance obligations, due process obligations, and non-discrimination requirements under federal civil rights laws including T. VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act. CMS should offer clearer guidance on the level of assistance that states must provide to meet Medicaid, non-discrimination, and Due Process Clause requirements.

We strongly encourage CMS to strengthen the requirement for plain language on all public-facing materials in its programs and projects as well as state-based materials for Medicaid and

CHIP. The use of plain language is especially important for accessibility by people with intellectual disabilities and people who speak limited English. Use of plain language has been required since Congress passed the PLAIN Act in 2010, but still many states lag behind in providing the required plain language public-facing materials. First, CMS should provide financial and technical resources for states who are not consistently using plain language principles in their public-facing materials. Second, CMS should ensure the plain language requirement applies to important materials that reach enrollees. CMS monitors use of plain language on information that CMS produces, but CMS does not monitor or meaningfully enforce states' use of plain language on Medicaid applications and due process notices among other publications. Use of plain language benefits all enrollees, but its use is vital for those who need assistance to have meaningful access to these programs, such as a significant proportion of individuals with disabilities. Encouraging and enforcing the use of plain language only strengthens the likelihood that state programs meet the civil rights requirements in Sections 504 and 508, the ADA, Title VI, and Section 1557. Plain language is an important and crucial tool to advance health equity in Medicaid and CHIP.

As mentioned above in the context of waiting lists, it is currently impossible to monitor the disproportionate impact within and across states because disaggregated data is not available. CMS should also facilitate states to data-share across means tested programs, including Supplemental Nutrition Assistance, Temporary Assistance for Needy Families (TANF), Supplemental Security Income, and others to ensure that all families on each of these programs have access to the others.

CMS should also encourage states to expand the number and types of sites where people can obtain presumptive eligibility, such as expanding to ACL-funded programs, community health centers, schools, hospitals, and WIC sites. Pandemic flexibilities, such as allowing enrollment without a "wet signature" should also be retained. It is also crucial that navigators reflect the communities they come from and CMS should make efforts to ensure that people of color and people with disabilities are represented.

Outreach to at-risk groups is also crucial and CMS should ensure that states are maximizing their funding opportunities, such as via CHIP administrative funding, and that states are reporting their outreach activities so that outside organizations can coordinate with state efforts.

CMS should also review all waivers to ensure that they are not actively increasing churn or discouraging enrollment. This would include premiums, cost-sharing beyond the statutory limits, and retroactive coverage. CMS should make enrollment data and the expected impact of the waiver on coverage and use of services an element of the 1115 application, in addition to strengthening equity analysis requirements to ensure that harms do not disproportionately fall on people with disabilities, communities of color, and others.

4. What key indicators of enrollment in coverage should CMS consider monitoring? For example, how can CMS use indicators to monitor eligibility determination denial rates

and the reasons for denial? Which indicators are more or less readily available based on existing data and systems? Which indicators would you prioritize?

We believe that CMS should be monitoring unmet need for HCBS more closely, both by addressing the lack of transparency with regards to waivers and by creating other metrics for unmet need. For instance, anecdotal reporting from our networks suggests that many people with disabilities are not approved for the number of hours they need and must fill in gaps with family caregivers or go without care. This was an issue extensively discussed in a recent hearing on HCBS held by the Senate Special Committee on Aging (<https://www.aging.senate.gov/hearings/an-economy-that-cares-the-importance-of-home-based-services>). CMS should develop and use metrics to measure unmet HCBS needs and the efforts of States to close these gaps.

But monitoring issues related to enrollment is impossible without data. Especially with the upcoming unwinding of the public health emergency, we are particularly concerned that we will not have sufficient data to identify problems early on. We urge CMS to require regular reporting of the following metrics, and ensure this data is publicly available, both during the unwinding of the public health emergency and afterwards:

- Total number of pending applications
- Total number of applications
- Total number of applications renewed using a pre-populated form
- Total number of applications terminated for procedural reasons
- Total number of pending renewals
- Total number of renewals determined ex parte
- Total number of renewals found ineligible, and the number of fair hearings pending more than 90 days
- Total number of individuals found ineligible, but re-enrolled within three months, six months, and one year

It would also be helpful for CMS to track call center statistics and online assistance data (when available). As mentioned above, it is absolutely crucial that this data be available promptly and not lag so that everyone can have a clear picture of the current challenges.

Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage. CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income (SSI)/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).

1. How should states monitor eligibility redeterminations, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?

For people with disabilities, gaps in coverage can mean the difference between life and death. Many disability and aging groups sent a letter recently to CMS highlighting our concerns about how the unwinding of the public health emergency will impact people with disabilities. We believe that access to data on the renewals will be particularly crucial during this time and as we have discussed above, we believe that maximizing ELE and expanding presumptive eligibility sites would be helpful.

As discussed previously, all requests to beneficiaries must be in plain language. We would urge CMS to take the steps outlined above. States vary widely in their policies and practices, capacity, and commitment with respect to carrying out these functions in ways that help rather than harm to beneficiaries. CMS, of course, already has extensive knowledge of where individual states and DC respectively fall on this spectrum. States, researchers, advocacy organizations, and beneficiaries also have important insights and perspectives to share that broadens and deepens this understanding. CMS should use this collective body of knowledge to develop a public and transparent report card that benchmarks the current performance of States on continuity of coverage as well as a range of actions each can take to demonstrably improve on it.

2. How should CMS consider setting standards for how states communicate with beneficiaries at-risk of disenrollment and intervene prior to a gap in coverage? For example, how should CMS consider setting standards for how often a state communicates with beneficiaries and what modes of communication they use? Are there specific resources that CMS can provide states to harness their data to identify eligible beneficiaries at-risk of disenrollment or of coverage gaps?

We urge CMS to develop best practices on communication with beneficiaries at-risk of disenrollment, with the involvement of beneficiaries as discussed above.

One particular issue in this space is the risk of disenrollment for individuals in jails and prisons. Individuals in jail and prison are disproportionately individuals with disabilities: states and federal incarcerated individuals are approximately 2.5 times more likely to have a disability than the general population. Because states may not claim federal financial participation (FFP) for benefits provided to incarcerated children and adults, justice-involved individuals are at greater

risk for disruptions in coverage. However, that prohibition limits states from obtaining FFP, and is not a bar on eligibility.

States can prevent disruptions in care by suspending Medicaid benefits or suspending eligibility, without terminating Medicaid eligibility. Suspension allows for quicker reinstatement upon release, as it does not require individuals to complete a new application. While most states currently suspend rather than terminating, some do not. Furthermore, approximately half the states do not have working systems to automatically suspend and then reinstate eligibility, thus relying on antiquated systems that are all too often subject to human error, leading to delays and incorrect denials.

While CMS has issued clear guidance that states are not required to terminate eligibility, we encourage CMS to raise up additional opportunities that currently exist to improve care coordination for individuals leaving carceral settings, and share best practices not only with states, but with advocates. For example, many states require MCOs to engage in pre-release care coordination and discharge planning. States can also use Medicaid administrative claiming for pre-release enrollment work and some case management, use Medicaid to fund improved systems to automate Medicaid activation upon release. We recommend that CMS work with states and advocates to identify sustainable funding sources to ensure continuity of care for individuals leaving carceral settings, and to help set up systems to track such enrollment, to ensure access to needed services upon release.

Children in the juvenile justice system, like adults, are at risk of losing benefits even when they remain eligible. Most children spend less than 6 months in such settings. Unless states take proactive steps to ensure that children's benefits are only temporarily suspended and are active upon release, even brief stays in carceral settings can lead to long-term disruptions in access to care.

The 2018 SUPPORT Act took an important step to protecting incarcerated youths' access to Medicaid by prohibiting states from terminating youths' Medicaid eligibility upon incarceration. Instead, states must now suspend eligibility or benefits for the period of incarceration and then to lift that suspension upon release. See Jennifer Lav, *New Omnibus Opioid Law Contains Medicaid Fix for Justice-Involved Children and Youth*, Nat'l Health Law Prog. (Jan. 30, 2019), <https://healthlaw.org/new-omnibus-opioid-law-contains-medicaid-fix-for-justice-involved-children-and-youth/>. This allows for youth leaving the juvenile justice system to more quickly and seamlessly receive behavioral health care they need upon release, including counseling, case management, substance use disorder treatment, and other supports. In addition, the SUPPORT Act requires states to conduct a redetermination of eligibility before youth are released from custody without requiring them to submit a new application. Finally, the law mandates that states process applications from eligible youth who apply for Medicaid prior to their release.

We are concerned, however, that the promises of the SUPPORT Act have not been fully realized. In late 2020, a bipartisan group of Senators and Representatives noted that the full implementation of these provisions has been delayed in states across the country. CMS

released guidance on implementation of this provision in January 2021, and additional technical assistance in March 2022, but state advocates continue to report circumstances where youth who are currently in juvenile justice settings face barriers to accessing Medicaid-funded alternative settings. Furthermore, public information is difficult to locate regarding state status of implementation of these reforms and youth rights to access care upon release or transfer to a hospital.

We suggest that CMS separately track, update, and share publicly information about implementation of the SUPPORT Act, including the methodology used by states to suspend either benefits or eligibility. We also recommend that CMS provide training and information—including state examples—of processes states have adopted to increase the rate of Medicaid enrollment of youth released from juvenile facilities.

3. What actions could CMS take to promote continuity of coverage for beneficiaries transitioning between Medicaid, CHIP, and other insurance affordability programs; between different types of Medicaid and CHIP services/benefits packages; or to a dual Medicaid-Medicare eligibility status? For example, how can CMS promote coverage continuity for beneficiaries moving between eligibility groups (e.g., a child receiving Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] qualified supports who transitions to other Medicaid services such as home and community based services [HCBS] at age 21, etc.); between programs (Medicaid, CHIP, Basic Health Program, Medicare, and the Marketplace); or across state boundaries? Which of these actions would you prioritize first?

Children with significant disabilities often face a “services cliff” when they age out of EPSDT, as the EPSDT benefit is much more comprehensive and covers services that many Medicaid state plans do not. For example, a child may receive private duty nursing or personal care assistance as required pursuant to EPSDT, but may lose that service when they turn 21. While some states cover these services via HCBS waivers, such waivers may have extraordinarily long wait lists, forcing the young adult to wait years, even decades, for services.

CMS should require states to provide transition planning for persons facing transitions in coverage and care, including for young adults who age out of EPSDT. States with managed care can require transition planning in their managed care contracts. However, both states and CMS should conduct compliance monitoring to ensure that Medicaid enrollees actually receive these services.

CMS should also issue guidance addressing other important transitions, such as young adults with disabilities aging out of their parents' private insurance coverage and young adults with disabilities going through the Supplemental Security Income age-18 redetermination.

4. What are the specific ways that CMS can support states that need to enhance their eligibility and enrollment system capabilities? For example, are there existing data sources that CMS could help states integrate into their eligibility system that would

improve ex-parte redeterminations? What barriers to eligibility and enrollment system performance can CMS help states address at the system and eligibility worker levels? How can CMS support states in tracking denial reasons or codes for different eligibility groups?

Objective 3: Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this care will be aligned with the beneficiary's needs as a whole person. CMS is seeking feedback on how to establish minimum standards or federal "floors" for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or "floors" would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., by specific state regions and rural versus urban), language needs, and cultural practices.

1. What would be the most important areas to focus on if CMS develops minimum standards for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?

Minimum Standards for HCBS and LTSS

It is incredibly important for CMS to develop minimum standards for access to services for HCBS. These standards should reflect a federal floor that states can build on.

Measuring access to long-term services and supports (LTSS) and home and community based services (HCBS) is different from measuring access to other clinical services and states are significantly "behind the curve" when it comes to measuring access due to a dearth of metrics (<https://clpc.ucsf.edu/publications/managed-long-term-services-and-supports-assessing-provider-network-adequacy>). The most frequently used access criteria such as time and distance standards are generally inappropriate to services provided in a fixed home, community, or institutional location. Additionally, LTSS and HCBS services have (1) a wider range of amount, duration, and scope variations (for example, home attendant services that may be prescribed for 7 hours per week, or 17 hours, or 27 hours, etc.) and (2) a wide range of unique conditions that may complicate providing services (such as travel time to an individual's home or very particular skills needed for at-home care for a specific individual). Given these factors, access to HCBS required for individuals' health, inclusion is less reliable. To help ensure access to LTSS and HCBS, CMS should develop metrics to evaluate:

- If needed services are being prescribed. HCBS is not a medical service. However, in LTSS and HCBS, it is all too common to evaluate need based on provider and system

capacity rather than actual individual need. In this process, individuals are routinely pressured into accepting far less services and support, which can lead to serious and sometime deadly consequences.

- If provider capacity is sufficient. (The more typical network adequacy analysis).
- What proportion of prescribed hours is *actually* being filled, and a record of why those hours were not filled. One of the most pervasive problems in LTSS and HCBS is that many individuals only receive a fraction of the services they need even, though they *have* an approved prescription for the services (for example, they may receive only 20 of their 40 hours prescribed), especially due to provider shortages.
- The number of providers identified during the planning process/provider change period who were actually willing to accept the beneficiary for all needed services. how assessed “need” is being inappropriately influenced, for example, basing need on extraordinary services and supports from friends or family, or unreasonable expectations on service recipients themselves.

CMS should also develop methods to stratify metrics to identify how aggregated access data may mask serious access differences among the extremely diverse population relying on these services.

While Medicaid requires states to ensure that payments are sufficient to enlist enough providers so that services are available at least to the extent that such services are available to the general population, there is often no identifiable comparison in Medicare or private insurance for these services.

To address inadequate rates, we recommend that CMS amend the equal access rule to expressly include HCBS waivers and managed care. Specifically, CMS’ distinction between state plan services and services provided via HCBS waivers makes little sense as a matter of statutory interpretation, and it is bad policy. Nothing in 42 U.S.C. § 1396a (a)(30)(A) restricts its application to a narrow set of “state plan services.”

While states are required to report on their rate methodology when they request a new HCBS waiver, CMS could add additional safeguards to ensure that this analysis of rates will meet the needs of participants. This look-behind could include any number of factors that would inform the sufficiency of rates, including an analysis of individuals who had hours of waiver services approved but unstaffed or understaffed, a requirement that states analyze direct service provider turnover and capacity, and that states explain if their rates are adjusted for inflation, and if not, how that impacts availability of services. We also recommend including additional factors to ensure that rates are sufficient to meet the needs of people who may need staff with special training or skills, such as the ability to use assistive technology; require one or more forms of AAC to effectively communicate with others; ASL or other language skills; the training and skills to handle complex behavior needs without abuse, neglect, or over medication; and other needed cultural competency skills. If such needs are not part of the rate planning, people with complex needs will continue to be denied care or have limited access and disparities in access to HCBS will worsen.

Currently, states are performing HCBS rate studies pursuant to ARPA, which may provide information to CMS about how such data could be measured and monitored in the future (<https://www.mathematica.org/blogs/new-investments-in-medicaid-home-and-community-based-services-deserve-evaluation>). CMS should particularly look at rate studies that measure what rate would it take to ensure specific identified services are filled in all areas of the state for all levels of need.

We also recommend that CMS reiterate training (<https://www.medicaid.gov/sites/default/files/2019-12/trends-in-rate-august-2017.pdf>) and guidance, and continue to lift up helpful strategies regarding rate sufficiency and methodology for HCBS (<https://www.medicaid.gov/sites/default/files/2019-12/hcbs-wavr-paymnts-financng-trnds-sept-2021.pdf>). Examples include incorporating transportation (including gas and mileage) into the rate paid for providers or including personal care aides' travel costs between individuals' homes. This approach more accurately tracks with the actual operating costs to provide services, particularly in rural areas where the time and distance providers have to travel can create barriers to services. Other examples include moving away from a straight fee schedule for all services in one category, and instead using tiered rates based on acuity or other factors to account for individuals who have more intense needs or face other barriers to obtaining services. States can also use geographic variation to ensure that services are equally available across the state, or make supplemental or enhanced payments to providers to help workforce retention or other quality initiatives for specific services. While many states already utilize some combination of these tools, to a varying extent, additional guidance and technical assistance from CMS could help advocates understand how they can engage to urge states to use all the tools at their disposal to help ensure that those who need HCBS are actually able to receive it.

We also encourage CMS to address how states use individualized budgeting and the impact on access to services, including rates. Budgeting is often used by states and MCOs as a hard and fast limit on services, despite these budgets often being based on assessment tools that are difficult to understand, secretive, and often based on biased data or unwarranted assumptions and stereotypes (<https://healthlaw.org/preventing-harm-from-automated-decision-making-systems-in-medicaid/>). These budgets are also typically based on complex statistical aggregations of population data. They include significant outliers, but often exceptions are either not available, difficult to get, not appealable, or all of the above. Person-centered planning with such budgets becomes an exercise in how to make a person's needs fit what is available rather than how they may receive what they need according to their personal preferences, unless there is clear guidance otherwise and even then budget tools can limit access to what people need (<https://files.nc.gov/ncdhhs/Joint-Communication-Bulletin--J297--LME-MCO-LS-V-Wos-Instruction--002-.pdf>). The impact of assessments and budgets has been the subject of litigation and complaints throughout the country, often involving claims related to their impact on HCBS recipients' community integration or risk of institutionalization. Low assessed budgets frequently limit or prevent a person from paying adequate rates to pay for services, such as in the *Waskul*, 979 F.3d 426 (6th Cir. 2020) or *Belancio*, No. 17-CV-1180-EFM, 2018 WL 2538451 (D. Kan. Sept. 21, 2018) cases. There should be clear guidance with standards and expectations for the

use of budgetary tools that protects the right and practical capability of HCBS participants to access the services they need as well as increased transparency, look behind methods, and accountability for when such tools are used.

Further, encouraging states to continue some of the initiatives they have undertaken during the public health emergency (PHE) beyond the end of the PHE could help expand the pool of providers. For example, during the PHE states have permitted qualified providers from other states; allowed family caregivers to become paid caregivers while still ensuring participant choice of providers; increased payment rates for direct care workers; and expanded coverage of telehealth in terms of services, providers, and modalities. All of these strategies present a fairly low risk to participants, and can generally improve the direct care workforce stability and improve access to services. CMS could provide additional public-facing guidance related to this opportunity, while actively encouraging states to retain certain measures post-PHE, and share publicly their plans for doing so.

Minimum Standards for Behavioral Health

For specialty behavioral health, any minimum standards developed related to access to services must be measured by more specific categories than simply “behavioral health.” Simply measuring access to “inpatient” and “outpatient” behavioral health care is insufficient. Instead, access to sub-specialty behavioral health services should be monitored separately.

As a starting point, it is important to disaggregate SUD providers and mental health providers, to avoid situations where a plan meets the defined access standard by only providing mental health but not SUD services, or vice versa. A mental health provider that does not provide support for SUD treatment does little to nothing for the individual with only SUD.

Certain core services essential for individuals with high support needs to live in the community should be measured separately. These include Medication Assisted Treatment (MAT), Assertive Community Treatment (ACT), Supported Housing, Supported Employment, and Mobile Response Services. This group of behavioral health services require separate minimum access standards and tracking for two reasons. First, they are more akin to HCBS waiver services than traditional office-based outpatient services in how they operate, and therefore are not adequately measured via office or facility-focused measurements. However, these behavioral health services are rarely delivered via HCBS waivers, and therefore not subject to the same HCBS waiver monitoring and oversight that non-behavioral health HCBS services are subject to. Second, many of these services are extremely time-sensitive. For example, mobile crisis access should be measured in a matter of minutes or hours, not days. Because delays in accessing these interventions can wholly defeat the effectiveness of the intervention itself, separate monitoring and measures are required.

2. How could CMS monitor states' performance against those minimum standards? For example, what should be considered in standardized reporting to CMS? How should CMS consider issuing compliance actions to states that do not meet the thresholds, using those standards as benchmarks for quality improvement activities, or

recommending those standards to be used in grievance processes for beneficiaries who have difficulty accessing services? In what other ways should CMS consider using those standards? Which of these ways would you prioritize as most important?

3. How could CMS consider the concepts of whole person care or care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?

Enhancing Compliance with the Mental Health Parity and Addictions Equity Act

Medicaid is the largest payer of mental health services in the United States and plays a vital role in ensuring access to behavioral health services for Medicaid's more than eighty million low-income enrollees (<https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html>). Current federal parity protections apply only to Medicaid Managed Care Organizations (MCOs), Medicaid Alternative Benefit Plans (ABPs) and the Children's Health Insurance Program (CHIP), but not to fee-for-service Medicaid. To truly strengthen behavioral health coverage in Medicaid, federal parity protections should also extend to fee-for-service Medicaid. CMS should work with Congress to extend parity requirements.

Much work remains to truly enforce the existing promises of the Mental Health Parity and Addictions Equity Act (MHPAEA) within Medicaid and CHIP. Despite significant efforts by both Congress and CMS, parity noncompliance within Medicaid and CHIP remains a problem. A 2021 issue brief issued by MACPAC indicated that the federal parity law has not improved access to behavioral health coverage for people enrolled in Medicaid or CHIP (<https://www.macpac.gov/wp-content/uploads/2021/07/Implementation-of-the-Mental-Health-Parity-and-Addiction-Equity-Act-in-Medicaid-and-CHIP.pdf>).

Enforcing behavioral health parity is a significant challenge. The current system of parity compliance relies almost entirely on consumer complaints, placing the burden on an individual seeking behavioral health services to be able to identify that their denial, increased costs, or additional administrative burdens are a parity violation, and then walk through a convoluted web of paperwork, appeals, and agency enforcement mechanisms. Additionally, analysis of parity complaints is complex, requiring evaluation of both quantitative treatment limits (QTLs) (e.g., limits on the number of visits to a provider or the length of a specified treatment) and non-quantitative treatment limits (NQTLs) (e.g., medical necessity criteria used to deny treatments or prescription drug formulary designs) (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet). Often, this analysis cannot be completed because of a lack of disclosure from the plans of the information necessary to

identify parity issues (<https://healthlaw.org/resource/amicus-n-r-v-raytheon-company-u-s-court-of-appeals-first-circuit/>). Even if plans disclose some level of information, the findings in the *Wit v. United Behavioral Health* District Court decision show how ingrained some of the unlawful limits to behavioral health care may be, as well as the difficulty of appealing denials of care deemed necessary by treating clinicians (<https://healthlaw.org/nhelp-files-friend-of-court-brief-to-protect-access-to-promised-behavioral-health-care/>). While some progress has been made in identifying and eliminating quantitative treatment limits, addressing NQTLs has remained challenging as has the existence of treatment exclusions (<https://www.macpac.gov/wp-content/uploads/2021/07/Implementation-of-the-Mental-Health-Parity-and-Addiction-Equity-Act-in-Medicaid-and-CHIP.pdf>).

To improve parity compliance, CMS must take a more proactive role in enforcing MHPAEA. Under current regulations, parity analysis is left primarily to states or MCOs (42 C.F.R. § 438.920). In particular, we remain concerned about MCO's willingness to perform a comprehensive analysis of NQTLs, and have even less confidence that plans will disclose the type of information truly necessary to perform this comparison or that they will disclose the information at a level that allows identification of parity violations. Plans have every incentive to obscure parity violations, as maintaining such illegal plan structures allows them to deny care and save costs. States also need support and guidance from federal enforcement agencies to be able to conduct thorough parity analysis. CMS should mandate disclosure and transparency requirements for all health plans that enables ready analysis. In addition, we ask that CMS require states to demonstrate compliance with EPSDT through a valid analysis rather than simply attesting to EPSDT compliance for parity purposes. Numerous court cases have found states in violation of the basic EPSDT requirements of informing, screening, and providing and arranging for behavioral health treatment a child needs (<https://healthlaw.org/resource/epsdt-litigation-trends-and-annotated-docket/>). Finally, we suggest that any regulations issued going forward clarify that explicitly affirm that parity protections can be privately enforced by Medicaid and CHIP beneficiaries.

Additionally, as we noted above, our parity enforcement system remains largely complaint driven, with the onus placed on individuals to file appropriate appeals and complaints, and there is no clear way to file a complaint for Medicaid or CHIP. Navigating this patchwork system of enforcement is confusing and overwhelming. To improve this, CMS should coordinate with other parity enforcement agencies to create a centralized, easily accessible, public complaint process. Further enforcement agencies should work together to produce easy-to-understand educational materials for the general public. These materials should include clear examples of what parity violations look like and should be part of an ongoing outreach campaign to provide up-to-date support, information, and resources on behavioral health parity.

4. In addition to existing legal obligations, how should CMS address cultural competency and language preferences in establishing minimum access standards? What activities have states and other stakeholders found the most meaningful in identifying cultural and language gaps among providers that might impact access to care?

5. What are specific ways that CMS can support states to increase and diversify the pool of available providers for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?

Self-directed services can be a useful tool to expand the provider pool, as it permits individuals to recruit and hire employees from their own social and community networks. Although many states have self-direction available, it may only be available under one waiver authority and not under another, or is available for those who receive FFS but not those in MLTSS. It should be available throughout the Medicaid program. Even when it is available, the function of fiscal management agencies can cause access problems. These entities are responsible for helping people in self-direction programs handle employee payment and other important functions. But sometimes they create their own challenges through slow payment, administrative burdens in hiring employees, and other issues that limit payment to and processing of employees. Such problems directly influence access to care HCBS participants using self-direction often have few options to correct such malfunctions. There is usually limited or no choice in fiscal management agencies and states often provide very little, if any, problem solving support. Because self-direction itself can improve or resolve some access to care barriers, any guidance on access to HCBS should promote self-directed services.

Objective 4: CMS has data available to measure, monitor, and support improvement efforts related to access to services (i.e., potential access; realized access; and beneficiary experience with care across states, delivery systems, and populations). CMS is interested in feedback about what new data sources, existing data sources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

1. What should CMS consider when developing an access monitoring approach that is as similar as possible across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care programs) and programs (e.g., HCBS programs and dual eligibility in Medicaid and Medicare) and across services/benefits? Would including additional levels of data reporting and analyses (e.g., by delivery system or by managed care plan, etc.) make access monitoring more effective? What type of information from CMS would be useful in helping states identify and prioritize resources to address access issues for their beneficiaries? What are the most significant gaps where CMS can provide technical or other types of assistance to support states in standardized monitoring and reporting across delivery systems in areas related to access?

2. What measures of potential access, also known as care availability, should CMS consider as most important to monitor and encourage states to monitor (e.g., provider networks, availability of service providers such as direct service workers, appointment wait times, grievances and appeals based on the inability to access services, etc.)? How could CMS use data to monitor the robustness of provider networks across delivery systems (e.g., counting a provider based on a threshold of unique beneficiaries served, counting providers enrolled in multiple networks, providers taking new patients, etc.)?

Managed Care and Managed LTSS Network Access

Some beneficiaries in managed care spend untold hours searching for available providers for services they need, and many give up after fruitlessly wading through wrong numbers, outdated listings, and providers who are not accepting new patients. Others end up with surprise bills for out-of-network services due to errors in provider directories, or simply cannot find a listed provider at all.

States must work to eliminate the burden of this bureaucratic red tape, and one of the best ways to do that is transparency. CMS could build on some of the provider directory accuracy provisions from the 2021 Consolidated Appropriations Act and require states to update MCO and FFS provider directories at least every quarter, respond to consumer network questions promptly, and hold Medicaid beneficiaries harmless if they obtain services from an out-of-network provider listed as in-network. CMS could require states to publish periodic (at least annual) scorecards for accuracy and typical appointment wait times for different services in FFS and MCO networks. Such scorecards would need to include benchmarks with [enforceable standards](#) to incentivize states and plans to comply.

The 2016 Managed Care rule update created a new mandatory EQR activity to validate network adequacy, and the preamble to that rule suggested that CMS was looking at increasing direct testing of provider networks. The protocol laying out how states should conduct this new required activity has not yet been released, but evidence collected in the intervening years has continued to accumulate reinforcing the importance of actively auditing MCO's assurances about their provider networks and directories.

In 2014 HHS' Office of the Inspector General [conducted secret shopper surveys](#) of Medicaid plans that found over half the provider directory entries were incorrect or not available for appointments. Since then, a number of states have also found that direct testing of networks and provider directories through mechanisms like secret shopper surveys helps identify consumer access barriers. States including Texas, Maryland, Missouri, New Hampshire, and Ohio have conducted surveys that revealed massive error rates in provider directories and documented long wait times to obtain a scheduled appointment. Maryland's [extensive survey of on-line and paper provider directories](#) led to nine corrective action plans for MCOs in 2019. Texas' [EQRO study](#), which only successfully contacted 52% of providers in 2018, includes a list of best practices for more accurate provider directories.

Until the new CMS protocol is released, states that do not validate network adequacy face no penalties. Enhanced match for activities related to required network adequacy validation is also contingent on the new protocol, though states may be able to classify direct testing of this kind under existing optional EQR activities that qualify for enhanced match. CMS should prioritize publishing the needed protocol and actively promote this type of active auditing with states, including through technical assistance that advertises how states can obtain higher 75% FMAP for conducting MCO provider network availability surveys through EQR. The TA should detail common problems designing and conducting these surveys to ensure that data collected is actionable.

CMS should also recommend how to design these surveys to account for potential differences in accessibility for medically underserved groups, including people with disabilities, people with limited English proficiency, and people of color. Such individuals should be involved from the beginning on designing, implementing and conducting this survey research. For example, many people with disabilities still struggle when network providers lack the equipment necessary to provide services that accommodate their unique needs.

HCBS Core Measure Set

We have long advocated for robust, meaningful, publicly reported home-and-community-based services (HCBS) quality measures in Medicaid. HCBS quality measures are an essential component of a broader oversight system to ensure that Medicaid enrollees, including people with disabilities and older adults receive services that meet their needs, goals and preferences and help them thrive in the community. In our work as a coalition, we see the need for these measures as an assurance that people who use HCBS have access to the quality services they need to enjoy the full benefits of community living.

We appreciate that the Centers for Medicare and Medicaid Services (CMS) has recognized the urgency and importance of creating a recommended set of HCBS measures. The HCBS core measure set will raise expectations for states and health plans to prioritize HCBS measurement and promote standardized methodologies that make it easier to create benchmarks and compare across states. In the future, a robust measure set may provide HCBS participants with data they can use to choose health plans (and eventually providers).

Still, we need much more and faster. Given how critical HCBS is to people with disabilities and older adults, and given the large share of Medicaid spending dedicated to HCBS, a CMS recommended HCBS core measures set is long overdue. (MACPAC, *FactSheet, Medicaid Home-and Community-Based Services: Characteristics and Spending of High-Cost Users*, 1 (June 2018).) We urge CMS to implement an HCBS core set and move toward mandatory reporting. This could parallel the transition to required state reporting of the child core set and adult behavioral health measures by FY 2024 (<https://www.macpac.gov/wp-content/uploads/2020/03/State-Readiness-to-Report-Mandatory-Core-Set-Measures.pdf>). In the meantime, we ask that CMS continue to support the development and implementation of measures that help address some of the many gaps, including especially *outcome* measures, provider-level measures, and a commitment to reporting key measures stratified by key population demographics.

Most of the available metrics for HCBS depend on surveys of individuals' experience of care. Survey instruments like National Core Indicators (NCI), NCI-AD, CMS's HCBS CAHPS survey, and the Council on Quality and Leadership's Personal Outcome Measures tool, provide rich data across many important areas, including autonomy, community integration, care quality, and person-centered planning. These are some of the best data sources we have, but they are also limited. Because of small sample sizes in many states, the results provide only the broadest overview of quality and may not pick up on important variations across populations, geography, plans, or providers. Due to the infrequent implementation – every other year in some states – they also may miss changes over time.

To the extent that the core measure set depends largely on these survey instruments, CMS should make clear the expectation that states broaden their sample size to allow for more fine-grained analysis of performance. Moreover, CMS should take steps to fast track other approaches to measuring HCBS access, such as using T-MSIS claims data, that can provide more timely results at the provider level. Two areas of particular need are:

- Assessing caregiver needs. 53 million adults play key roles in providing unpaid LTSS to family and friends. Nearly one-quarter report that caregiving is worsening their own health and one-fifth report caregiving is straining their finances. We recommend that CMS urge states to require care managers or health plans to conduct assessments of the physical, emotional, mental, social, and financial needs of family caregivers or natural supports, and address the needs identified. This is a promising practice that at least six states require of managed care plans.
- Addressing workforce gaps. Workforce gaps, particularly in direct care, lead directly to low quality care. We urge CMS to support development of measures, including measures of cultural competence (defined by the National Quality Forum as the degree to which the workforce delivers services aligned with the cultural background, values, and principles of the HCBS consumer). In the meantime, we urge CMS to recommend states track and report ratios of support workers to participants and staff turnover.

Finally, people with disabilities and older adults who receive these services should be involved in the design, development, implementation, and selection of such measures.

Workforce Measures

The role of the direct-care workforce in the availability of and access to HCBS is especially crucial. There is also a lack of basic data on the HCBS workforce at the state and federal levels (PHI 2021). This makes tracking the workforce and addressing fundamental workforce issues difficult. “State officials and beneficiary advocates whom we interviewed shared that this lack of data is particularly challenging because, without the data, they cannot accurately estimate the size of the workforce or the average income.” (MACPAC 2022).

We urge CMS to establish required reporting on measures and metrics related to workforce volume, workforce stability, and compensation. In 2009, the CMS-funded National Direct Service Worker Resource Center issued recommendations on a minimum data set that would

apply consistent workforce data collection across states and HCBS service provider types within states. The minimum set included three areas of data:

1. Workforce Volume (number of full-time and part-time workers);
2. Workforce Stability (turnover and vacancy rates); and
3. Compensation (wages and benefits)

The National Quality Forum's (NQF) 2016 HCBS Quality Measures Framework identifies Workforce as a key domain for quality and access. NQF's final report noted both the lack of workforce data collection and the importance of tracking numbers of workers, turnover and vacancy rates, and wages and benefits across the HCBS workforce as sub-domains within the Quality Framework. NQF also included worker training and worker participation in HCBS systems as additional sub-domains. In 2020, CMS issued an RFI around HCBS measure recommendations based around the NQF framework.

Currently, the Disabled and Elderly Health Programs Group at CMS is developing an HCBS core measures set. A workforce minimum data set that includes at least measures on numbers of workers; turnover and vacancy rates; and worker wages and compensation would be far more effective at capturing state, provider and program level workforce data that is so desperately needed for effective policy making. Although there is very little existing workforce data being collected consistently across states, some states are taking steps to measure workforce shortages. Oregon, California, and Illinois are all collecting data on consumers' approved hours of care, vs. actual amount of delivery hours, in order to identify worker shortages. As mentioned above, these are important issues for people with disabilities and older adults.

We would recommend including measures that capture, in detail, workforce volume (availability), workforce stability (retention/turnover), and compensation (wages and benefits). Workforce volume should be stratified by agency employer vs. independent provider, and by home care worker age, race/ethnicity, gender, and languages spoken (including a comparison of workforce language competency compared to indicated language preferences of consumers).

Workforce Stability (retention/turnover) should include annual turnover rates (percentage of workers who left their positions for any reason over a twelve-month period) and turnover rates for new workers (e.g., with less than 6 months of tenure). CMS should also explore ways to measure vacancy rates (for agencies, measured as number of empty positions divided by the total number of empty positions plus total filled positions), as well as number of self-directed consumers unable to fill positions; it may also be useful for CMS to examine service continuity, as measured by (a) frequency and length of services interruptions, and (b) calculating the average number of different workers who serve each beneficiary in a calendar year

Compensation (wages and benefits) should at least measure average hourly wage and average annual earnings across programs and employer types for personal care services and could

include ratio of average hourly wage and average annual income for home care workers compared to workers at long-term care facilities (including nursing homes, and assisted living facilities); and reporting on specific health and employment benefits offered to such workers.

Measuring Equity

COVID-19 has painfully reexposed the deep inequities in our healthcare system. COVID's terrible impact on older adults and people with disabilities – particularly those in congregate settings – is frequently in the news. A second dominant narrative highlights COVID's disparate impact on communities of color. In reality, these two narratives should be intertwined. We know already that racial and ethnic health disparities common in acute care settings have also been found in HCBS. Direct care workers who provide HCBS are also disproportionately Black or other women of color. But we still lack systemic data on the full extent of COVID-19's effect on people of disabilities, let alone people of color with disabilities and the workforce that supports them. If there is one urgent lesson to take away from the tragedy of this pandemic, it is that the U.S. health system has to do much more to promote health equity. Medicaid should be ground zero for this change.

Health equity should be at the forefront of Medicaid quality measurement endeavors. CMS's national quality strategy, which sets racial and ethnic health equity as a “foundational principle,” identifies specific actions that could help states improve health equity, two of which relate directly to data collection:

- stratifying quality reporting by race, ethnicity, disability, and primary language/expressive means to help identify health inequities; and
- building IT infrastructure that can readily incorporate such demographic data.

The proposed HCBS core measure set must build on these recommendations to set an expectation that all states stratify core quality data by key demographic categories – including race, ethnicity, disability status, age, sex, sexual orientation, gender identity, primary language/expressive means, urban/rural environment, and service setting. To understand the complexities of disparate health care access for people with disabilities, policymakers need data broken down by key demographic groups for as many measures as possible. Where possible, such data should also be cross-tabulated, for example, showing the interaction between race and disability status. This data is essential to identify health inequities, target interventions at the communities or populations that need them most, and track progress in reducing or eliminating them.

In accordance with the national quality strategy, CMS should provide states with technical assistance and enhanced administrative match to update computer systems to be able to report each core measure (including the adult and child sets) by key demographic groups. This can help identify health disparities in acute care that people with disabilities routinely experience. Measure stewards should build this capability into the measure development process. Data stratification must become a basic expectation for quality data reporting. We also recommend CMS provide states with technical assistance and enhanced administrative match to update

computer systems to facilitate reporting of each HCBS measure (as well as adult and child measures) by key demographic groups. Stratifying data is not nearly as challenging if it is included as a basic design expectation from the beginning.

We also realize that performance measures alone will not provide enough oversight to ensure timely access to needed services. CMS should complement the core measure set with other oversight methodologies to provide a more complete picture of HCBS access and care quality. Qualitative approaches like site visits or semi-structured, open-ended beneficiary interviews can provide richer understanding of the different environments where services are provided. This context can inform interpretations of the results from quantitative measures as well as potential actions to address problems as they are found.

CMS should provide resources to strengthen the authority, capacity, and funding for long-term care ombuds, HCBS ombuds, and Protection & Advocacy systems to play a complementary but independent role in supporting people with disabilities to solve individual challenges accessing care, and monitoring and publicly reporting systemic problems and recommendations to CMS.

3. In what ways can CMS promote a more standardized effort to monitor access in long-term services and supports (LTSS), including HCBS, programs? For example, how could CMS leverage the draft HCBS measure set, grievances and appeals, or states' comparisons of approved Person-Centered Service Plans to encounter or billing data in managed care or fee-for-service to ensure appropriate services are being received? Which activities would you prioritize first?

CMS should set substantive standards against which compliance with the 30(A) equal access and managed care provisions can be measured. We urge CMS to develop a framework that would require states to develop substantive standards for access based on meaningful input solicited from a wide range of stakeholders through a public process, review of key measures of access that includes an assessment of workforce capacity and payment rates, and stronger mechanisms to enforce review requirements. Congress has authorized CMS to take this step under a number of statutes. CMS could ground new rulemaking in the general access standard in Section 1902(a)(30)(A), as well as the managed care access standards and beneficiary protections in Sections 1903(m)(1)(A)(i), and 1932. In addition, Section 2402(a)(3)(B)(iii) of the ACA expressly directs HHS to promulgate regulatory standards for states to assure “an adequate number of qualified direct care workers to provide self-directed personal assistance services,” “achieve a more consistent administration of [HCBS] policies and procedures across programs,” and strengthen monitoring through a “complaint system” and other mechanisms.

We note that some states – but by no means all -- are beginning to move in this direction. Washington, for example, is using a portion of the enhanced FMAP provided under the American Rescue Plan to undertake rate reviews. Pending legislation in Massachusetts would require the state to undertake a regular review of rates that would include analysis of a variety of factors (including wage rates, costs of health insurance and employee benefits, and training)

when promulgating final rates for home care agencies the state would need to show that they had been calculated based on the required analysis.

CMS could also direct states to establish an Advisory Board on HCBS Access & Payment Rates that would operate in conjunction with the state's rate setting processes for HCBS. The Board membership would include representation from people with disabilities receiving HCBS, home care and other direct care workers, professional organizations of these workers (if they represent a threshold level of a given category of direct care workers), and the state agencies providing HCBS. This proposal builds on CMS's prior rulemaking regarding MCACs, and could be grounded in a range of statutory authorities.

4. How should CMS consider requiring states to report standardized data on Medicaid fair hearings, CHIP reviews, managed care appeals and grievances, and other appeal and grievance processes that address enrollment in coverage and access to services? How could these data be used to meaningfully monitor access?

5. How can CMS best leverage T-MSIS data to monitor access broadly and to help assess potential inequities in access? What additional data or specific variables would need to be collected through T-MSIS to better assess access across states and delivery systems (e.g., provider taxonomy code set requirements to identify provider specialties, reporting of National Provider Identifiers [NPIs] for billing and servicing providers, uniform managed care plan ID submissions across all states, adding unique IDs for beneficiaries or for managed care corporations, etc.)?

Objective 5: Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible. Section 1902(a)(30)(A) of the Social Security Act (the "Act") requires that Medicaid state plans "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Section 1932 of the Act includes additional provisions related to managed care. Section 2101(a) of the Act requires that child health assistance be provided by States "in an effective and efficient manner..." CMS is interested in leveraging existing and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. CMS also wants to address provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.). In addition, CMS is interested in non-financial policies that could help reduce provider burden and promote provider participation.

1. What are the opportunities for CMS to align approaches and set minimum standards for payment regulation and compliance across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure

beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?

CMS should require that states demonstrate that all payments remain compliant with the standards of Section 1902(a)(30)(A) of the Social Security Act (“access provision”), which requires states to “assure that payments... are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” This would require strengthening of CMS’ current access review requirements implementing the statute and, at minimum, clearly identifying its application to home and community-based services.

CMS should develop reimbursement rate-setting guides and sub-regulatory guidance which makes clear to states the standards in which payments should be set to meet the access provision. Access standards should be set to reflect not only the costs incurred to deliver the service, but also to reflect the needs of the population reliant on individualized services and offer choice of provider.

We were concerned to see CMS issue a two-year extension of enforcement discretion in review of the access monitoring review plan, given most plans appear to have not been updated or reviewed since 2016. Access monitoring review plans should continue to be required for state plan amendments and extended to cover all long-term care and home and community-based services. Without substantive review, home and community-based services are experiencing a direct care workforce crisis due to stagnant reimbursement rates which have been left unadjusted for upwards of decades at a time.

CMS should require rates to be reviewed at least every three (3) years and require an automatic annual inflationary increase. The process should demonstrate stakeholder input and review from, at minimum, providers, workers, and beneficiaries. Substantive changes to the service should trigger an immediate review to determine whether added duties impact reimbursement. Cost data used to inform rates should be no more than one-year old or demonstrate inclusion of inflationary increases. Rates should be developed with a minimum set of separate line-items identified by CMS which must be identified and incorporated into rate reviews (e.g. wages, employee related expenses, program-related expenses, and general and administrative expenses) for transparency of review.

2. How can CMS assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access and encourage payment policies and contracting arrangements that could have a positive impact on access within or across state geographic regions?

For decades, the United States has witnessed a significant shortage of direct care workers due to stagnant reimbursement rates and the inability of providers to offer wages that enable them to compete with industries offering entry-level positions, such as fast-food restaurants or retail and

convenience stores. The effects of underinvestment in the direct care workforce can be seen in turnover rates which hover near 50% nationally. With the onset of COVID-19, new pressures and hazards of providing essential, close-contact services during the pandemic have further exacerbated and accelerated the workforce crisis.

While many in the private sector pivoted by offering increased wages and hazard pay, community providers—who rely almost exclusively on Medicaid funding and are thus beholden to paying wages that state Medicaid reimbursement rates will permit—lacked the immediate resources to fund these kinds of unanticipated programmatic costs. At approximately \$13 per hour, the median wage for direct care workers nationally is simply insufficient to slow the exodus of direct care workers from the field and the closure of programs which threatens access to home and community-based services.

According to ANCOR's, *The State of America's Direct Support Workforce 2021*, 77% of providers were turning away new referrals, 58% of providers were discontinuing programs and services, and 84% of providers were delaying the launch of new programs or services due to lack of staffing. See:

https://www.ancor.org/sites/default/files/the_state_of_americas_direct_support_workforce_crisis_2021.pdf. Survey results further indicated that nearly 3 in 10 (29%) respondents reported spending more than \$500,000 annually in costs related to high turnover and vacancy rates, while more than 1 in 6 respondents (18%) reported spending more than \$1 million annually.

Nearly all providers agreed that the COVID-19 pandemic continues to deeply impact their ability to hire and retain direct care workers. These relentless challenges illustrate why increased funding is critical to begin addressing the magnitude of unmet need in our communities. In addition to the access provision requirements for state plan services, CMS reviews and approves waiver applications for home and community-based services. CMS' technical assistance guides require that states document and describe their rate review process to include when rates were initially set and last reviewed; how the state measures rate sufficiency and compliance with §1902(a)(30)(A); the rate review method(s) used; and the frequency of rate review activities. However, CMS continues to approve plans for services which have not been reviewed or adjusted for decades at a time despite rising market and labor costs and increased service activity requirements.

3. Medicare payment rates are readily available for states and CMS to compare to Medicaid payment rates, but fee-for-service Medicare rates do not typically include many services available to some Medicaid and CHIP beneficiaries, including, but not limited to, most dental care, long-term nursing home care, and home and community-based services (HCBS). What data sources, methods, or benchmarks might CMS consider to assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?

Currently, the U.S. Department of Labor Bureau of Labor Statistics (BLS) does not maintain separate Standard Occupational Classifications (SOC) for direct care workers, including but not

limited to direct support professionals. BLS incorporates most direct care workers into an umbrella category that includes professionals such as home health aides, social workers, and camp counselors. Direct care workers have distinctly different responsibilities and activities not reflected in the umbrella. An accurate SOC is necessary to inform policymaking.

CMS' support and communication with BLS in creation of separate SOCs for direct care workers is critical to aligning objectives across shared regulatory authority and would assist states to appropriately fund the direct care workforce. SOCs are used to help all levels of government identify employment trends and design policies and rate reimbursement methodologies. A classification that does not reflect the true nature of direct care work prevents policymakers from making informed decisions. With accurate SOCs for direct care workers, CMS could appropriately assess when reimbursement rates fall below the average necessary wage.

Data metrics which assess the quality of the workforce can also be used as a benchmark for sufficiency of rates. When payment is sufficient, turnover and vacancy rates should be low and the workforce available to provide individualized services. At minimum, states should be collecting and reporting to CMS a description of the characteristics of the direct care workforce that provides home and community-based services, including the number of full- and part-time direct care workers, the average and range of direct care worker wages, the benefits provided to direct care workers, and the turnover and vacancy rates of direct care worker positions. The state should also collect and submit demographic data related to the workforce to identify disparate impacts and ensure equity.