Via Electronic Submission to regulations.gov

July 3, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Agency/Docket Number CMS-2442-P, proposed rule aimed at improving access to care, quality and health outcomes, and better addressing health equity issues in the Medicaid program across fee-for-service (FFS), managed care delivery systems, and in home and community-based services (HCBS)

Dear Administrator Brooks-LaSure,

The National Association for Home Care & Hospice (NAHC) and the Home Care Association of America (HCAOA) respectfully submit these comments to the Centers for Medicare and Medicaid Services (CMS) in response to the above-referenced proposed rulemaking published in the Federal Register on May 3, 2023 at 88 FR 27960.

Since 1982, NAHC has been the largest organization representing hospice, home health, and home care providers across the nation. Our members include a wide array of provider types, including nonprofit and proprietary, urban and rural, hospital-affiliated, public and private corporate entities, and government-run agencies.

Founded in 2002, HCAOA is one of the home care community's leading trade associations—currently representing over 4,300 companies that employ countless caregivers across the United States. Our member agencies provide medical, skilled, personal and companion home care, enabling seniors and individuals with disabilities to remain in their homes as long as possible at a cost that is more affordable than institutionalized care. Home care also encompasses Private Duty Nursing (PDN), which is medically necessary nursing services under Medicaid caring for medically fragile patients, primarily children. Our members and their caregivers assist with a variety of non-medical activities of daily living, such as bathing, dressing, eating, and other services necessary for seniors and the disabled to thrive at home.

Executive Summary

NAHC and HCAOA are supportive of many of the provisions in this proposed rulemaking. We specifically support and provide comments that we believe would strengthen and improve the following provisions:

- Access Reporting: 42 CFR §441.311(d);
- Payment Rate Transparency: 42 CFR §447.203(b)(1);
- Interested Parties Advisory Group: 42 CFR §447.203(b)(3)(ii)(6);
- State Analysis Required for Payment Restructuring and Access: 42 CFR §447.203(c);
- HCBS Quality Measure Set: 42 CFR §441.312;
- Strengthening Oversight of Person-Centered Plans: §441.301(c)(3)(ii)(A);
- Incident Management System: 42 CFR §441.302;
- HCBS Grievance System: 42 CFR §441.301(c)(7); and
- Medicaid Advisory Committee and Beneficiary Advisory Group: 42 CFR §431.12.

We also provide recommendations that we believe would make the following provisions more effective and improve the ability to successfully implement:

- Definition of DCW: 42 CFR §441.302(k)(1)(ii);
- Reporting on Proportion of Payments to DCWs: 42 CFR §441.311(e); and
- Payment Rate Disclosure: 42 CFR §447.203(b)(3)(ii).

Unfortunately, the HCBS Payment Adequacy provision at 42 CFR §441.302(k)(3)(i) is the most impactful part of this rule and is untenable for our members. We provide significant analysis and detail to demonstrate why:

- The proposal lacks statutory authority;
- There is no data to support it;
- It contradicts CMS HCBS quality efforts;
- Existing policies do not support such a mandate;
- State rate models demonstrate inconsistency of the proposal with HCBS practices;
- Provider cost data also does not align with the proposal;
- Provider surveys indicate significant confusion and negative impacts for patients and caregivers;
- The mandate is administratively complex and would be extremely challenging to enforce;
- The proposal would create inequities within and across states;
- The proposed rule undermines state authority; and

- The proposed rule would disproportionately impact small and rural providers.

We believe that there are opportunities to implement regulations that improve the structure and outcomes of state HCBS reimbursements and offer an alternative proposal. We believe that our proposal would enhance HCBS payment methodologies in a way that:

- Provides more structure for state rate-setting processes;
- Creates a transparent approach that clearly delineates the components of a Medicaid reimbursement methodology;
- Supports and increases worker compensation;
- Maintains state flexibility and autonomy regarding provider rate setting;
- Preserves the ability to perform both required and supplementary administrative activities that are crucial to high-quality HCBS delivery; and
- Adheres to the statutory requirements regarding 1902(a)(30)(A).

We look forward to ongoing discussions and collaboration with CMS, states, and other partners in order to strengthen and improve HCBS, increase wages for workers, and supports ongoing provider viability.

Overarching Comments

Our associations would like to thank CMS for its interest in improving the quality of and access to home and community-based services. We agree with the stated intent of this proposed regulation and support efforts to expand access to quality home and community-based services (HCBS) in Medicaid. As discussed in our joint report, *The Home Care Workforce Crisis: An Industry Report and Call to Action*, which addresses the needs of the home care aide and nursing workforce, the supply and demand issues for home-based care, and actionable solutions for stakeholders.

To create the report, HCAOA and NAHC gathered some of the industry's most experienced leaders from home care organizations across the nathe workforce shortage in home-based care has reached crisis proportions and will require a broad swath of changes to an array of policies and procedures to address the significant challenges that we face when assuring adequate workforce for home-based care.[1] We are grateful that CMS is examining this issue and is attempting to identify ways to address and mitigate the shortage of workers. We are very interested in collaborating with CMS and the Administration to develop comprehensive approaches to increasing access to Medicaid-funded HCBS.

Toward that end, NAHC and HCAOA have been extremely supportive of many of the efforts by Congress and the Administration to strengthen access to HCBS. We know that this is not a problem that will be easily solved and believe that there is the need for ongoing efforts to find sustainable, achievable, policies. As discussed later in this letter, we are also supportive of many of the policies contained within the NPRM. We will continue to support various efforts to provide increased funding for HCBS and look forward to ongoing collaboration with the Administration and Congress to find sustainable solutions that increase compensation to direct care workers (DCWs) and improve the lives of our caregivers.

However, we are extremely concerned about the core approach CMS proposes at 42 CFR §441.302(k)(3)(i) that purports to address the workforce crisis within this regulation. The provision would mandate that 80% of payments spent on personal care, home maker, and home health aide services be spent on compensation to DCWs. Unfortunately, this aspect of the rule does not address the chronic underfunding of Medicaid HCBS and instead attempts to reallocate the use of current Medicaid reimbursements. We note that prior legislative efforts to enhance DCW compensation included substantial infusions of funding to buttress the HCBS system and to ensure that the policy proposals were achievable. It is therefore disappointing that this rule does not address the

[1] https://www.hcaoa.org/uploads/1/3/3/0/133041104/workforce_report_and_call_to_action_final_03272023.pdf

inadequacy of HCBS funding and instead would impose arbitrary limits on providers' administrative expenses – many of which are due to state and federal requirements and are not within the control of the providers themselves.

We also want to stress the importance of many of the functions that CMS dismisses as simply "Administrative Overhead" and "Profit" in their public statements.[2] This is an unfair characterization that grossly misrepresents the forces driving home care agency expenditures and disregards the many state and federal regulations imposed upon HCBS providers. A non-exhaustive list of requirements included in the "Administrative Overhead and Profit" that the proposed rule seeks to constrain includes:

- Physical office locations, frequently required by state licensing standards;
- Intake and scheduling functions not performed by a direct care worker;
- Electronic Visit Verification as required by 1903(l) of the Social Security Act;
- Mandated nurse supervision of direct care workers;
- Background checks and fingerprinting for new hires;
- Health Screenings;
- Personal protective equipment and other infection control expenses;
- Costs for providing training;
- Quality oversight and reporting;
- Health and welfare management activities;
- Mileage reimbursement; and
- Data and information technology, such as case management systems or electronic records.

Furthermore, the approach will also disincentivize agencies from investing in initiatives and activities that support workers beyond the strict state and federal requirements. In fact, many of the activities highlighted in CMS' report from the Direct Service Workforce Learning Collaborative[3] would not be feasible if this proposal proceeds. This includes initiatives such as:

- Enhanced training and skills development;
- Career ladders for the workforce;
- Enhanced onsite supervision;
- Transportation; and
- Diversity, Equity, and Inclusion Training and Programming.

[2] See https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall05022023.pdf
[3] https://www.medicaid.gov/media/file/hcbs-learning-collaborative-summary.pdf

Beyond those initiatives highlighted in the learning collaborative report, other initiatives that providers have implemented would also be at risk, such as:

- Employee Assistance Programs and other counseling supports;
- Additional paid-time off for things such as bereavement;
- Additional quality improvement programs such as falls monitoring, flu shot/vaccination education; and
- Data capturing activities to identify & address gaps in care.

Additionally, there appears to be an inherent contradiction within the Access rule when taken in its entirety. While the rule seeks to put a hard cap on the proportion of certain Medicaid service expenditures utilized for administrative functions, it simultaneously imposes new administrative requirements such as a critical incident reporting system, enhanced quality measurement, and grievance reporting. Many of those requirements are primarily the responsibility of states; however, the reporting necessary to appropriately populate these systems will also require additional effort, IT expenditures, and administrative staff from providers. **It is incongruous to both impose requirements that increase the administrative burden on providers while at the same time limiting the resources available to fund those same functions.**

Existing low reimbursement rates, coupled with the current administrative requirements and the new pressures from the different parts of this rule will create an untenable situation for many providers. This results in the proposed rule being counterproductive to its stated purpose. Instead of increasing access to Medicaid services, the sum of the rule's components will put providers, including many rural providers and small businesses that serve ethnic and cultural minority populations, out of business, thus exacerbating access challenges.

We are unsure about the scope of the likely provider closures because, though we have spent a substantial amount of time and effort since the release of the NPRM collecting and analyzing information to understand the potential impact of this rule, there is no national data available to truly assess the current allocations of HCBS provider payments and model the changes that would occur if this rule is finalized. We have spoken to a wide range of organizations and experts in the Medicaid community and, thus far, no one has been able to identify any information that is more reliable and substantive than what we have been able to compile in the two short months since the NPRM was released. We hope that the information and analysis included in the remainder of this comment letter provides a greater understanding of the current landscape of HCBS provider finances, obligations, and limitations and leads to a different policy choice.

Beyond our concerns about the proposal itself, we are also deeply concerned that the proposal was issued without consultation of the providers it seeks to regulate. As the largest

representatives of HCBS providers, our industry associations were not consulted when CMS began discussions on the proposed rule, a technical error that we believe has created a rule that does not utilize appropriate data to understand the costs of providing service and properly analyze the likely impact. We understand the need to be cautious about providing too much information regarding potential future rulemaking; however, we know that CMS solicited feedback from other associations and outside entities during the development of the rule. We believe that NAHC, HCAOA, and our members can provide valuable insight into the various state and federal policies that drive administrative expenditures, the challenges and opportunities related to recruitment and retention of qualified workers, and potential regulatory options to improve worker compensation and overall quality of life. We are further disappointed that the inclusion of this provision within the broader Access rule has distracted from so many other positive changes that are proposed.

We are alarmed that, based on both the content of the rule and the messaging surrounding it, the Administration seems to be taking an approach that frames provider agencies as adversaries to the interests of DCWs. We want to stress that this is not the case – we and our members care deeply for the caregivers that work each day to provide necessary supports and services to individuals in the community. Many of the providers in our memberships actually lose money on the Medicaid lines of business and must subsidize these operations with other revenue, such as Medicare, private pay, and, where available, commercial insurance. Many providers lose money on the Medicaid program despite paying above minimum wage to their workers. When asked why they continue to participate in Medicaid despite the regulatory burdens, low payment rates, and challenging operational issues, providers often speak to their moral obligations, the desire to give back to the community, and the needs of individuals on the Medicaid program. These same agencies seek to increase wages and support quality of life for the caregivers they employ and constantly advocate for improved policies that enable agencies to provide better support for DCWs.[4] We hope that CMS will reframe these discussions to look upon provider agencies as partners in efforts to improve fair pay and livable wages for DCWs rather than as adversaries and barriers to these goals.

We therefore urge CMS to rescind the portion of this proposed rule requiring 80% of the Medicaid reimbursements for certain personal care, home health aide, and homemaker services be spent on DCW compensation. Although we are opposed to the 80-20 provision within this rule, we are eager to collaborate with CMS to find alternative solutions that address the need to increase compensation to DCWs while simultaneously allowing HCBS providers to meet their statutory and regulatory requirements. **We would be pleased to work with CMS on**

[4] See https://www.dallasnews.com/opinion/commentary/2023/04/21/raise-state-rates-for-home-caregivers/ for example

different approaches that highlight patient access and quality of care and provide an alternate proposal on page 49 of this letter.

Despite our opposition to the requirements of 42 CFR §441.302(k)(3)(i) we again want to thank the Administration and CMS for the attention being paid to the HCBS workforce. If we are to solve this crisis, it will require strong collaboration across all parts of the system, including the federal and state governments, advocates, providers, managed care plans, DCWs, and participants. NAHC, HCAOA, and our members stand ready to be active and dedicated partners in this effort.

42 CFR §441.302(k)(3)(i): HCBS Payment Adequacy

As noted in our introduction, this is the most significant policy within the NPRM for our membership. We recognize and understand that CMS' promulgated policy establishes a statewide requirement for 80% of the Medicaid payments to be provided as compensation to DCWs. However, we note that many states will likely implement this policy by establishing requirements on each provider to ensure that the aggregate amounts are within the statewide limit. Thus, we believe that, regardless of the nature of the statewide assurance, the practical result of the proposal (if finalized) is that every Medicaid provider will need to show compliance with the 80-20 requirement.

While the NPRM requests comments on a variety of aspects, such as the percentage of payments that must be provided as compensation, the types of expenses included in the definition of compensation, and the timeline for implementation, we do not believe that any such threshold is a viable policy option. We are strongly opposed to the imposition of any such threshold and therefore respectfully refrain from offering suggestions about alternative ways to implement this requirement. Simply put, this is an unworkable standard that does not appear to be based on any analysis of existing state rate setting methodologies, HCBS provider requirements, and current provider expenses. **We encourage CMS to abandon any arbitrary mandate on the use of Medicaid reimbursements and instead recommend a different approach to ensuring HCBS payment adequacy and increasing DCW compensation.**

Lack of Statutory Authority

In the preamble to the rule, CMS cites sections 2402(a)(1) and 2402(a)(3)(A)(iii) of the Affordable Care Act (ACA) as well as section 1902(A)(30)(a) of the Social Security Act as the legal basis for implementing this policy. Neither of these provisions appears to provide any authority for, or even reference to, the allocation of reimbursements once received by the provider. Notably, the ACA citations state:

Affordable Care Act 2402(a)

The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

(1): allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other [than] (sic) the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

(3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to—

(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and (B) oversee and monitor all service system functions to assure—

(iii) an adequate number of qualified direct care workers to provide self-directed personal assistance services.

Ergo, the purpose of section 2402(a) is to increase the coordination of services and improve the flexibility of state systems to promote preferences of individuals, including expanded use of self-direction. The only component of this provision that addresses worker capacity is specifically targeted to "self-directed personal assistance services." The purpose of this section was clearly demonstrated by the HHS guidance issued in 2014, which focused on Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs.[5] There is nothing in the law that would provide any basis for a mandated use of funding after a provider receives Medicaid reimbursement.

Similarly, the section of the Social Security Act cited by the NPRM states:

Social Security Section 1902(a)

(a) A State plan for medical assistance must—

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization

[5] https://acl.gov/sites/default/files/programs/2017-03/2402-a-Guidance.pdf

> review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and 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 provision specifically focuses on creating appropriate rate methodology in the state plan that achieves the core goals of efficiency, economy, quality of care, and access. Again, there is nothing within this section that would create authority for mandated use of funds after distribution by the Medicaid agency. Instead, the focus is on ensuring sufficient provider participation and establishing proper rate methodology to assure quality of care. Unfortunately, though we agree with CMS on the need to improve enforcement of this provision and to increase the availability of providers, the proposed approach will have the opposite effect by forcing many small and rural providers to close their doors. Further, the cap on administrative expenses would reduce quality by limiting the ability of providers to finance the necessary clinical oversight, reporting, and information technology that support quality improvement and monitoring efforts.

CMS' proposed rule in 42 CFR §441.302(k) also takes the statutory language of 1902(a)(30)(A) and modifies it in a manner that substantially changes its meaning. While the statute's language focusing on ensuring that payments are, "sufficient to enlist enough providers," CMS' proposed rule modifies this to say that payments must be, "adequate to ensure a sufficient direct care workforce." The distinction here may seem small, but it is an extremely impactful change that ignores the role of provider agencies and the important functions they provide. Agencies are frequently the enrolled "provider of record" for Medicaid purposes and handle important functions such as scheduling, billing, training, health and welfare monitoring, and quality of care assurances in addition to the direct care. CMS' proposed language effectively misinterprets the statutory language and attempts to remove the actual providers from the equation to solely focus on one aspect of the responsibilities of these entities rather than the broad range of supports and protections that are components of overall service delivery.

In sum, not only does there not appear to be any statutory basis for this provision, the proposed rule actually runs counter to the intent of the citations provided by CMS to justify the proposal. For more detail on our concerns with the legality of the proposal, please see the Appendix to these comments. **We urge CMS to remove the proposed 80% requirement and instead address the need to support the HCBS workforce and assure an adequate number of <u>providers</u> by strengthening 1902(a)(30)(A) through an alternate approach. We provide recommendations for such an approach on page 49.**

There is no Data to Support Such a Proposal

Since the release of the NPRM, we have spent a substantial amount of time trying to understand the impact of the payment adequacy provision. We have searched through existing Medicaid data sets as well as Medicare cost reports. We have spoken with state staff and their associations, researchers, advocates, and other interested parties in the Medicaid program. We have also talked to providers of care and managed care organizations. Based on our own research and the reports of all the entities we have engaged as part of our analysis, we do not believe there is a dataset available that identifies the proportion of Medicaid expenditures paid to DCWs vs. those used for various administrative expenses. In fact, several of our colleagues indicated that the analysis we provide beginning on page 16 was the most comprehensive data they have yet seen on the proposal.

We believe that this dramatic proposal, made without reliance on available data, will have wide-ranging, negative impacts on our industry and the broader health care sector. While we have spent a substantial amount of time evaluating the rule using currently available information, we recognize that our analysis is only a subset of the overall home care industry and is limited to those providers that were willing and able to share financial information with us and to those states that performed a publicly available rate analysis. It is not a comprehensive look at the impact of the rule, yet, as far as we and anyone else we have spoken to about the proposal are concerned, it is the most substantial data analysis available thus far. We therefore think it is inappropriate and premature to advance such a substantial change to Medicaid financing and provider requirements in the absence of any tangible data that can be used to assess the impact of the rule.

Instead, we encourage CMS to collect and analyze information in order to understand the current landscape of HCBS financing and provider expenditures. While there is not currently, nor do we encourage, any universal cost-reporting requirements in Medicaid, there are a number of ways that CMS can collect information needed to better understand the industry prior to enacting regulatory changes. This could include the following approaches:

- Financial surveys of providers participating in Medicaid;
- A CMS commissioned review of the current financial landscape for states, DCWs, and providers;
- Review of state rate-setting reports and the underlying components of the cost-build up methods; and
- Review and analysis of data from states that require HCBS cost-reporting data.

We want to stress that is not an all-encompassing list and we encourage CMS to work with States, their rate-setting contractors, auditors, and our memberships to gain a better understanding

of the various rules and requirements, Medicaid reimbursement methodologies and payment rates, and the use of funds by providers. We stand willing to assist and are fully committed to identifying productive and sustainable ways to improve workforce pay without detrimental impacts on access to or quality of care provided.

Current Proposal Contradicts CMS HCBS Quality Efforts

It is important to note that this rule is in direct contradiction to CMS' recently released HCBS Quality Measures Set. This first-of-its-kind quality measure set has set out to promote consistent quality measures intended to provide insight into the quality of HCBS programs while also enabling states to measure and improve health outcomes for people relying on long-term services and support (LTSS) in Medicaid. CMS touted the release of this voluntary measure set as a critical step in promoting health equity among the millions of older adults and people with disabilities who need LTSS because of disabling conditions and chronic illnesses. While HCAOA and NAHC have been fully supportive of this effort, we strongly believe the 80/20 provision of this proposed rule to be deeply incongruent. CMS is simultaneously looking to improve quality and impose stricter quality measures (which we support) while also constraining costs and payments for services. These priorities cannot coexist. If CMS is truly dedicated to improving quality in HCBS and developing the next generation of regulations, they should allow providers to implement the new strategies with their current resources rather than forcing providers to make decisions between quality innovation and closing their doors.

Existing Policies Do Not Support Such a Mandate

In the preamble to the rule, CMS cites state experience with pass-throughs as one justification for the proposal and cites pre-existing policies in Illinois, Minnesota, and state distribution of funding provided by Section 9817 American Rescue Plan Act (ARPA) as precedent for imposition of this mandate. Unfortunately, these references are incongruous with the policy that CMS proposes for multiple reasons, including:

- Illinois' mandate is 77% of the reimbursements and includes additional expenditure categories beyond those proposed by CMS;
- Minnesota's mandate is 72.5% of reimbursements and does not include universal reporting; and
- The ARPA funding was money distributed to providers in addition to the base HCBS reimbursements and pass-through requirements only applied to the supplemental funds.

For states that included a pass-through requirement in their ARPA funding, it is important to note that such requirement was included in the supplemental payments and not in the base

Medicaid payment rate. Including a mandated threshold in the additional funding, rather than the entire reimbursement, ensured that sufficient funds remained to cover administrative expenses and did not force providers to cut supervision, quality management, or other crucial functions that are counted towards administrative expenses in this NPRM.

Additionally, in Minnesota and Illinois, the states did not implement an 80% requirement nor did they calculate the threshold in the manner that CMS proposes. Furthermore, the state built these pass-through assumptions into their program rules and requirements. These distinctions are important to note because they have a significant impact on the way that the calculation is performed and on the resulting impact to provider viability. Most notable is the fact that each of these policies was crafted at the state level and is reflective of the unique state reimbursement methodology requirements on supervision, training, and other administrative requirements.

Furthermore, as far as we are aware, there is no data to evaluate the effectiveness of these policies. The most recent evaluation we have been able to identify is twenty-one years old, published by the US Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE) in 2002.[6] This analysis concluded that, "To date, supporting data are lacking to demonstrate the efficacy of the wage pass-through as a tool to reduce worker vacancies and turnover." Importantly, the ASPE report also noted the fiscal realities that providers still face today "both provider rates and pass-through amounts are set within the context of the state budget process, provider payments — and thus, indirectly, wages to workers — are dependent on overall budget availability and on the political choices governors and state legislators must make between competing spending priorities within that budget." Though anecdotal, we and our members have heard ongoing concerns about the ability of individuals to find DCWs in both Minnesota and Illinois despite the inclusion of these policies. We question whether there is any evidence to support the belief that such a mandate would result in increased availability of DCWs despite CMS' assertions in the preamble.

We also want to highlight that the two state thresholds in effect for HCBS are substantially lower than the CMS proposal. While Minnesota's 72.5% or Illinois' 77% may not seem like a significant departure from 80%, it is important to remember that the impact is not a linear progression as the percentages get higher. For example, in a hypothetical scenario of a $100 payment, it would require nearly a 30% reduction in administrative costs to go from 72.5% to 80%:

[6] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/40596/wagepass.pdf

	Dollars to Worker	Dollars to Admin
Initial	$72.5	$27.5
New	$80	$20
Change	+10.3%	-27.3%

Similarly, an increase from 77% to 80% would result in a 15% reduction to administrative expenditures:

	Dollars to Worker	Dollars to Admin
Initial	$77	$23
New	$80	$20
Change	+3.8%	-15.0%

In Medicaid programs that already operate on razor thin margins and often struggle to find funding to pay for all the required, let alone desired, quality and health and welfare functions, a 27% or even 15% reduction to administrative expenses would be devastating. Further, this hypothetical example only applies to states that have already built a mandate into their existing payment and regulatory structure. As we show below, the impact across the country will be even more stark if CMS moves forward with this proposal.

Other potentially comparable examples are also incongruous with the CMS proposal. For example, many advocates have compared this requirement to the Medical Loss Ratios that are imposed upon managed care plans. Similar to the 80-20 proposal, MLRs place thresholds on health plans for the proportion of expenses that must be spent on certain activities. [7] There are several crucial differences that make the MLR an inappropriate example to base a HCBS proposal on. These include:

- In Medicaid, Managed Care rate setting is done on an annual basis using actuarial principles and must include reasonable costs for contracted activities. In other words, the rate setting requirements are much more stringent than in fee-for-service, leading to payments that are more in-line with the actual cost of business.
- MLRs include additional costs beyond provider reimbursement in their calculations, such as quality improvement activities.

[7] https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/medical-loss-ratio

- Nothing about an MLR prohibits *providers* from operating their businesses in a manner consistent with routine costs and state or federal regulatory requirements.
- Perhaps most importantly, MLRs were established by statute and implemented by the Administration. MLRs were not arbitrarily imposed without Congressional authority.

Several states, including Massachusetts, New Jersey, and New York have requirements regarding the amount spent on compensation to direct care workers for their nursing homes.[8] These policies are also sometimes cited as examples supporting the implementation of a similar policy on home care policies. However, there are again important caveats that make the nursing home requirements an inappropriate source for establishing mandates in HCBS. This includes:

- Nursing homes have shared staffing models and congregated participants, allowing for multiple lines of payment to support the broader operations of the business;
- Scheduling and travel time for workers to the client location does not entail the same level of complexity and effort in a facility-based service model;
- Nursing home payment structures are significantly different, and higher, than home-based care and generally include inflationary factors and/or cost-based reimbursement in Medicaid programs; and
- The models cited in MA, NJ, and NY all incorporate costs for additional workers beyond hands-on staff, such as:
    - Massachusetts' definition includes a wide range of staff, such as director of nurses; in-house clerical staff regularly interacting with residents and caregivers (e.g., receptionists, business office staff working onsite); security staff; staff development coordinator; dietary; housekeeping/laundry; quality assurance professionals, and many others.[9]
    - New Jersey's requirements include salaries for staff that perform resident care oversight, planning, quality assurance, support services, food service, housekeeping, infection control, medical services, medical recordkeeping, social services, and transportation.[10]
    - In New York, the mandate includes a wide range of expenditures including things beyond staff salaries, such as transportation, social services, pharmacy,

[8] https://nursinghome411.org/wp-content/uploads/2022/04/Policy-Brief-Direct-Care-Min.-Spending-Laws.pdf
[9] https://www.mass.gov/doc/administrative-bulletin-21-02-101-cmr-20600-standard-payments-to-nursing-facilities-nursing-0/download
[10] https://www.nj.gov/humanservices/providers/rulefees/ruleadop/ruleadoptfiles/R.2021%20d.120%20(53%20N.J.R.%201783(a)).pdf

housekeeping, food services, activities, nursing administration, social services, and medical education.[11]

State Rate Models Demonstrate Inconsistency of Proposal with HCBS Practice

After the NPRM was released, we met with state contractors that perform independent rate studies to develop reimbursement methodology for HCBS. We sought to understand the different components and assumptions that were built into the rates and to identify some examples of how this proposal would actually interface with the way that states currently construct their reimbursement methodology. We then collected as many publicly available rate studies as possible to model the impact of this proposal against the current way that states set their reimbursement methodology for Personal Care Services.[12]

The following terminology is helpful when assessing the rate calculations and likely impact of the rule that we provide below. These are common line-items used in the "cost buildup" approach to rate-setting, wherein the contractors develop individualized components within the rate model and then arrive at a final reimbursement by summing these components.

- Wage: The hourly wage paid to the worker.
- Benefits: The hourly equivalent of any health insurance, payroll taxes, retirement, and other associated benefits provided to workers.
- Adjusted Wage: The sum of wage and benefits.
- Productivity Adjustment: A calculation used to adjust the cost of employing the worker based on the number of billable hours weekly. The productivity adjustment accounts for time that is not billable as a service, such as travel to clients, vacation, sick leave, paperwork, and supervision.
- Total: The final equivalent hourly compensation to workers taking into account the wage, benefits, and productivity adjustment.
- Mileage: Mileage or public transit reimbursement for travel to clients or, where applicable, cost of company-provided transportation.
- Supervision: The hourly equivalent cost of providing supervision to the worker based on the wage of the supervisor and the amount of time spent in supervision.

[11] https://nursinghome411.org/wp-content/uploads/2022/04/Policy-Brief-Direct-Care-Min.-Spending-Laws.pdf
[12] We specifically focused on Personal Care Services for this analysis as it is the most commonly included service subject to the proposed rule within the rate models we were able to collect.

- Program Support:[13] required costs associated with providing services that are not strictly administrative, such as providing personal protective equipment to the worker, some scheduling and other administrative staff time, certain other medical supplies, and other state/federal requirements.
- Administrative Expenses: the cost of buildings, payroll, electronic visit verification, other information technology, agency administration, and other related expenses.
- Total: The final payment rate, expressed as an hourly equivalent for these calculations.

South Dakota:

South Dakota's recently completed a rate study in 2022; however, it is not in compliance with the CMS proposal. This rate model recommended a 20% increase to the reimbursement rate for personal care services, which was fully-funded by the legislature and is currently in effect.[14] Importantly, this rate model contains a $17.36 hourly wage for workers which exceeds the estimated "livable wage" according to the Massachusetts Institute of Technology.[15] Unfortunately, despite all of these positive aspects to the payment rate, the reimbursement is out of compliance:

Item	Current Model	Percent of total
Wage per Hour	$17.47	
Benefits	32.63%	
Adjusted Wage	$23.17	
Productivity Adjustment	$1.32	
Total Compensation	$30.59	74.83%
Mileage	$1.48	3.62%
Supervision	$0.81	1.98%
Program Support	$0.68	1.66%
Administration	$7.32	17.91%
Total	**$40.88**	

Source: https://dhs.sd.gov/docs/SD%20In%20Home%20Services%20Rate%20Study%20Report-%20FINAL.pdf

[13] Note: Based on our review of the rate models, the items included in "program support" and "administrative expenses" may be somewhat interchangeable depending on the entity performing the rate development and the assumptions used. In all of our calculations below, both Program Support and Administrative Expenses are allocated towards the 20% of allowable non-worker compensation as proposed by the rule.
[14] See: https://dss.sd.gov/docs/medicaid/providers/feeschedules/HCBS_Waiver_Services/HOPE_Waiver_SFY24.pdf
[15] https://livingwage.mit.edu/states/46

To come into compliance without further increasing the reimbursement, providers would need to cut administrative expenses by nearly 30%:[16]

Item	Proposed Rule at Equal Rate	Ratios	Change in allocation
Total Compensation	$32.70	80.00%	6.92%
Mileage	$1.48	3.62%	0.00%
Supervision	$0.81	2%	
Program Support	$0.68	1.66%	0.00%
Administration	$5.21	12.73%	-28.89%
Total	**$40.88**	**100%**	

Alternatively, if it is impossible to cut administrative expenses this drastically due to the various state and federal mandates that administrative costs are necessary to fulfill, an additional 26% rate increase would be necessary to elevate total compensation to 80% of the reimbursement without reducing administrative expenses:

Item	80% Target if fixed other costs	Percent of total	Change in Allocation
Wage per Hour	$23.51		
Benefits	32.63%		
Adjusted Wage	$31.18		
Productivity Adjustment	1.32		
Total Compensation	$41.16	80.00%	
Mileage	$1.48	2.88%	
Supervision	$0.81	1.57%	
Program Support	$0.68	1.32%	
Administration	$7.32	14.23%	
Total	**$51.45**		**25.87%**

[16] In these models we assume that, due to the nature of mileage, supervision, and program support, they cannot be reduced, and Administration is the only area that would be cut if the proposal is finalized. We note above that there may be some overlap between the two categories; however, we believe that this is the most straightforward way to estimate impact based on available data.

Oregon:

Oregon's methodology from a 2021 rate study is also out of compliance with the mandate:

Item	Current Model	Percent of total
Wage per Hour	$17.57	
Benefits	31.10%	
Adjusted Wage	$23.03	
Productivity Adjustment	1.281	
Total	$29.51	71.75%
Mileage	$1.30	3.16%
Supervision	$4.15	10.09%
Program Support	$0.00	0.00%
Administrative Overhead	$6.17	15.00%
Total	**$41.13**	

Source: https://www.oregon.gov/dhs/Compass-Project/Documents/new-rate-models.pdf

Notably, between mileage and supervision, providers would have less than 7% of the total rate remaining to perform all other administrative requirements and responsibilities. While the supervision amount may seem high, we would like to note that this type of supervision is an important part of assuring that the workforce is adequately trained, and that health and safety of participants is appropriately monitored. It would be an extremely negative outcome for the state to reduce supervision requirements to come into compliance with this proposed regulation.

	At Same Payment Rate	Ratios	Change in allocation
Total Compensation	$32.90	80.00%	11.50%
Mileage	$1.30	3.16%	0.00%
Supervision	$4.15	10%	0.00%
Program Support	$0.00	0.00%	0.00%
Administrative Overhead	$2.78	6.75%	-55.02%
Total	**$41.13**	**100%**	**0.00**

In Oregon, an even starker 55% reduction to administrative expenses would be required to come into compliance with the rule. Alternatively, the rule would force a 41% rate increase to avoid noncompliance without administrative cuts:

Item	80% Target if fixed other costs	Percent of Total	Change in Allocation
Wage per Hour	$27.68		
Benefits	31.10%		
Adjusted Wage	$36.29		
Productivity Adjustment	1.281		
Total	$46.49	80.00%	
Mileage	$1.30	2.24%	
Supervision	$4.15	7.14%	
Program Support	$0.00	0.00%	
Administrative Overhead	$6.17	10.62%	
Total	**$58.11**	**100.00%**	**41.28%**

Montana:

Montana's rate model is similarly noncompliant with the proposed rule. Of note, the state's rate model does not independently allocate funding for mileage or supervision. These appear to be incorporated into program support and administrative overhead, respectively. Importantly, though the rate study was performed and included a recommended rate based on available data, the legislature did initially not fully-fund the recommendations. Instead, Montana appropriated funding to meet a percentage of the benchmark rather than the entire rate.[17] Fortunately, a subsequent legislative session did contain funding to gradually increase the payment rates to the full benchmark rate, resulting in a historic 59.7% increase to the prior reimbursement level.[18]

[17] https://dphhs.mt.gov/assets/2023Legislature/MontanaProviderRateAdjustments.pdf
[18] https://dailymontanan.com/2023/05/04/service-providers-say-funding-medicaid-rates-mental-health-historic-unprecedented/

Item	Current Model	Percent of total
Wage per Hour	$15.30	
Benefits	32.30%	
Adjusted Wage	$20.24	
Productivity Adjustment	31.2	
Total	$26.72	74.89%
Mileage		0.00%
Supervision		0.00%
Program Support	$3.06	8.58%
Administrative Overhead	$5.90	16.54%
Total	**$35.68**	

Source:
https://dphhs.mt.gov/assets/ProviderRateStudy/Reports/MTProviderRateStudyReport.pdf

Even with this significant increase in funding, an administrative reduction of 30% or a rate increase of 25.5% would be necessary for the methodology to come into compliance with CMS' proposal:

Item	Proposed Rule at Equal Rate	Ratios	Change in allocation
Total Wage	$28.54	80.00%	6.83%
Mileage	$0.00	0.00%	
Supervision	$0.00	0%	
Program Support	$3.06	8.58%	0.00%
Administrative Overhead	$4.08	11.42%	-30.92%
Total	**$35.68**	**100%**	**0.00**

Item	80% Target if fixed other costs	Percent of total	Change in Allocation
Wage per Hour	$20.52		
Benefits	32.30%		
Adjusted Wage	$27.15		

Productivity Adjustment	31.2		
Total	1.32		
Mileage	$35.84	80.00%	
Supervision	$0.00	0.00%	
Program Support	$0.00	0.00%	
Administrative Overhead	$3.06	6.83%	
Total	**$5.90**	**13.17%**	**25.55%**

Maine

Maine is one of the few states to build a provider tax into their rate model, which is allowable if it is levied on home health agencies that are providing HCBS.[19] This provider tax presents a unique challenge because it remains a static proportion of the overall rate even as other parts are adjusted.

Item	Current Model	Percent of total
Wage per Hour	$14.20	
Benefits	35.90%	
Adjusted Wage	$19.30	
Productivity Adjustment	1.31	
Total	$25.28	66.61%
Mileage	$1.88	4.95%
Supervision		0.00%
Program Support	$3.27	8.62%
Administration	$5.37	14.15%
Provider Tax	$2.15	5.66%
Total	**$37.95**	

Source: https://www.burnshealthpolicy.com/wp-content/uploads/2022/02/Final-Sections-18-20-21-29-Rate-Models.pdf

[19] 42 CFR §433.56(a)(6)

As a result, administrative expenses would take a 94.6% reduction to remain compliant with the rule:

	Proposed Rule at Equal Rate	Ratios	Change in allocation
Total	$30.36	80.00%	
Mileage	$1.88	4.95%	0.00%
Supervision	$0.00	0%	
Program Support	$3.27	8.62%	0.00%
Administration	$0.29	0.76%	-94.60%
Provider Tax	$2.15	5.66%	0.00%
Total	**$37.95**	**100%**	**0.00**

Due to the dollar amount of the provider tax increasing along with the total payment, the methodology would require a 93% increase to come into compliance with the 80/20 proposal:

Item	80% Target if fixed other costs	Percent of total	Change in Allocation
Wage per Hour	$32.96		
Benefits	35.90%		
Adjusted Wage	$44.79		
Productivity Adjustment	1.31		
Total	$58.68	80.00%	132.11%
Mileage	$1.88	2.56%	
Supervision	$0.00	0.00%	
Program Support	$3.27	4.46%	
Administration	$5.37	7.32%	
Provider Tax	$4.15	5.66%	93.11%
Total	**$73.35**	**94.34%**	**93.28%**

As these charts demonstrate, the unique nature of the provider tax in the rate model would force an administrative reduction of 94.6% or a rate increase of 93.28% to come into compliance with the regulation. Such taxes are allowable by federal Medicaid statute and, though not common in HCBS programs, are not unique enough to disregard as a Maine-specific anomaly. Furthermore, even if this were unique to Maine, it highlights the disparate ways that states design their programs

and how a wide range of state statutory and regulatory requirements can have significant impacts on the allocation of funding between administrative and other functions.

Vermont

This year the Vermont legislature considered a recently completed rate study that recommended a 51% rate hike to providers of personal care and homemaker service. The legislature did not fully-fund the rate study and instead provided a 15% rate increase. Even if the recommended rate increase was provided in entirety, with a substantial increase in funding, the methodology would not comply with the proposed CMS mandate.

Item	Current Model	Percent of total
Wage per Hour	$21.00	
Benefits	47.20%	
Adjusted Wage	$30.91	
Productivity Adjustment	1.18	
Total	$36.48	72.38%
Mileage	$2.70	5.36%
Supervision	$0.72	1.43%
Program Support	$3.17	6.29%
Administration	$7.33	14.54%
Total	**$50.40**	

Source: https://legislature.vermont.gov/assets/Legislative-Reports/Specific-Home-And-Community-Based-Service-Provider-Rate-Study-Report-2023-02-06.pdf

Providers would have to reduce their administrative expenses by more than 50% below the rate study's recommended amount to achieve compliance with the mandate:

Item	Proposed Rule at Equal Rate	Ratios	Change In Allocation
Total Compensation	$40.32	80.00%	10.53%
Mileage	$2.70	5.36%	0.00%
Supervision	$0.72	1.43%	
Program Support	$3.17	6.29%	0.00%
Administration	$3.49	6.92%	-52.40%

Total	**$50.40**		**0.00**

Alternatively, despite the rate model's substantial recommended increase, compliance would require the state to provide an additional 38% above that amount, for a total 109% increase from the 2022 rate of $33.32. Given that the state was not willing or able to provide the full recommended 51% increase, it seems extremely unlikely that the legislature would have the means to provide 109%. Further, it is important to note that Vermont allowed a provider tax to expire this legislative session and the rate model would be even more inconsistent with CMS' proposal if that tax were extended.

Item	80% Target if Fixed Other Costs	Percent of Total	Change in Allocation
Wage per Hour	$32.05		
Benefits	47.20%		
Adjusted Wage	$47.18		
Productivity Adjustment	1.18		
Total	$55.67	80.00%	
Mileage	$2.70	3.88%	
Supervision	$0.72	1.03%	
Program Support	$3.17	4.56%	
Administration	$7.33	10.53%	
Total	**$69.59**	**100.00%**	**38.09%**

California

Due to California's large size and diversity of regions, the recent rate model includes different cost-buildup methodologies for the various parts of the state. We did not run calculations for every single regional model; however, we selected a sample of regions to show the how the cost-buildup approach varies based upon the characteristics of the region. Specifically, we chose the rate methods for:

- Suburban:
  - The Orange County Regional Center: serving the heavily populated suburban areas south of Los Angeles;
  - The North Bay Regional Center, which serves the Napa, Sonoma, and Solano counties north of San Francisco.

- Rural:
    - The Far North Regional Center, serving nine rural counties of Butte, Shasta, Modoc, Trinity, Glenn, Lassen, Plumas, Tehama and Siskiyou; and
    - The Inland Regional Center, which serves the heavily populated but extremely large and spread-out counties of San Bernadino (the largest county in the country by landmass) and Riverside.
- Urban: The Golden Gate Regional Center, serving San Francisco and its adjacent counties of San Mateo and Marin.

California is notable because the rate model includes worker's compensation expenditures which have been reported as a significant cost of employing workers that is not included in the proposed CMS calculation. Similarly, the supervision in this rate model – which is an important health and safety protection due to the nature of individuals served by the regional centers – is a substantial portion of the non-worker expenditures. Those two line-items alone count for over 10% of the total rate model and are not ones that could be easily adjusted without negative impacts to workers and program participants.

ORANGE COUNTY & NORTH BAY REGIONAL CENTERS

Item	Current Model	Percent of total
Wage per Hour	$16.14	
Benefits	23.90%	
Adjusted Wage	$20.00	
Productivity Adjustment	1.2	
Total	$24.16	69.25%
Mileage	$1.10	3.15%
Worker's Compensation	$0.78	2.24%
Supervision	$2.92	8.37%
Program Support	$1.74	4.99%
Administration	$4.19	12.01%
Total	**$34.89**	

FAR NORTH AND INLAND REGIONAL CENTERS

Item	Current Model	Percent of total
Wage per Hour	$15.33	

Benefits	24.76%	
Adjusted Wage	$19.13	
Productivity Adjustment	1.21	
Total	$23.30	68.55%
Mileage	$1.33	3.91%
Worker's Compensation	$0.74	2.18%
Supervision	$2.80	8.24%
Program Support	$1.74	5.12%
Administration	$4.08	12.00%
Total	**33.99**	

GOLDEN GATE REGIONAL CENTER

Item	Current Model	Percent of total
Wage per Hour	$18.56	
Benefits	21.78%	
Adjusted Wage	$22.60	
Productivity Adjustment	1.2	
Total	$27.30	70.29%
Mileage	$0.95	2.45%
Worker's Compensation	$0.90	2.32%
Supervision	$3.30	8.50%
Program Support	$1.73	4.45%
Administration	$4.66	12.00%
Total	**$38.84**	

Source: https://www.dds.ca.gov/rc/vendor-provider/rate-study-implementation/

Adjusting the ratios without increasing the total reimbursement would have the following impact:

ORANGE COUNTY & NORTH BAY REGIONAL CENTERS

Item	Proposed Rule at Equal Rate	Ratios	Change in allocation
Total Compensation	$27.91	80.00%	15.53%
Mileage	$1.10	3.15%	0.00%
Worker's Compensation	$0.78	2.24%	0.00%
Supervision	$2.92	8%	0.00%

Program Support	$1.74	4.99%	0.00%
Administration	$0.44	1.26%	-89.55%
Total	**$34.89**		

FAR NORTH AND INLAND REGIONAL CENTERS

Item	Proposed Rule at Equal Rate	Ratios	Change in allocation
Total Compensation	$27.19	80.00%	16.70%
Mileage	$1.33	3.91%	0.00%
Worker's Compensation	$0.74	2.18%	
Supervision	$2.80	8%	
Program Support	$1.74	5.12%	0.00%
Administration	$0.19	0.55%	-95.39%
Total	**$33.99**		**0.00**

GOLDEN GATE REGIONAL CENTER

Item	Proposed Rule at Equal Rate	Ratios	Change in allocation
Total Compensation	$31.07	80.00%	13.82%
Mileage	$0.95	2.45%	0.00%
Worker's Compensation	$0.90	2.32%	
Supervision	$3.30	8%	
Program Support	$1.73	4.45%	0.00%
Administration	$0.89	2.29%	-80.94%
Total	**$38.84**		**0.00**

Alternatively, the state could adjust payment rates to come into compliance:

ORANGE COUNTY & NORTH BAY REGIONAL CENTERS

Item	80% Target If Fixed Other Costs	Percent of Total	Change in Allocation
Wage per Hour	$30.77		
Benefits	23.90%		
Adjusted Wage	$38.12		

Productivity Adjustment	1.2		
Total	$45.75	80.00%	
Mileage	$1.10	1.88%	
Worker's Compensation	$1.49	2.54%	
Supervision	$2.92	5.00%	
Program Support	$1.74	2.98%	
Administration	$4.19	7.17%	
Total	**$57.19**		**63.90%**

FAR NORTH AND INLAND REGIONAL CENTERS

Item	80% Target If Fixed Other Costs	Percent of Total	Change in Allocation
Wage per Hour	$31.12		
Benefits	24.76%		
Adjusted Wage	$38.83		
Productivity Adjustment	1.21		
Total	$46.98	80.40%	
Mileage	$1.33	2.28%	
Worker's Compensation	$1.50	2.57%	
Supervision	$2.80	4.79%	
Program Support	$1.74	2.98%	
Administration	$4.08	6.98%	
Total	**58.43**		**71.91%**

GOLDEN GATE REGIONAL CENTER

Item	80% Target If Fixed Other Costs	Percent of Total	Change in Allocation
Wage per Hour	$33.55		
Benefits	21.78%		
Adjusted Wage	$40.86		
Productivity Adjustment	1.2		
Total	$49.03	80.00%	
Mileage	$0.95	1.63%	

Worker's Compensation	$1.62	2.77%	
Supervision	$3.30	5.65%	
Program Support	$1.73	2.96%	
Administration	$4.66	7.98%	
Total	**$61.29**		**57.80%**

The overall impact to providers and the state agency would be substantial and it does not appear that there would be any easy way to come into compliance with the rule.

Indiana

At the time drafting, Indiana was currently soliciting public feedback on their proposed reimbursement rate changes. Despite this being a draft reimbursement methodology under development, current information indicates that this payment will likely also be out of compliance with CMS' proposal:

Item	Current Model	Percent of total
Wage per hour	$15.43	
Benefits	37.70%	
Adjusted Wage	$21.25	
Productivity Adjustment	1.19	
Total	$25.42	72.88%
Mileage	$0.80	2.29%
Supervision	$1.58	4.53%
Program Support	$1.84	5.28%
Administration	$5.24	15.02%
Total	**34.88**	

Source: https://www.in.gov/fssa/ompp/health-coverage/medicaid-hcbs-programs/2019-2020-hcbs-rate-methodology-project/

We note that the model used in Indiana was somewhat different than other states, so we had to make several assumptions for the previous calculations to fit with the projections we developed. Notably, we decided to make the numbers add up to the "total" provided by Indiana's rate model by modifying the productivity adjustment to increase the total compensation to workers.

In other words, our assumptions below specifically added additional money to DCWs to avoid any perceptions that we are inflating numbers to exaggerate the impact of the rule. The actual rate may be further out of compliance than the calculation above.

If CMS were to finalize the proposed requirements, it would have the following impact on Indiana's newly developed rate model:

Item	Proposed Rule at Equal Rate	Percent of Total	Change in Allocation
Total	$27.90	80.00%	9.78%
Mileage	$0.80	2.29%	0.00%
Supervision	$1.58	5%	
Program Support	$1.84	5.28%	0.00%
Administration	$2.76	7.90%	-47.42%
Total	**34.88**		**0.00**

Item	80% Target if fixed other costs	Percent of Total	Change in Allocation
Wage per hour	$24.45		
Benefits	37.70%		
Adjusted Wage	$33.67		
Productivity Adjustment	1.19		
Total	$37.84	80.00%	
Mileage	$0.80	1.69%	
Supervision	$1.58	3.34%	
Program Support	$1.84	3.89%	
Administration	$5.24	11.08%	
Total	**47.30**	**100.00%**	**35.61%**

Oklahoma

Earlier this year, Guidehouse Consulting provided Oklahoma with a completed rate study that recommended increasing the 15-minute rate for personal care services from $5.26 to $6.90, which would be a 15.8% rate increase. Similar to Indiana, we had to make a few assumptions in order to develop the line items in the information below. Most notably, the supervision amount in

the Oklahoma model is derived from identifying the difference between the sum of all of the individual components and the total hourly reimbursement rate.

Item	Current Model	Percent of total
Wage per hour	$11.64	
Benefits	31.39%	
Adjusted Wage	$15.29	
Productivity Adjustment	1.2	
Total	$18.35	66.49%
Mileage	$3.93	14.24%
Supervision	$0.34	1.23%
Program Support	$1.49	5.40%
Administration	$3.49	12.64%
Total	**27.60**	

Source: Oklahoma Rate Studies: Community Living, Aging and Protective Services (CAP), Developmental Disability Services (DDS), and Child Welfare (CW) Divisions; Guidehouse, Inc. January 31, 2023.[20]

The Oklahoma rate model includes mileage both for staff to arrive at locations for the HCBS delivery as well as for client transportation, hence the disproportionately large transportation costs compared to other states. Resulting calculations indicate that the providers would need to find an alternative funding source to cover administrative costs, or perhaps the state could create a separate service for "nonmedical transportation" if the CMS proposal is finalized.

Item	Proposed Rule at Equal Rate	Ratios	Change in allocation
Total Compensation	$22.08	80.00%	20.32%
Mileage	$3.93	14.24%	0.00%
Supervision	$0.34	1.23%	
Program Support	$1.49	5.40%	0.00%
Administration	-$0.24	-0.87%	-106.86%
Total	**27.60**		**0.00**

[20] As far as we know, the study has not yet been published online at this time; however, Oklahoma shared a copy with providers in February 2023.

Item	80% Target if fixed other costs	Ratios	Change in allocation
Wage per hour	$23.47		
Benefits	31.39%		
Adjusted Wage	$30.84		
Productivity Adjustment	1.2		
Total	$37.00	80.00%	
Mileage	$3.93	8.50%	
Supervision	$0.34	0.74%	
Program Support	$1.49	3.22%	
Administration	$3.49	7.55%	
Total	**46.25**	**100.00%**	**67.57%**

Notably, Oklahoma DHS sent a letter to providers indicating that the Agency was not requesting funding to implement the rate study[21] and, as of June 20, 2023, the published rate remains $5.26/15 minutes.[22]

Virginia

Due to the unique nature of the Northern Virginia region (ie: the Washington, DC suburbs) compared to the rest of the state, Virginia has two distinct rates: one for the northern counties and one for the remainder of the state. We provide an analysis of both models below.

NORTHERN VIRGINIA

Item	Current Model	Percent of Total
Wage per hour	$15.73	
Benefits	32.30%	
Adjusted Wage	$20.81	
Productivity Adjustment	1.21	
Total	$25.18	74.30%
Mileage	$0.76	2.24%

[21] https://oklahoma.gov/okdhs/services/dd/providerletters/pl02222023.html
[22] https://oklahoma.gov/okdhs/services/aging/rrs.html

Supervision	-	0.00%
Program Support	$4.22	12.45%
Administration	$3.73	11.01%
Total	**$33.89**	

REST OF STATE

Item	Current Model	Percent of total
Wage per hour	$14.34	
Benefits	34.40%	
Adjusted Wage	$19.27	
Productivity Adjustment	1.21	
Total	$23.32	68.81%
Mileage	$0.84	2.48%
Supervision	-	0.00%
Program Support	$3.62	10.68%
Administration	$3.43	10.12%
Total	**31.21**	

Source: https://www.burnshealthpolicy.com/wp-content/uploads/2021/08/VA-DBHDS-Proposed-Rate-Models_2021-07-30.pdf

Of note, the Virginia models do not include a separate line-item for Supervision and instead appear to incorporate these costs into the Program Support category. The potential results of the CMS proposal on the Virginia rate model would be:

NORTHERN VIRGINIA

Item	Proposed Rule at Equal Rate	Ratios	Change in allocation
Wage per hour	$15.73		0.00%
Benefits	32.30%		0.00%
Adjusted Wage	$20.81		0.00%
Productivity Adjustment	1.21		0.00%
Total	$27.11	80.00%	7.67%
Mileage	$0.76	2.24%	0.00%

Supervision	$0.00	0%	
Program Support	$4.22	12.45%	0.00%
Administration	$1.80	5.31%	-51.79%
Total	**33.89**	**100%**	**0.00**

REST OF STATE

Item	Proposed Rule at Equal Rate	Ratios	Change in allocation
Wage per hour	$14.34		0.00%
Benefits	34.40%		0.00%
Adjusted Wage	$19.27		0.00%
Productivity Adjustment	1.21		0.00%
Total	$24.97	80.00%	7.07%
Mileage	$0.84	2.69%	0.00%
Supervision	$0.00	0%	
Program Support	$3.62	11.60%	0.00%
Administration	$1.78	5.71%	-48.05%
Total	**31.21**	**100%**	**0.00**

NORTHERN VIRGINIA

Item	80% Target if fixed other costs	Percent of total	Change in Allocation
Wage per hour	$21.77		
Benefits	32.30%		
Adjusted Wage	$28.80		
Productivity Adjustment	1.21		
Total	$34.85	80.00%	
Mileage	$0.76	1.74%	
Supervision	$0.00	0.00%	
Program Support	$4.22	9.69%	
Administration	$3.73	8.56%	
Total	**43.56**	**100.00%**	**28.53%**

REST OF STATE

Item	80% Target if fixed other costs	Percent of total	Change in Allocation
Wage per hour	$19.41		
Benefits	34.40%		
Adjusted Wage	$26.09		
Productivity Adjustment	1.21		
Total	$31.57	80.00%	
Mileage	$0.84	1.93%	
Supervision	$0.00	0.00%	
Program Support	$3.62	8.31%	
Administration	$3.43	7.87%	
Total	**39.46**	**98.12%**	**26.42%**

Summary and Discussion of Rate Models

To recap and summarize the previous review of State rate setting reports, there are a wide range of approaches taken and costs included within the development process. Additionally, state-specific factors such as rural driving distances, supervision requirements, taxes, and a variety of other issues can have significant impacts on the model development as well as the resulting proportion of reimbursement rates that are used to fund compensation to DCWs, as defined by the rule. In fact, the only thing we can definitively say that all these states have in common is that **none of the rate models we reviewed are compliant with the 80% requirement in the proposed rule.**

Summary of Compliance with 80/20 rule			
State	**Current Percentage**	**Reduction in Admin**	**Increase in rates**
South Dakota	74.76%	-29.21%	26.18%
Oregon	71.75%	-55.02%	41.28%
Montana	74.89%	-30.92%	25.55%
Maine	66.61%	-94.60%	93.28%
Vermont	72.38%	-52.40%	38.09%

CA-Orange County	69.25%	-89.55%	63.90%
CA-Far North and Inland Regional	68.55%	-95.39%	71.91%
CA-Golden Gate	70.29%	-80.94%	57.80%
Indiana	72.88%	-47.42%	35.61%
Oklahoma	66.49%	-106.86%	67.57%
VA-Northern Virginia	74.30%	-51.79%	28.53%
VA-Rest of State	68.81%	-48.05%	26.42%
AVERAGE:	**70.91%**	**-65.18%**	**48.01%**

We believe that it is important for us to highlight the fact that these reports were developed by independent consulting firms working on behalf of, and paid for by, the State agencies. These entities do not have an incentive to incorporate unnecessary administrative expenditures, exorbitant executive salaries, or profits into the rate recommendations. In fact, as entities working on behalf of state agencies, these contractors have an incentive to avoid increasing provider rates as much as is feasible to avoid creating significant negative budgetary impacts on their clients. Additionally, during our discussions with companies that perform rate studies for states, they indicated that states frequently have policies in place to place a limit on executive pay and/or profit within the data used to develop the methodologies. Even when states do not have an explicit policy, the rate setting process generally includes protocol to exclude outlier data from providers that would have the effect of skewing administrative overhead and/or profits.

We hope that the data provided above is helpful to CMS as it evaluates the potential outcomes of the proposed rule. We again wish to reiterate that we support efforts to increase caregiver wages; however, the proposed approach is simply untenable based on the realities of delivering Medicaid HCBS. We stand ready to work with CMS to establish different approaches to support DCWs.

Provider Data Aligns with the Concerns Identified in State Rate Models

To supplement our analysis of available state rate reports, we also issued a detailed survey to our members that collected information about the various expenditures that comprise their normal business activity. In addition to the broader data we summarize below, we also want to highlight several points that arose during the survey:

- *The return rate was low.* The data collection we embarked upon was intensive, and our return rate was low. In contrast to the 158 responses we received to our qualitative online

survey, which was open for less than two weeks, we received less than 50 cost surveys despite providing over three weeks for responses. Many providers informed us that the information was unavailable due to the way their financial records and data systems were organized.

- *Information provided was variable*. Narrative responses and explanations accompanying the reports frequently discussed the inability to separate the different components – particularly certain types of insurance and other group purchasing expenditures – in a manner that would provide meaningful allocations between DCWs and other non-direct workforce staff.
- *Data was difficult to parse.* Providers were frequently unable to separate out the caregivers subject to the proposed rule from other staff that provide services to individuals. This can be due to staff providing both Medicaid and other services, as well as due to employing staff funded solely by Medicaid that provide a combination of 1905(a) services, services subject to the mandate, and 1915 or 1115 services that are not included in the mandate. The complexity of identifying the various statutory and regulatory authorizations for the Medicaid services was a significant detriment to data collection efforts.

These provider challenges with providing data are important to recognize because we organized our survey to match the NPRM. Therefore, the challenges with responding to our survey will likely also arise if states are expected to collect information to enforce and report on the mandate. We also note that larger providers were more likely to respond to our survey, which we hypothesize is because those providers have the necessary fiscal/accounting staff, data systems, and other resources to provide this information. We therefore believe that smaller providers (which, as we discuss later, appear to be the most negatively impacted by this proposal) will struggle the most with data reporting and collection.

With those caveats in mind, we believe that our provider data is generally consistent with the assumptions built into the state rate setting models that we reviewed. The average amount of the rate allocated to DCW compensation in state rate models is 70.9%, ranging from a low of 66.49% to a high of 74.89%. In our provider surveys, an average of 67.58% of Medicaid reimbursements were allocated to direct care workers, with a high of 83% and a low of 49% and a standard deviation of 12%.

Importantly, there are a few major takeaways from the 16% of providers that reported meeting the mandate:

- The majority of the providers had other lines of business, with Medicaid representing a small portion of overall expenditures. In other words, revenue from Medicare and private-pay was offsetting the Medicaid expenditures.
- Several of the providers reported Medicaid expenditures that exceeded revenue. I.e. these providers were losing money on their Medicaid business line, particularly due to compensation increases necessary to recruit an adequate number of staff without any corresponding Medicaid reimbursement increase.
- These providers reported extremely low administrative costs, including several responses that had no administrative staff or other associated expenses, suggesting that these costs were being counted to a different revenue source.

In contrast, when examining the providers that reported DCW compensation ratios below 60%, several major factors seem to be driving the comparatively low proportion:

- All of these providers reported required DCW supervision costs above the average across the entire dataset. On average, all respondents spent 9.7% of their Medicaid expenditures on DCW supervision whereas these "low proportion" providers spent an average of nearly twice that at 18.1%.
- Several of these providers operated in rural/frontier areas which resulted in higher-than-average costs for transportation (in two cases, mileage reimbursements represented 5% of overall expenditures) as well as for building and administrative staff, due to the need for branch offices even in areas with low census.

Additionally, it is important to remember that service delivery is supported by a number of other workers, including scheduling staff, billing and accounting, information technology employees, and other necessary functions. When separating out expenditures to capture pay for the wide range of workers involved in running a home care business, we noted the following:

- Isolating expenditures to compensation for both DCWs and required clinical supervision, the total proportion of expenditures increased to an average of 76% across our respondents with a high of 105% (i.e.: the DCW and supervision costs alone exceeded Medicaid reimbursement) and a low of 60%.
- Compensation for all staff ranged from 105% (the same provider reported no additional administrative expenses beyond DCWs and supervision) to 75% of total outlays, with staff comprising an average of 86.76% of total expenses.

Indeed, despite most providers in our dataset not meeting the proposed 80% requirement, we note that over two thirds (68%) of providers that included both total Medicaid revenue and

total Medicaid expenditures within their dataset were spending more than they received for those services. Providers reporting the complete data on Medicaid averaged a 23% loss on their Medicaid service lines. In this same subset of providers, only 18% reported spending at least 80% of their Medicaid revenue on direct worker compensation as defined in this proposed rule. The provider-reported Medicaid losses align with other available data. For example, a MedPAC analysis of home health agency cost reports found that Medicare margins averaged 25.9%, but all-payer margins were 11.9%, indicating losses on other lines of business such as Medicaid.[23]

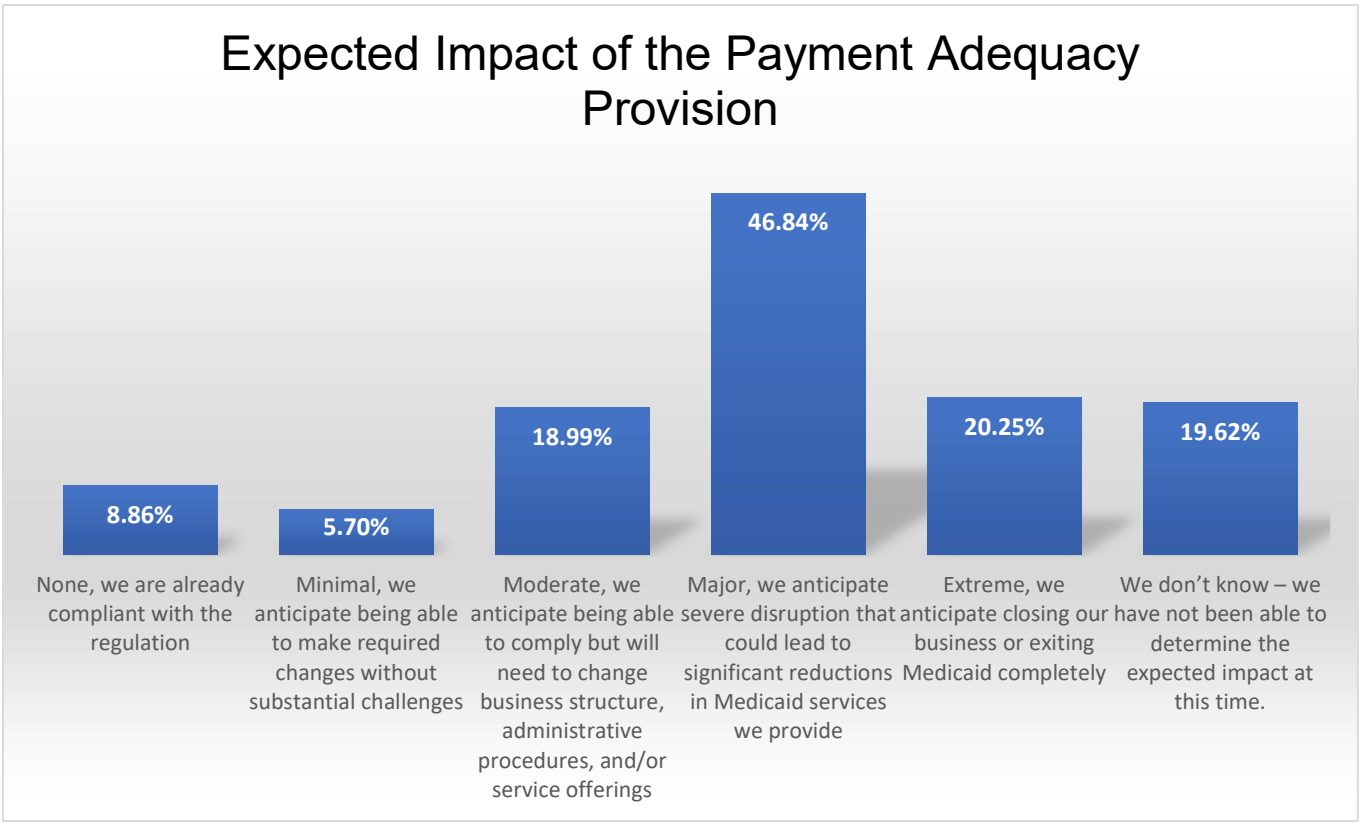
Although there is some variation in the overall proportion of expenditures on DCWs from company to company, the general theme from submitted provider surveys indicates that there does not appear to be significant flexibility to reduce non-DCW costs without making significant cuts to rural branch offices, DCW supervision, and other staff performing functions that support service delivery. Further, the current strategy that many providers use to subsidize inadequate Medicaid reimbursement with other payment sources is unlikely to be economically viable if the rule moves forward as proposed.

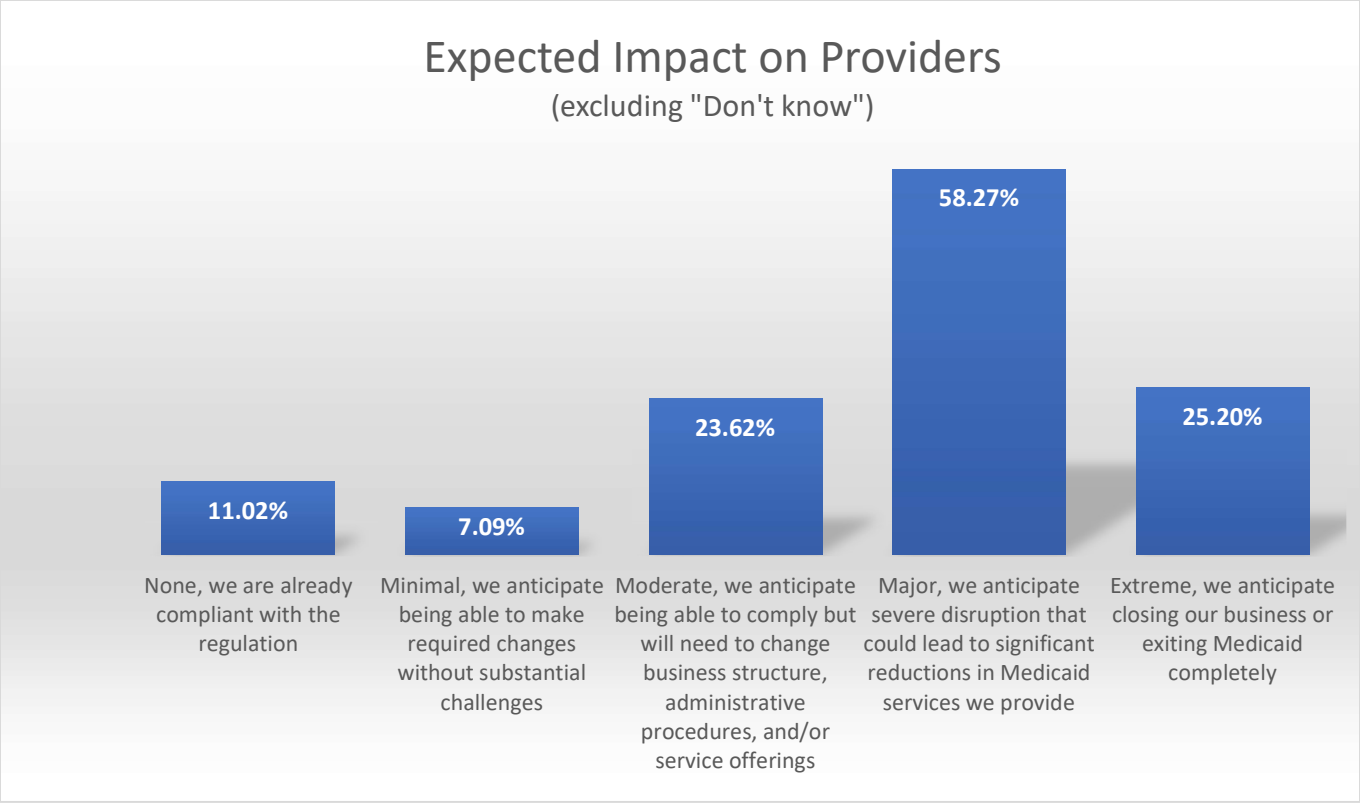
Provider Surveys Indicate Significant Confusion and Negative Impacts for Patients and Caregivers if Finalized

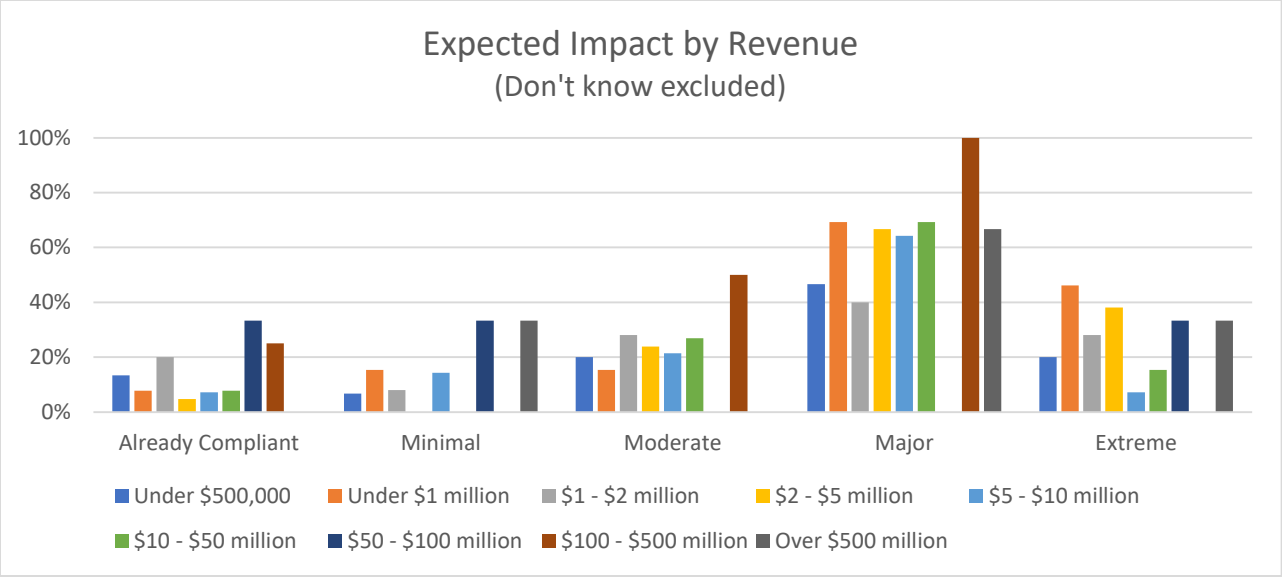
The HCAOA nationwide member survey indicates that 87 percent of agencies that currently provide Medicaid services would exit the Medicaid space entirely if this rule was implemented. Needless to say, this would be devastating to the countless Americans who have come to rely on our care. 74 percent of agencies stated that funding for caregiver training and education would have to be cut in order to comply with the proposed rule, two critical aspects of caregiver job satisfaction. This negatively impacts caregiver workforce development and defeats the purpose of a proposed rule focused at least partially on improving the status of caregivers within the overall health care economy.

Similarly, in the NAHC survey of members, over two-thirds of the 158 respondents anticipated that the rule would have a "major" (46.8%) or "extreme" (20.3%) impact on operations which would result in service reductions to individuals and potentially the end of the organization's Medicaid operations. Importantly, the survey also demonstrated how much remains "unknown" about the proposed rule. Approximately 20% of respondents were unable to provide anticipated impact due to uncertainty about exactly how the rule would affect them. When excluding "don't know" responses, over 80% of those surveyed expected a major or extreme impact on operations.

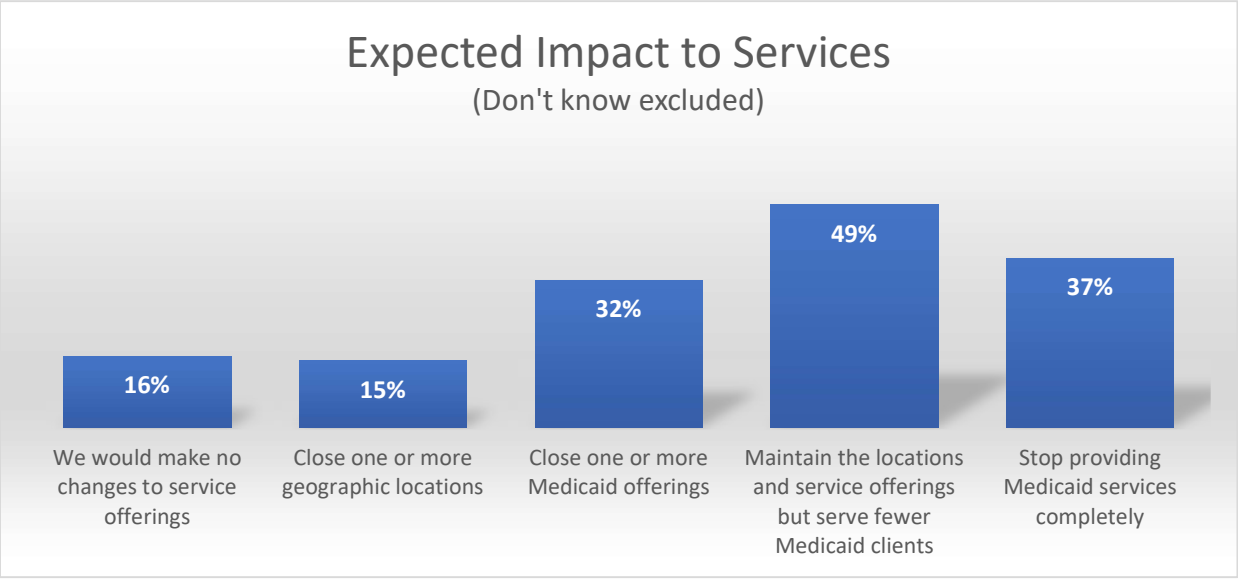
[23] https://www.medpac.gov/wp-content/uploads/2022/07/MedPAC-ESRD-hospice-SNF-HHA-IRF-Jan-2023.pdf


Expected Impact of the Payment Adequacy Provision
8.86%
5.70%
18.99%
46.84%
20.25%
19.62%
None, we are already compliant with the regulation
Minimal, we anticipate being able to make required changes without substantial challenges
Moderate, we anticipate being able to comply but will need to change business structure, administrative procedures, and/or service offerings
Major, we anticipate severe disruption that could lead to significant reductions in Medicaid services we provide
Extreme, we anticipate closing our business or exiting Medicaid completely
We don't know – we have not been able to determine the expected impact at this time.

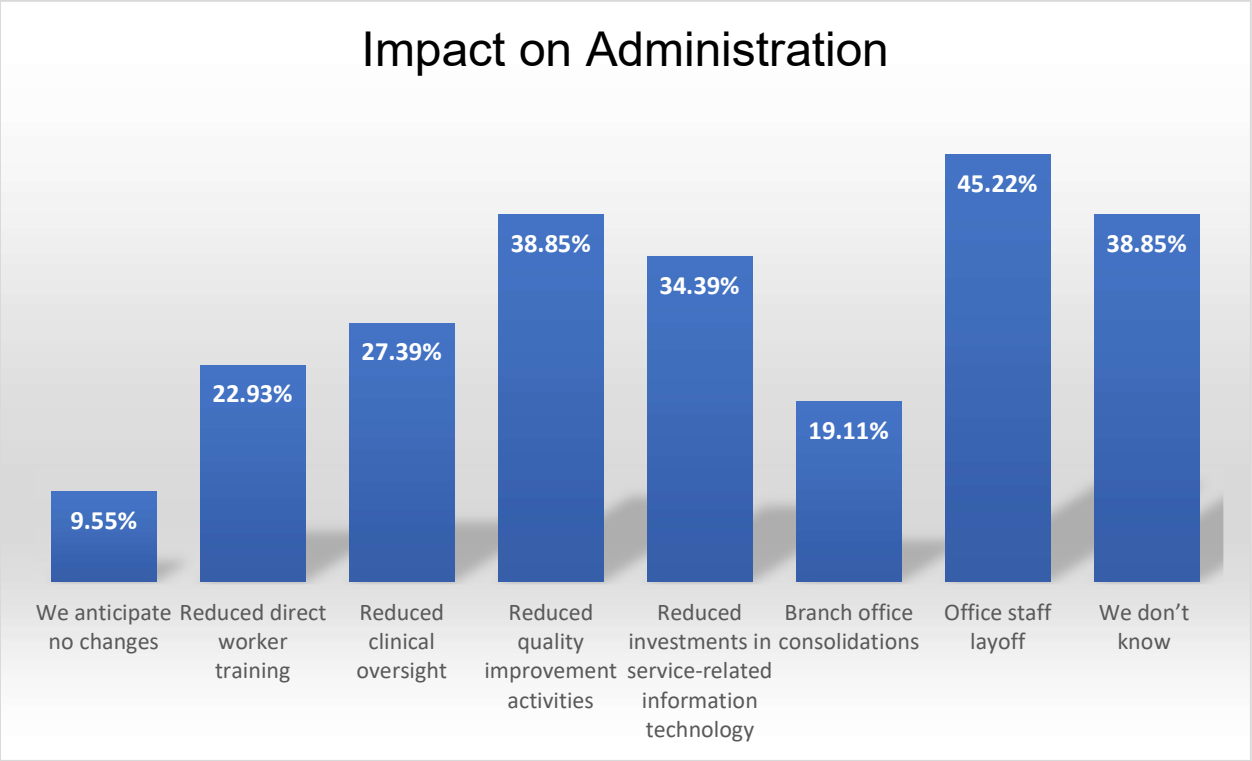

Expected Impact on Providers
(excluding "Don't know")
11.02%
7.09%
23.62%
58.27%
25.20%
None, we are already compliant with the regulation
Minimal, we anticipate being able to make required changes without substantial challenges
Moderate, we anticipate being able to comply but will need to change business structure, administrative procedures, and/or service offerings
Major, we anticipate severe disruption that could lead to significant reductions in Medicaid services we provide
Extreme, we anticipate closing our business or exiting Medicaid completely



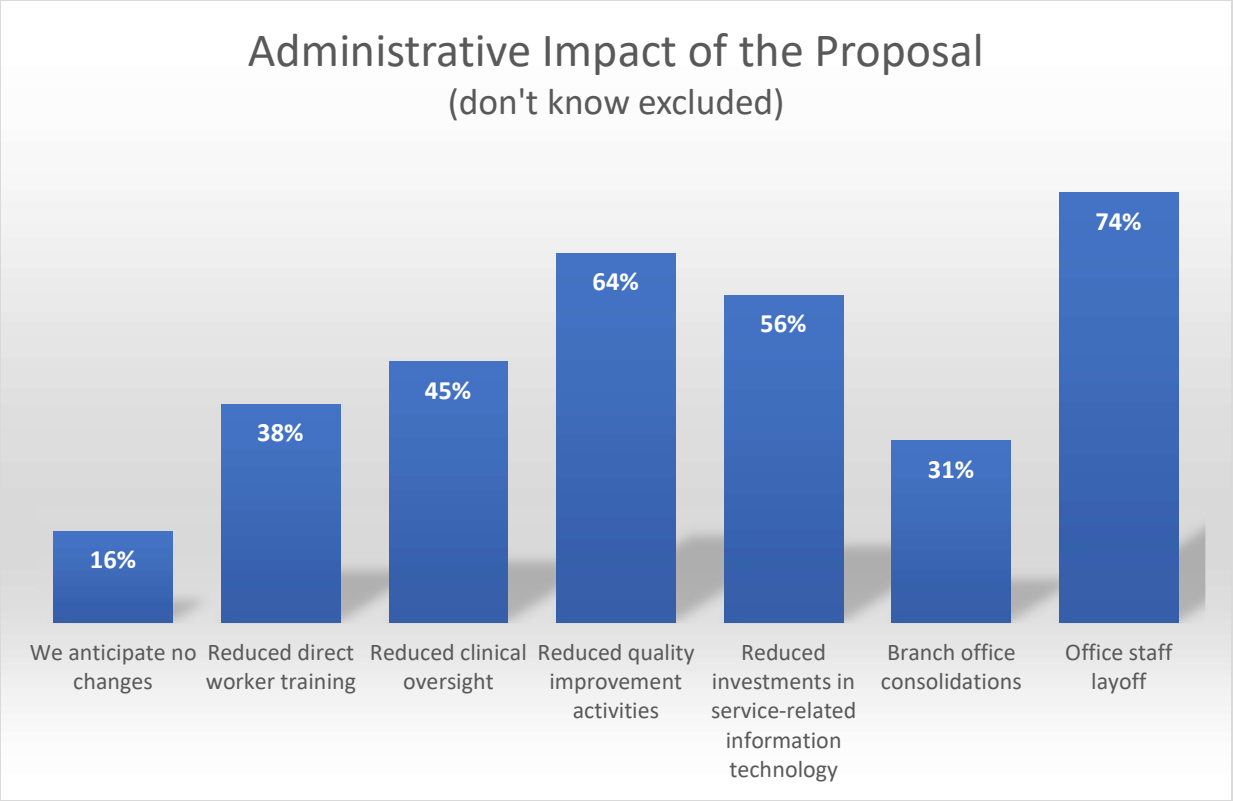
Similarly, a third of respondents were unsure of how their service offerings would be impacted by the proposal; however, those who were able to estimate impacts overwhelmingly anticipated that the rule would reduce services. When excluding "don't know" answers, 69% of respondents said that they would either close one or more Medicaid programs (32%) or stop participating in Medicaid completely (37%).



Respondents to the survey were also unsure of the potential impact on their administrative operations. Over a third (39%) of survey participants were not yet able to predict administrative changes that the rule would require. Only 9% of all respondents anticipated no reductions in administrative activities, which logically makes sense given that roughly the same number (8.86%) reported current compliance with the 20% cap on administration.



Office staff layoffs (74%) represented the most likely administrative response of those individuals who were able to anticipate the outcomes of the rule. This is followed closely by a reduction to quality improvement activities (64%) and information technology investment (56%). Notably, several respondents included comments discussing how regulatory requirements, such as requirements for offices in service jurisdictions as well as training and supervision mandates, limited the ability to reduce those costs in any meaningful fashion.



Though limited to the subset of providers responding to the surveys, the data clearly demonstrates outcomes of this rule contrary to its overall intent. In sum, providers would be forced to reduce or eliminate services, access would be diminished, and quality oversight would suffer. All of these results would have stark negative impacts on the individuals who rely on Medicaid HCBS.

The Mandate is Administratively Complex and Would be Extremely Challenging to Enforce

CMS' proposal to parse out specific services and statutory authorities, coupled with the realities of service delivery across the country, make for an extremely confusing approach that is difficult for many providers and partners to understand. NAHC and HCAOA spent a substantial amount of time analyzing the proposed rule and understanding the application of the 80% requirement to the various parts of the Medicaid system. Since the release of the proposal, we have also spent a considerable amount of effort trying to explain the provisions to our members and partners as well as clarifying misconceptions about the policy.

As a result of both the complexity of the proposal coupled with the existing landscape for HCBS, we believe that it would be challenging (if not impossible) to enforce from an operational perspective. There are many factors that make the proposed approach likely unworkable, including, but not limited to:

- Unavailability of Data: it is important to note that unlike in the Medicare program, there is no requirement for universal cost reporting in Medicaid HCBS. Some states do require provider cost-reports, but such policies are limited to a few states and are nowhere near standard practice across the country. Simply measuring, let alone enforcing, this mandate would require an extraordinary effort from states and providers. The required reporting from providers would lead to a substantial increase in the administrative burden at the same time that CMS attempts to restrict and reduce resources available to perform administrative activities.
- Inability to Track Funding through Managed Care: In 2021, roughly half of all states provided at least some of their long-term services and supports through Medicaid Managed Care Organizations (MCOs).[24] CMS' proposal specifically applies the requirement to services delivered via both Managed Care and Fee-for-Service and does not prescribe any differences in application of the mandate. This is significant because the regulation applies a state-level assurance to payments made for certain services authorized by certain parts of the Social Security Act, yet managed care plans receive a monthly capitation amount from the state. Based on the current regulation, appears as though states and plans would need to identify the portion of the capitation rate attributable to personal care, homemaker, and home health aide services authorized by sections 1915(c), (i), (j), (k), or 1115 of the Social Security Act, then trace the flow of funding through to the provider and DCWs. Based on our discussions with providers and review of available data submitted to our survey, we believe that collecting and reporting data in this manner is practically impossible.

  Alternatively, if CMS believes that the policy could be fulfilled simply by having MCOs report on the payments made to providers and the attributable compensation to workers, it is unclear how 1905(a) services would be appropriately excluded from the calculations. It is also unclear how capable the plans will be of monitoring the flow of funding between their organization, the providers, and the workers.
- Workers Operating in Multiple Programs: depending upon the way that the state and a provider operate, a DCW may provide services through a number of different statutory authorities and/or service definitions. Providers would be expected to track the portion of

[24] https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/

a worker's time and salary and trace it back to the statutory authority that the service was authorized by, and then parse out the portion of worker's pay, benefits, and other compensation attributable to the implicated services. This would be extremely burdensome and would, again, place additional administrative requirements on providers while the rule simultaneously attempts to restrict the use of funding for administrative activities.

The Proposal Would Create Inequities Within and Across States

As our review of state rate-setting reports demonstrated, the wide variety of state policies has a significant impact on the rate methodology and the associated proportion of the payment rates that are available for the worker vs. reserved for necessary administrative functions. Furthermore, administrative costs can be due to a number of factors well beyond the control of providers and even the state Medicaid agency, such as:

- Fuel prices;
- State corporate tax rates;
- State liability insurance costs; or
- Population density.

Creating a standardized rule such as this would create inequities across the country and would penalize those providers which operate in states with more stringent health and welfare requirements, higher tax rates, or other areas of more stringent regulation.

Providers that operate in states with managed long-term services and supports (MLTSS) also have additional administrative burdens. Those providers must engage with multiple plans to negotiate payment rates and ensure that they are in-network for the plans. Additionally, the providers must submit data and other required information to the various MCOs in the state. As more states move to MLTSS, and as more MCOs expand and strengthen quality improvement initiatives, pay for performance programs, and other data collection requirements, the administrative responsibilities on home care providers will only continue to increase.

The way that the rule is constructed also creates inequities within the same state. Many Medicaid services in different waivers are extremely similar despite being authorized through different statutory and regulatory service categories and draw from similar provider pools. For example, many personal care services provided to individuals with intellectual and developmental disabilities are encompassed within a larger "habilitation" benefit, which would not be implicated by this rule. However, the same type of personal care provided to older adults and people with physical disabilities would be included in the requirements based on how this rule is drafted. This will create inequities within the Medicaid program based upon the populations served and the way

that services are defined by a particular state or even across the different HCBS options within the same state.

Additionally, the finances of providers are particularly sensitive to differences between urban and rural settings. For illustrative purposes, we looked at the difference between New York city and the upstate region, which represents perhaps the most stark urban/rural divide within the same state in our country. According to a cursory review of New York provider cost data that was shared with NAHC and HCAOA, 72% of Licensed Home Care Services Agencies (LHCSAs) in the downstate region (ie: New York City and suburbs) would be compliant with the proposed rule. In contrast, only 22% of LHCSAs in the upstate region appeared to meet the 80-20 mandate.

The proposed rule creates further inequities across models of care delivery by treating agency and self-directed services in completely different manners. We and our members support the role of self-direction in HCBS services, but it is important to remember that self-direction is not desired by, or appropriate for, every individual. A truly person-centered HCBS system provides an array of service options to individuals that allows beneficiaries to make meaningful choices about the way they receive their support. Unfortunately, this rule would significantly favor self-directed care in an inappropriate manner. For example, providers must accept the state reimbursements as "payment in full" for services rendered. These rates are loaded to include payment for all of the necessary functions associated with delivering the service, such as billing, training, payroll, scheduling, administrative functions, etc. In contrast, in self-direction, states often contract directly with fiscal intermediaries to perform billing and accounting functions, as well as with third parties to provide training, background checks, fingerprinting, EVV, and other health, safety, and quality measures.

Thus, even though the state is spending money that detracts from the entire pool of funds available for worker compensation, the specific reimbursement rate to the DCWs does not include these administrative activities. In other words, all the same activities are being financed, but the way that the money is being counted is more favorable to self-direction than to agencies. Again, we want to reiterate that we are not opposed to self-directed models of care and that we support the ability of individuals to self-direct when they choose to; however, it is not prudent public policy to create such stark inequities that favor one model of care over another.

The Proposed Rule Undermines State Authority

As CMS acknowledged in the 2015 Access Final Rule, "States have broad flexibility under the Act to establish service delivery systems for covered health care items and services, to design the procedures for enrolling providers of such care, and to set the methods for establishing provider

payment rates."[25] Unfortunately, the proposed Access Rule does not adhere to this established principle. Our review of state rate setting methodologies clearly demonstrates that this proposal would place significant constraints on state authority to include administrative requirements and to build them into the reimbursement methodology. Indeed, if the rule is finalized as proposed, states would need to rescind requirements that have been advanced, frequently with the support of CMS, regarding supervision, training, background checks, and physical buildings since there is little way for providers to be compliant with the proposal when such administrative requirements exist. Further, the rule would conflict with state-specific policies regarding taxes, insurance mandates, minimum wages, and other areas where states are afforded autonomy under both the Medicaid statute and the principles of Federalism.

We agree that there should be additional emphasis placed on the way that rates are established, and further believe it is important for states to use a justifiable, data-driven approach. However, we also believe that it is important to provide states with the ability to manage their own Medicaid programs and to develop policies and financial structures that best reflect their own unique geographic, economic, and social environments. These principles are why we constructed our proposal to establish more structure around the process for rate setting without imposing limits on what a state may include in a rate, how the funding is expected to be allocated, or what state may require as part of their individual regulatory authority.

The Proposed Rule would Disproportionately Impact Small and Rural Providers

Our member surveys indicate that, if implemented, CMS' proposed rule would have a dramatically negative impact on the ability to deliver home care services in rural settings. Over 97% of providers who responded to the HCAOA survey indicated that they would be forced to cut services to clients in areas outside urban settings. Similarly, 86% of the respondents to NAHC's survey who predicted that the rule would force them to reduce services also indicated that the service reductions would impact rural areas. 80% of these same respondents to the NAHC survey also believed that the service cuts would lead to reduced services to cultural and/or ethnic minorities.

An Alternate Approach to Assuring Payment Adequacy

As mentioned several times previously, NAHC and HCAOA have worked to develop an alternative approach to the HCBS Payment Adequacy provision. Our approach is intended to achieve multiple programmatic goals simultaneously, including:

[25] 80 Fed. Reg. at 67,578.

- Providing more structure for state rate-setting processes;
- Creating a transparent approach that clearly delineates the components of a Medicaid reimbursement methodology;
- Supporting and increasing worker compensation;
- Maintaining state flexibility and autonomy regarding provider rate setting;
- Preserving the ability to perform both required and supplementary administrative activities that are crucial to high-quality HCBS delivery; and
- Adhering to the statutory requirements regarding 1902(a)(30)(A).

As background, the current version of CMS' Waiver technical guide contains the following guidance for rate-setting:

> States must review their rate setting methodology, at minimum, every five years to ensure that rates are adequate to maintain an ample provider base and to ensure quality of services. This rate review process can encompass a variety of rate review methods. For example, a state could elect to rebase their existing rate setting methodology. Rate rebasing would involve evaluating an existing fee schedule rate setting methodology and adjusting or updating individual rate components with more current data. States must describe their rate review process. The state's description of the rate review process should include:
>
> - When rates were initially set and last reviewed;
> - How the state measures rate sufficiency and compliance with §1902(a)(30)(A) of the Act;
> - The rate review method(s) used; and
> - The frequency of rate review activities.

Later in the technical guide, CMS states that:

> CMS **may request** the rate model from the state during the informal or formal RAI process (emphasis added).

The result is that there is no formal process for CMS to regularly review the underlying rate models nor is there any defined process for CMS to actually ensure that there is a validated rate process that is being implemented. Consequences from this lack of oversight and requirements include:

- Rates that are stagnant and not increased for many years;[26]
- Payment structures that do not include changes to state and federal requirements implemented since the rate was developed;
- Reimbursement models that do not provide adequate funding to pay livable wages to workers;
- Rate recommendations that are developed but not funded/implemented by the state legislature/administration;[27] and
- Reductions based on budgetary concerns rather than specific policy goals that are approved with little review/oversight.

Due to these concerns, we have the following recommendations for an alternative approach to establishing HCBS Payment Adequacy:

- Modify proposed 42 CFR §441.302(k) to say that rates must be, "adequate to ensure a sufficient number **of providers as well as a sufficient** direct care workforce."
- Add regulatory definitions for "rate review" and "rate model," to include:
    - A rate review process that uses generally accepted accounting practices to develop a payment methodology that assures continued adequacy of each component of the rate model;
    - A rate model that includes individualized components for core provider cost drivers, including but not limited to specific cost components for:
        - Employee wages and other compensation;
        - Employee benefits and fringe;
        - A productivity adjustment to account for billable hours;
        - Other employee related expenses such as worker's compensation, taxes, liability insurance, etc;
        - Travel costs;
        - Required supervision;
        - Provider taxes;
        - Training costs;
        - Program related expenses

[26] As one example, Pennsylvania's last provider rate study was conducted by Mercer in 2011 and provided to the PA Department of Human Services in January 2012. The PA have only been increased three times since 2012: 2% in 2014; 2% in 2020; and 8% (ARPA funds) in 2021 without any updated underlying analysis of the cost of care.
[27] See the earlier discussions of Vermont, Montana, and Oklahoma for examples of rate studies and recommended models that were not funded. These are just a few of the many instances where data-driven rate models are not adopted due to fiscal concerns.

        - Electronic Visit Verification;
        - Administrative expenses; and
        - All other state and federal statutory and regulatory requirements (ie: physical presence requirements, etc) accounted for and transparently identified.
    - The rate model should include a process for updates based upon inflation to provide recommended rates reflective of the current economic conditions;
- Require states to perform a formal rate review at least every five years for HCBS provided under:
    - 1915(c), (d), (i), (j), (k);
    - 1115; and
    - 1905(a)(7), (8), (21), and (24).
- Require the rate review to include a public comment period that solicits feedback from providers and other stakeholders regarding a draft of the rate report and require the state to respond to such feedback prior to finalization;
- Require states to submit a copy of the rate review report and recommendations with any waiver renewal or state plan amendment and make the report publicly available on their website; and
- Require states to justify any variance between the report recommendations and the actual established payment rates.

This approach provides more structure to CMS' important role of oversight in the Medicaid program without usurping state autonomy. The proposal would give states guidance on expectations for rate development while maintaining the ability for each Medicaid program to establish payment methodologies that reflect their own specific service definitions, regulatory requirements, and economic conditions. As with other parts of the proposed rule, CMS could utilize the authority in 42 CFR 430 Subparts C and D for compliance actions when these requirements surrounding rate setting are not met.

We believe that our proposal is a viable option for addressing this critical part of the proposed regulation and is favorable to the policy in current NPRM for the reasons discussed above. We encourage CMS to consider our proposal and to engage with us, our members, and our partners in the Medicaid HCBS delivery system to implement this policy in a manner that supports and strengthens the overall HCBS provider capacity and increases support to DCWs.

Definition of DCW: 42 CFR §441.302(k)(1)(ii)

We are concerned that CMS seems to be inadvertently conflating medical and nonmedical services by the proposed inclusion registered nurses, licensed practical nurses, nurse practitioners, or clinical nurse specialists providing nursing services to HCBS participants. While we recognize and agree that worker shortages include HCBS nursing staff, we do not believe it is appropriate to include nurses in the same category of DCWs as personal care attendants and other workers who are focused on providing support with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). In general, companies employing clinical nursing staff do not include them in the same worker category as DCWs. Similarly, state reimbursement rate development frequently leverages the Department of Labor's (DOL) data which is based upon the Standard Occupational Classification System (SOC). The SOC has a distinct category for Personal Care Aides, which is grouped with Home Health Aides in the hierarchy.[28] This creates distinctions regarding the pay, required clinical supervision, and associated supports provided to these individuals. It would create unnecessary confusion and challenges with reclassifying providers if CMS were to advance a national definition of DCW for Medicaid that differs from DOL. We recommend that CMS collaborate with DOL to ensure that DCW definitions are aligned.

Around the country, there is great emphasis on improving DCW recruitment and retention by focusing on items such as career ladders, expanded training, skills development, and other opportunities to advance careers. Including nurses in the broad definition of DCWs seems to be somewhat incongruous with existing efforts to support these workers. Furthermore, though we also recognize that challenges with Medicaid reimbursement and the resulting downward pressure on worker wages also impact nurses in the field, we believe it is more acutely urgent to focus on improving the wages and compensation for non-clinical staff. Medicaid reimbursement for services provided by non-clinical DCWs frequently results in pay levels that qualify for public benefits and, in many cases, are at or below the poverty level. Improving the working conditions, compensation, and overall quality of life for these workers deserves specific and dedicated attention and effort. We believe that a blending of clinical staff into this DCW definition would have the effect of detracting from the ability of states and provider agencies to effectively target initiatives to the DCWs most in need.

Concerns Regarding DCW Definition's Potential Impact on Clinical Care and HCBS

CMS also requests comments on whether additional services should be included within the proposed HCBS payment adequacy requirement. As stated previously, we do not believe that

[28] https://www.bls.gov/soc/2018/major_groups.htm#31-0000: SOC 31-1120 Home Health and Personal Care Aides

this proposal should apply to any services at all. Although it is not included within the proposed rule, we also want to specifically address Private Duty Nursing (PDN) as it is frequently confused and conflated with broader HCBS programs. As the associations representing our nation's PDN providers, HCAOA and NAHC are concerned by the proposed rule's inclusion of nurses in the definition of DCW and the potential implications for clinical services that may therefore be inappropriately categorized as part of HCBS now or in the future, like PDN. We also note that PDN services are sometimes supported by Home Health Aides in HCBS waivers and want to clarify that all PDN services are excluded from these proposals.

Access Reporting: 42 CFR §441.311(d)

We support CMS' proposal to require that states report annually on several important measures that will help quantify access to HCBS. Specifically, we agree that there should be nationally available, understandable, and comparable information regarding the current size of state waiting lists and how states manage those lists. The disparity in waiting lists across the country is difficult to discern given that states place individuals on the lists and manage them in many ways. We are further concerned that the use of alternate terms like "interest list" and the differing approaches to how such lists are structured may lead to some states opting out of this reporting. As such, we recommend that CMS also create an expectation that states report whenever the number of applicants exceeds the available waiver slots.

One potential way to effectuate this is in § 441.303(f)(6). Currently, CMS proposes to require that states submit this information "If the State has a limit on the size of the waiver program and maintains a list of individuals who are waiting to enroll in the waiver program." Alternatively, CMS could require states to submit information "if the number of applicants exceeds the limit on the size of the program," which would impose the mandate regardless of how the waiting lists are defined and organized.

We further support the two access measures that are intended to assess provider capacity: the requirement to report on the time it takes between service authorization and service delivery, as well as the number of authorized hours vs. the number of hours delivered. We understand that these are imperfect measures; however, we think that they are important data points that can help assess systematic issues with provider enrollment and access to care. There may be many factors influencing the results of these measures, including those beyond the control of states or providers, such as individuals rescheduling or changing their services to meet their own needs and preferences. We therefore believe that it is important to also include a root-cause analysis in instances where the preliminary data indicates a gap in access to care. This could be an additive

requirement for states that fall below a certain threshold of the proportion of authorized services that are actually delivered.

In addition to the DCW crisis, there is limited availability of case managers and eligibility workers which can also lead to delays in individuals accessing services. For example, a delay between application and eligibility determination can have serious negative impacts for an individual in need of HCBS.[29] Similarly, if there is a case manager shortage, it may take a substantial amount of time between when an individual is determined eligible and the assessment and development of a plan of care. We therefore recommend that CMS include additional data in the reporting requirements of this section. Specifically, we recommend that states also report on the amount of time between an individual's date of application and eligibility determination, as well as the time between eligibility determination and the plan of care development (i.e.: authorization of services). Additionally, CMS should require states to establish reasonable caseloads for HCBS case managers and report on the average caseload.[30]

Additionally, though this may be more applicable to the corresponding CMS Managed Care rule,[31] we wish to also highlight that MCO prior authorization practices, including differing lengths of authorizations and delays of authorizations also represent barriers to access. We believe that CMS should strengthen requirements, both for reporting and enforcement, regarding the timeliness of service authorizations in MLTSS programs. Delayed and missing authorizations can create huge problems for providers and participants. Providers must either continue to provide care (and pay caregivers) without assurance that the authorizations will eventually be updated and the services reimbursed or the individuals risk not receiving necessary care.

Reporting on Proportion of Payments to DCWs: 42 CFR §441.311(e)

We recognize and agree that there is a lack of consistent, reliable information regarding the proportion of Medicaid payments that are provided to DCWs as compensation. As discussed earlier, we have spent considerable time attempting to understand the current landscape to evaluate the potential impact of this proposal and have had little success finding any consistent, reliable data. We therefore support the concept of increasing the availability and transparency of this information.

[29] See this article for one example of the impact that lack of eligibility staff can have on HCBS applicants: https://www.thebaltimorebanner.com/community/public-health/maryland-medicaid-home-care-backlog-K573AO6C3ZFDPH436D55LB6EYU/

[30] States and MCOs may use many different terms to describe service coordination/case management. CMS should apply these requirements to case managers regardless of their name.

[31] CMS-2439-P

We are concerned, however, that CMS is drastically underestimating the amount of time and effort that it will take states and providers to compile, report, and analyze this data. Adhering to the proposed reporting requirements in this section would require comprehensive Medicaid cost reporting in a manner that most providers are not currently able to provide. Significant administrative effort, and expense, would be necessary to collect this information and we do not believe that it is feasible in the current Medicaid structure.

Instead, we recommend that CMS commission national studies to evaluate existing Medicaid payment rates, current DCW payment rates, and the proportion that are passed through to DCWs. Such studies could also assess how the variation in state regulations and reimbursement rates influences the proportion of funds that DCWs receive as compensation, as well as the overall fiscal stability of Medicaid HCBS providers. Performing this type of analysis, using statistically significant national and state sample sizes, would provide a more achievable approach without the substantial burden on providers and states that would accompany an annual, universal, cost reporting mandate.

Payment Rate Transparency: 42 CFR §447.203(b)(1)

We appreciate that CMS is increasing transparency regarding payment rates in this rule. We specifically are supportive of the requirement to post fee schedules in a clear, easy to read format that is publicly accessible from the state Medicaid website. While this information is sometimes available online, it is often challenging to access and may be distributed sporadically based on the various waivers and operating agencies responsible for administering HCBS. Requiring states to make consolidated, easy to understand, information readily available will better inform the public, providers, and participants about the payment rates for Medicaid services.

We are also particularly supportive of the requirement for states to clearly identify the date the payment rates were last updated. As you may know, HCBS provider rates frequently go many years without any updates and this requirement will enable the public, as well as policymakers that may not be as familiar with the intricacies of rate-setting, to better understand the dynamics of stagnant rates.

Payment Rate Disclosure: 42 CFR §447.203(b)(3)(ii)

We are appreciative and supportive of efforts to increase transparency regarding Medicaid payments; however, we are unclear what the proposed requirement to publish an hourly equivalent of the Medicaid payment rate for home health care aide, personal care, and homemaker services is attempting to accomplish. Given that proposed 42 CFR §447.203(b)(1) requires states to make Medicaid fee schedules publicly available and readily accessible, and Medicaid fee schedules

generally include a time component or unit of service, it is unclear whether this is additive to the previous requirement.

If CMS is attempting to provide data that isolates the specific pay of the DCWs, it may be useful to clearly specify this desire – particularly because the regulatory language seems to imply that the disclosure would focus on the hourly equivalent of the Medicaid reimbursement rate, rather than the pay to the DCW. We also note that, absent full cost-reporting and wage analyses, states may not have specific information about the pay for DCWs. As discussed in our comments on section 441.311(e), we do not think that this type of universal cost reporting and wage analysis would be feasible in the Medicaid program. We recommend that, instead of this disclosure requirement, CMS use the hourly wage assumptions built into the rate study we suggest requiring on page 51 to increase transparency regarding worker pay. We believe that mandating such a study be performed and made publicly available would provide more relevant information than the current disclosure proposal.

We further note that in paragraph (B), CMS appears to use the term providers to mean DCWs when creating the mandate to disclose information about payments made to, "individual providers and to providers employed by an agency." It is important to remain clear about the distinction between a provider and a DCW. In Medicaid, when a DCW is employed by an agency, the Agency is the enrolled provider of record. As with the proposed language in 42 CFR §441.302(k), CMS' apparent conflation of the DCW and the Medicaid provider is a concerning oversight that disregards the important functions that Agencies perform to ensure quality, health and welfare, and other functions necessary to deliver HCBS. We recommend that CMS use the term "Individual Providers and Agency Providers" if the intent is to publish information about the hourly equivalent of Medicaid reimbursement rates. In contrast, if the intent is to publish information about the DCW hourly wages, we recommend that CMS use the terms "Individual Providers and DCWs employed by Agency Providers."

We are supportive of the requirement in paragraph (C) that states include information regarding the number of Medicaid-paid claims and the number of Medicaid enrolled beneficiaries who received a service within a calendar year for each of the services. We believe that this information will provide stakeholders with important information that will help with identifying the extent of covered services, potential areas of unmet need, and the fiscal impact of the program and any proposed changes. We believe that this portion of the proposed rule would provide useful information particularly in conjunction with the Access Reporting Requirements in 42 CFR §441.311(d) and urge CMS to move forward with proposed paragraph (C) even if the prior hourly payment disclosure is not finalized.

Interested Parties Advisory Group: 42 CFR §447.203(b)(3)(ii)(6)

We appreciate that CMS is proposing a group that will provide outside entities with an opportunity to engage with the state and provide comment and feedback on proposed payment rates. We look forward to collaborating with states to improve the working conditions and overall lives of DCWs. To better reflect the realities of the HCBS delivery system, as well as to better effectuate this proposed group, we believe that there are several clarifications and changes necessary.

We believe that "Interested Parties Advisory Group" is not a very descriptive term and may cause confusion about the focus of this group. Clearer language would help educate and recruit appropriate participation to ensure that the group's composition best supports the goals of providing advice and feedback to the state on payment rates for certain services. We recommend renaming the group to "HCBS Payment Advisory Group," which would also reflect our recommendation to expand the scope of services reviewed by this group discussed below.

In subparagraph (i), CMS again appears to incorrectly conflate workers with enrolled Medicaid providers. CMS specifically states that this group would apply to services where, "payments are made to the direct care workers specified in § 441.302(k)(1)(ii) for the self-directed or agency-directed services found at § 440.180(b)(2) through (4)." It is important to remain clear that agencies are the enrolled providers of record. Medicaid programs make payments to these enrolled providers (ie: agencies) who then pay wages to the DCWs they employ. It is not accurate to state that Medicaid "payments" are made to the DCWs. This distinction is important because the current proposal appears to remove agencies from the perceived flow of funding for Medicaid reimbursement, which may explain why those same provider agencies are not included in the list of mandatory participants on the group.

Further, we recommend that CMS expand the services in (i) so that this group is not limited solely to personal care, homemaker, and home health aide services. We believe that this payment advisory group would be best suited if it addresses HCBS services more broadly, particularly since many states define HCBS using a variety of statutory and regulatory options. We recommend that the HCBS Payment Advisory Group apply to services included in 1915(c) waivers, 1915(i) State Plan HCBS, 1915(j) Self-Directed Personal Attendant Services, 1915(k) Community First Choice programs, 1115 demonstration programs, and the following 1905(a) State Plan Services:

- 1905(a)(7) Home Health Care Services;
- 1905(a)(8) Private Duty Nursing Services;
- 1905(a)(22) Home and Community Care for Functionally Disabled Elderly Individuals; and

- 1905(a)(24) Personal Care Services.

We are particularly concerned that, in paragraph (ii), CMS excludes Agency providers from the list of required participants in this group. This again appears to be an instance where CMS excludes Agencies and conflates DCWs with enrolled providers. We recommend that paragraph (ii) be modified to state:

> (ii) The HCBS Payment Advisory Group must include, at a minimum:
>
> (A) Enrolled Medicaid provider agencies
> (B) Representatives from state associations for HCBS providers
> (C) Direct care workers
> (D) Beneficiaries
> (E) Beneficiaries' authorized representatives, and
> (F) Other interested parties impacted by the services rates in question, as determined by the State

In paragraph (iii) we recommend modifications to align the focus of the group with the broader array of HCBS services and payment reporting data that our earlier proposed changes would make. Additionally, we believe that, due to the various omissions of provider agencies throughout this proposed rule, changes would help to better clarify the role of the council and the 1902(a)(30) equal access provision. Therefore, we believe paragraph (iii) should say:

> (iii) The HCBS Payment Advisory Group will advise and consult with the Medicaid agency on current and proposed payment rates, the result of any studies on HCBS reimbursements, and access to care metrics described in § 441.311(d)(2), associated with services found at subparagraph (i) to ensure the relevant Medicaid payment rates are sufficient to enlist enough providers and direct care workers to ensure access to HCBS for Medicaid beneficiaries at least as great as available to the general population in the geographic area, including self-directed personal assistance services.

In paragraph (iv), we are concerned that only including a requirement to meet every two years will deprive the group of opportunity to comment and deprive the state of important feedback on access to and quality of care, when there are potential changes to the reimbursement rates. Additionally, this paragraph represents another instance where CMS conflates direct care workers and Medicaid-enrolled providers. We therefore recommend modifying paragraph (iv) to address potential changes to reimbursement rates as well as to reflect our earlier proposals to modify reporting requirements and expand the scope of services reviewed by this group.

(iv) The HCBS Payment Advisory Group shall meet at least every 2 years, and at least once prior to any change in payment rates or methodology that would have the result of reducing or restructuring provider payments in a manner that could diminish access, and make recommendations to the Medicaid agency on the sufficiency of reimbursement rates for the services found at subparagraph (i). The State agency will ensure the group has access to current and proposed payment rates and applicable access to care metrics as described in § 441.311(d)(2) for HCBS in order to produce these recommendations. The process by which the State selects interested party advisory group members and convenes its meetings must be made publicly available.

State Analysis Required for Payment Restructuring and Access: 42 CFR §447.203(c)

We appreciate that CMS is establishing more stringent requirements on State Plan Amendments that would have the result of reducing provider or restructuring provider payments in circumstances when the changes could result in diminished access. As we discussed earlier, the current lack of an adequate Federal oversight framework on HCBS rates has led to instances where reimbursements have been cut solely due to state budgetary priorities rather without any underlying assessment or understanding on the negative impact on access to care. This proposal will further strengthen the Federal role in assuring that reimbursements are consistent with the requirements of 1902(a)(30) without encroaching on the ability and authority of states to determine their own payment methodologies.

We further appreciate the clarification in the preamble that because certain services such as personal care and other HCBS have no Medicare alternative to compare with the Medicaid rates, these services would always be subject to the more expansive reporting requirements described in paragraph (c)(2). We believe that the requirements in (c)(2) would be strengthened by also requiring states to submit a copy of the most recent HCBS rate study we recommend establishing in our proposal on page 51.

We also recommend that states be required to perform a one-time access analysis after the publication of this rule. While the current proposal adds additional structure to proposals that *reduce payment rates*, we do not believe that it is appropriate to assume that the rates in effect currently are sufficient to assure access to care. Therefore, we believe that CMS should require states to submit the data described in paragraph (c)(1) and, if not all three of the requirements are met, also the data listed in (c)(2) within 18 months of the promulgation of the final rule in addition to when there are payment reductions and restructures.

We appreciate that CMS includes mechanisms for ongoing beneficiary and provider input in paragraph (4) of this section. We agree that there is an important role for both providers and

beneficiaries to play in identifying access concerns and we support requiring states to collect, aggregate, and respond to the comments. We also appreciate the requirement for states to establish a remediation plan for identified access concerns pursuant to paragraph (5) of this section. We recommend that CMS provide additional guidance regarding what would constitute "access deficiencies" that triggers the required response. The term is somewhat ambiguous and it is unclear what, exactly, would constitute a deficiency that states must address with a remediation plan.

HCBS Quality Measure Set: 42 CFR §441.312

We support the requirement for states to report on a national set of HCBS quality measures. The current HCBS quality assurance system is an antiquated process-oriented framework that does not focus on the actual outcomes of the system or the experiences of participants. An alternative approach is well overdue, and we are appreciative that CMS is looking to shift the way that HCBS quality is measured.

The July 2022 State Medicaid Director letter establishing an HCBS Quality Measure Set was the result of extensive stakeholder engagement and is a major step forward in a unified national approach to HCBS quality measurement and improvement.[32] It will promote more consistent use of valid and reliable measures that will allow for comparisons across states as well as to establish state-specific baseline data and create benchmarks for improvement. We support the proposal to create a broad regulatory framework for quality reporting and to establish a public process to update the measures on a regular basis. We also appreciate that this section specifically includes HCBS Providers as a group that must be consulted during the public input process, and that the section draws an appropriate distinction between providers and DCWs. This approach strikes an appropriate balance between the need to update measures to reflect changes in national programs and policy while also avoiding constant changes that overtax state and provider resources and prevents meaningful longitudinal comparisons.

Strengthening Oversight of Person-Centered Plans: 441.301(c)(3)(ii)(A)

We support the proposal to include reporting requirements to demonstrate that at least 90 percent of enrolled individuals have their person-centered plan reviewed and updated at least annually. We agree that person centered planning is a core component of both assuring health and safety of HCBS participants and of promoting and supporting community-inclusion. Person centered plans are the lynchpin of successful HCBS programs that appropriately enable individuals to choose how they wish to live.

[32] https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf

We note that concerns CMS outlines in the preamble regarding inappropriate delays to plan of care updates may be due to the broader workforce shortages across the HCBS industry. We believe that CMS should require a root-cause analysis in instances where a state does not meet the 90% benchmark. This could help assess whether there are concerns with policy, reporting, or workforce shortages driving issues with the plan of care updates.

Incident Management System: 42 CFR §441.302

We believe that the establishment of federal standards for an incident management system is a critical improvement that is greatly needed in HCBS. The creation of standardized incident management systems, coupled with the reporting requirements in section 441.311, will improve the ability of states to adequately ensure the health and welfare of participants. We support the establishment of a federal definition of critical incidents and agree that there should be a data system with the capabilities necessary to track and trend critical incidents, thus enabling states to identify areas of concern and establish protocol to respond to those issues.

We note that section (6)(i)(C) would place new specific requirements on providers for reporting critical incidents. We are not opposed to this measure as we think that standardized approaches for reporting will strengthen the ability to protect the health and safety of participants and to also identify "bad actors" in the system that may go unnoticed without proper analytic capabilities. We encourage states and CMS to work with us and our members to ensure that the incident management systems are developed with interoperable standards that enable providers to submit information accurately and consistently regardless of the state. We also wish to highlight that health and welfare oversight and assurance is an important function agency providers can assist CMS and states achieve, but it also requires administrative capacity to appropriately perform.

HCBS Grievance System: 42 CFR §441.301(c)(7)

We believe that establishment of a Grievance System will help states and providers be more responsive to concerns that do not rise to the level that requires a formal appeal, but that are important and in need of remediation. We appreciate that the grievance system provides an opportunity to resolve immediate issues with person centered planning and community integration (i.e.: HCBS "settings" requirements) for a participant in a structured and formalized way currently unavailable. Importantly, information collected and analyzed through this new system can also help identify areas in need of broader remediation, particularly as it relates to shortcomings in person-centered practices as well as issues with the community integration requirements in the HCBS settings rule.

There are a significant number of new requirements and administrative mandates placed on states in this proposed rule. It is unclear whether they are all achievable within the proposed timelines included in the rule. Though we believe that this grievance system is important and should be implemented, other areas such as the critical incident reporting system should take precedence due to the direct impact on health and wellbeing of participants.

Medicaid Advisory Committee and Beneficiary Advisory Group: 42 CFR §431.12

We believe that adequate and ongoing feedback is a necessary part of a well-functioning Medicaid program. States that embrace public input processes and view beneficiaries, providers, advocates, and other parts of the system as partners in improving care rather than adversaries can see significant benefits from collaborative problem solving and partnerships to implement shared priorities. We look forward to collaborating with CMS and states to strengthen the public input and advisory functions around the country.

In paragraph (d), we recommend that CMS include more explicit guidance regarding the composition of the Medicaid Advisory Committee (MAC). The current proposal would have categories of potential participants but does not appear to require a broad range of participation in the MAC. We recommend that CMS include, at a minimum, a HCBS provider agency, a DCW, and a HCBS provider association on the MAC.

We also support the proposed creation of the new beneficiary advisory group (BAG) that will serve as a subset of the MAC. It is important to solicit feedback from participants in the program in addition to professionals in the field. We recommend that CMS provide more clarification on what it means by "individuals with direct experience supporting Medicaid beneficiaries," particularly regarding whether the BAG would include paid caregivers or whether the focus here is on including the perspective of friends/family who served as natural supports for the member. Given that Medicaid is a means-tested program, enrolled individuals by definition have limited resources. We therefore also recommend that CMS provide a framework for ensuring that beneficiaries can actively participate, such as stipends, travel reimbursement, and other protocol to alleviate any financial concerns of members.

In subsection (g), we recommend that the committees also be tasked with providing recommendations regarding access to care for Medicaid participants. These recommendations can include issues such as current issues and feedback any remediation plans, if applicable, required by this rule at proposed section 447.203(c)(5).

Conclusion

We all agree that DCWs deserve to have livable wages and improved quality of life. We further believe that strong efforts are necessary at the federal, state, and local levels to improve reimbursements and ensure that there are sufficient providers and DCWs to deliver HCBS to Medicaid enrollees. Unfortunately, the Payment Adequacy portion of this rule is untenable and counterproductive to these shared goals. We urge CMS to consider our alternative proposal and to focus on activities that support improved compensation without compromising quality of care or health and welfare of participants. We also urge CMS to move forward with the positive parts of this proposal, such as improvements to payment rate transparency, quality measurement, and incident managements.

We appreciate the opportunity to submit comments on this proposed rule. We look forward to ongoing work on these important issues with CMS and stand ready to support efforts on a collaborative basis to strengthen our HCBS system. If you have any questions about this letter or its contents, please contact Damon Terzaghi at dterzaghi@nahc.org or Eric Reinarman at eric@hcaoa.org.

Sincerely,

William A. Dombi
President
National Association for Homecare & Hospice

Vicki Hoak
CEO
Home Care Association of America

These comments are also endorsed by the following organizations:

- Association for Home and Hospice Care of North Carolina Inc.
- California Association for Health Services at Home
- Connecticut Association for Healthcare at Home
- Delaware Association for Home & Community Care
- Georgia Association for Home Health Agencies, Inc.
- Granite State Home Health & Hospice Association (NH)
- Healthcare Association of Hawaii
- Home Care & Hospice Alliance of Maine

- Home Care & Hospice Association of New Jersey
- Home Care Alliance of Massachusetts
- Home Care and Hospice Association of Colorado
- Home Care Association of Florida
- Home Care Association of New York State, Inc.
- Home Care Association of Washington
- Homecare & Hospice Association of Utah
- Idaho Health Care Association
- Illinois HomeCare and Hospice Council
- Indiana Association for Home & Hospice Care, Inc.
- Iowa Health Care Association
- Kentucky Home Care Association
- Maryland National Capital Home Care Association
- Michigan HomeCare and Hospice Association
- Minnesota HomeCare Association
- Missouri Alliance for Home Care
- Nebraska Association for Home Healthcare and Hospice
- New Mexico Association for Home & Hospice Care
- New York State Association of Health Care Providers, Inc.
- Ohio Council for Home Care & Hospice
- Ohio Health Care Association
- Pennsylvania Homecare Association
- Rhode Island Partnership for Home Care
- South Carolina Home Care and Hospice Association
- Tennessee Association for Home Care
- Texas Association for Home Care and Hospice, Inc.
- Virginia Association for Home Care and Hospice
- VNAs of Vermont
- West Virginia Council of Home Care Agencies Inc.
- Wisconsin Association for Home Healthcare, Inc.

APPENDIX:

Legal Analysis of Medicaid HCBS 80/20 Proposal

FOLEY HOAG LLP

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Memo

Date:	June 29, 2023
To:	National Association for Home Care & Hospice (NAHC)
From:	Thomas R. Barker, Partner Alex Somodevilla, Associate Regina DeSantis, Associate
Regarding:	Legal Analysis of Medicaid HCBS 80/20 Proposal

You have asked for an analysis of the Centers for Medicare & Medicaid Services (CMS) proposal to require that at least 80 percent of all state Medicaid payments with respect to certain Home and Community Based Services (HCBS) be allocated to compensation for direct care workers, pursuant to the agency's purported authority under sections 2402(a)(1) and 2402(a)(3)(B)(iii) of the Affordable Care Act (ACA) and section 1902(a)(30)(A) of the Social Security Act (the Act).[1]

The Administrative Procedure Act (APA) requires courts to set aside agency actions when they are either "arbitrary, capricious, an abuse of discretion, or otherwise not accordance with law" or in excess of the agency's statutory authority.[2] Because courts have, under the so-called *Chevron* doctrine, traditionally given deference to an agency's interpretation of statutes it administers, legal challenges to an agency rule historically face some inherent hurdles. With that in mind, we believe there are colorable arguments that the agency will exceed its statutory authority if it finalizes the Proposed Rule, or that CMS's decision to finalize this proposal would be arbitrary and capricious under the APA. We also believe there is an argument that, if finalized, CMS's proposal could be found to have violated the Administrative Procedure Act's (APA's) notice and comment requirement by failing to provide stakeholders with the necessary data to adequately evaluate the impact of this policy.

I. The Proposed Rule May be Contrary to Law

In considering whether an agency's regulation is permissible, courts will follow a well-established two-step test set forth in *Chevron v. National Resources Defense Council*.[3] In "*Chevron* Step One," courts examine whether Congress has directly spoken to the precise question at issue. "If the intent of Congress is clear, that is the end of the matter."[4] If the court determines that Congress has not

[1] 88 Fed. Reg. 27960, 27983 (May 3, 2023).
[2] 5 U.S.C. § 706(2)(A), (C).
[3] *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984).
[4] *Id.*

directly addressed the precise question at issue, it will proceed to "*Chevron* Step Two" and examine whether the agency's action is based on a permissible construction of the statute.[5] Under this framework, courts must defer to an agency's interpretation of the statute if that interpretation is "reasonable."[6]

A. Chevron Step 1

The relevant question at this step of the analysis is whether Congress has directly spoken on the issue of whether CMS has the authority to require that a minimum percentage of a state's Medicaid HCBS payment to a participating provider be allocated specifically for wages for direct care workers. Here, there is an argument that a clear reading of the relevant statutory provisions calls for a narrower interpretation than that given by CMS in the Proposed Rule. For example, the plain language of Section 2402(a)(3)(B)(iii) is limited to assuring "an adequate number qualified direct care workers [that] provide ***self-directed personal assistance services***." A plain reading suggests that Congress intended for this provision to narrowly apply only to direct care workers providing self-directed personal assistance services (which are largely provided under 1915(j) waivers), and not to other types of HCBS waiver programs, including 1915(c), that are also covered by the Proposed Rule.

Furthermore, section 1902(a)(30)(A)'s requirement that state *Medicaid plans* "assure that *payments* are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers…." arguably only encompasses payments made by the state Medicaid program to the billing HCBS providers for services those entities provide to Medicaid beneficiaries, and does not encompass *wages* paid by the billing HCBS provider to the direct care worker.

B. *Chevron Step 2*

Even if one were to determine that the relevant statutes are ambiguous on this specific issue, CMS's interpretation should arguably not be entitled to deference because it is not a reasonable interpretation of the relevant statutes to conclude that the agency has the authority to dictate the percentage of state HCBS payments a provider must allocate as wages to the direct care worker.

i. Section 1902(a)(30)(A).

First, and as mentioned above, section 1902(a)(30)(A) only refers to ensuring that *payments* are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers…." Although the Medicaid Act does not define the term "payment" in this context, section 1902 of the Act consistently uses the term to refer to reimbursement made by the state Medicaid program under the state plan or waiver to the billing provider, and not as encompassing wages paid by the provider to staff.[7] The Supreme Court has taken this approach to viewing section 1902(a)(30)(A), describing this provision as "requiring that ***reimbursement rates*** be sufficient to enlist enough providers."[8] It should also be noted that the relevant HCBS waiver authorities

[5] *Chevron U.S.A. Inc.*, 467 U.S. 837, 842-43.
[6] *Id.*
[7] *See, e.g.*, section 1902(a)(13) of the Act (referring to "payment" made by the state Medicaid program to several different provider types).
[8] *Douglas v. Indep. Living Ctr. of S. Cal., Inc*., 565 U.S. 606, 614 (2012) (internal citations and quotations omitted) (emphasis added).

included under section 1915 of the Act, which governs HCBS waiver programs, also use the term "payment" to refer to payments made by the state Medicaid program.[9]

Moreover, the Medicaid Act separately uses the term "compensation", and not "payment," when referring to wages paid to the direct care worker providing HCBS. For example, the section of the Medicaid Act covering HCBS for functionally disabled elderly individuals includes a minimum requirement for "[g]uidelines for such ***compensation*** for individuals providing such care as will assure the availability and continuity of competent individuals to provide such care…."[10] This indicates that Congress knows how to draw a clear delineation between payments and compensation/wages. Had Congress wanted section 1902(a)(30)(A) to encompass wages or compensation, it would have done so by incorporating these terms into the statutory language.

In any event, even if the term "payment" in section 1902(a)(30)(A) could be reasonably interpreted to encompass direct care worker *wages* in some way, it likely cannot be reasonably interpreted to give CMS the authority to dictate the exact percentage of HCBS payment that must be allocated as wages for direct care workers. Section 1902(a)(30)(A) simply states that a state's Medicaid program must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers…." There is nothing in this statutory provision granting CMS the authority to step in and dictate the amount of those payments and how those payments must be allocated. It should be noted that when Congress has intended for CMS to have this level of authority over specific aspects of state Medicaid reimbursement or payment rates, it has said so expressly in the text of the Act.[11] Given that there is no express reference here, CMS's conclusion that section 1902(a)(30)(A)'s general language provides it with the authority to dictate state Medicaid HCBS wages is arguably unreasonable. Indeed, "[w]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion."[12]

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[9] For example, section 1915(c)(1) gives the HHS Secretary the authority to, pursuant to a waiver, provide that a Medicaid state plan "may include as "medical assistance" under such plan ***payment*** for part or all of the cost of [HCBS] … provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility … the cost of which could be ***reimbursed*** under the State plan."

[10] 42 U.S.C. § 1396t.

[11] For example, in the section of the Medicaid statute governing the Medicaid managed care program, Congress specifically states that services covered by a Medicaid managed care organization (MCO) must be "in accordance with a contract between the State and the entity under which prepaid ***payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts*** providing for expenditures" that exceed a certain threshold. 42 U.S.C. § 1396b(m)(2)(A)(iii). Likewise, section 1923 of the Act, which covers the requirement that states make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients, outlines in painstaking detail the requirements of the DSH program, as well as the role of the HHS Secretary to enforce these requirements, including through the implementation of certain Medicaid DSH allotment reductions. 42 U.S.C. § 1396r-4. Last, section 1902(a)(13)(C) of the Act, specifically provided that "payment for primary care services furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under" Medicare Part B. 42 U.S.C. § 1396a(a)(13)(C).

[12] *See Gozlon-Peretz v. United States*, 498 U.S. 395, 404 (1991) (quoting *Russello v. United States*, 464 U.S. 16, 23 (1983)).

Furthermore, the statutory and regulatory history of this provision are also inconsistent with CMS's reading of the statute. Prior to 1989, the requirement regarding the sufficiency of Medicaid payment to ensure an adequate number of providers in a geographic area was only established pursuant to regulation and was never interpreted as providing CMS with this wide scope of authority. In 1989, Congress amended section 1902(a)(30) of the Act to incorporate the sufficiency of payment requirement (referred to as the "equal access provision") into the Medicaid statute,[13] but at no point following this amendment of the statute was the provision interpreted as providing CMS with this level of authority.

Indeed, in a brief filed by the Clinton Administration in a 9th Circuit case regarding the scope of section 1902(a)(30)(A), the federal government opined that the purpose of 1902(a)(30)(A) was to give states "wide discretion to set Medicaid payments that are consistent with efficiency, economy, and access to quality care."[14] Given this purpose, "the Secretary does not dictate what level of payments will be sufficient to provide for equal access to such care and services … [n]or does the Secretary require the States to adopt any particular procedure or methodology for determining whether payments are necessary to meet the general criteria" in the statute."[15] Court decisions interpreting section 1902(a)(30)(A) in the years following its amendment were consistent with this interpretation.[16]

CMS maintained this interpretation and notably did not issue regulations interpreting the equal access provision of section 1902(a)(30)(A) until 2015. Leading up to the these regulations, the Obama Administration indicated CMS intended to issue regulations that it believed would represent an "authoritative interpretation" of 1902(a)(30)(A).[17] Notably, however, the proposed rule initially issued in 2011 did not claim authority to regulate payment rates and wages in this manner, and "recognized that States must have some flexibility in designing the appropriate measures to demonstrate and monitor access to care, which reflects unique and evolving State service delivery models and service rate structures."[18] Instead, CMS proposed to outline a data-driven process for States to follow in order to document their compliance with section 1902(a)(30)(A). CMS finalized this proposal in 2015,[19] and neither Congress nor CMS have spoken on the issue since then.

ii. Section 2402 of the ACA.

CMS's interpretation of section 2402 of the ACA is also arguably unreasonable. First, and as mentioned above, because the plain language of section 2402(a)(3)(B)(iii) is limited to assuring "an adequate number of qualified direct care workers [that] provide ***self-directed personal assistance services***" it is unlikely that CMS's reading of the statute, which would encompass the

[13] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239.
[14] *See* https://www.justice.gov/sites/default/files/osg/briefs/1996/01/01/w961742w.txt.
[15] *Id*.
[16] *See Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (finding that section 1396a(a)(30)(A) "requires each state to produce a result, not to employ any methodology for getting there," and absent proof that a rate structure results in inadequate access, states "may say what they are willing to pay and see whether this brings forth an adequate supply"); *see also Minnesota Homecare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (finding that section 1396a(a)(30)(A) "does not require the State to utilize any prescribed method of analyzing and considering [the statutory] factors.").
[17] *See* https://www.justice.gov/sites/default/files/osg/briefs/2010/01/01/2009-0958.pet.ami.inv.pdf.
[18] 76 Fed. Reg. 26342, 26344 (May 6, 2011).
[19] 80 Fed. Reg. 67576 (Nov. 2, 2015).

full scope of HCBS provided by a Medicaid program, would be found to be a reasonable interpretation of the statute.

Furthermore, section 2402(a)(1) provides only that states must develop systems designed to "*allocate resources* for services in a manner that is *responsive to the changing needs* and choices" of Medicaid beneficiaries. There is no reference *whatsoever* in section 2402(a)(1) to payment rates or wages in a state's HCBS program. As explained above, when Congress has intended for CMS to have this level of authority over specific aspects of state Medicaid reimbursement or payment rates, it has said so expressly in the text of the Act.

Moreover, "[t]he title of a statute or section can aid in resolving an ambiguity in the legislation's text."[20] Here, section 2402(a)(1) falls under subsection 2402(a), which is entitled – "Oversight and Assessment of the Administration of Home and Community-Based Services." The title here supports the argument that CMS's authority to regulate in this space is limited to the more passive role of "oversight and assessment" and would not encompass the more active role of dictating how state HCBS payment must be allocated for wages.

II. The Proposed Rule May be Arbitrary and Capricious

An agency rule is arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.[21]

Here, CMS's proposal, if finalized, would arguably be arbitrary and capricious, and in violation of the APA, because CMS has failed to consider an important aspect of the problem– i.e., the impact of this policy on HCBS provider agencies, and the resulting impact on Medicaid beneficiary access. In the Proposed Rule, CMS states that a Federal standard is needed as a "a concrete step in recruitment and retention efforts to stabilize this workforce by enhancing salary competitiveness in the labor market."[22] CMS then makes the connection between recruitment and retention of these workers and Medicaid beneficiary access to HCBS. However, at no point in the Proposed Rule does CMS discuss the role of HCBS provider agencies in providing HCBS across the country, and the impact this proposal would have on their operations and continued viability, and thus on Medicaid beneficiary access. Should CMS finalize this proposal without seriously engaging with this issue, a court may find that the agency "entirely failed to consider an important aspect of the problem."

Furthermore, as to the question of whether CMS will offer an explanation for its decision that runs counter to the evidence before the agency, it should be noted that the only study HHS has conducted on this issue found that the impact of similar state "wage pass-through" laws was mostly mixed, with a majority of states indicating that their law either had no impact on recruitment and retention of direct-care workers or they could not determine if there was an impact.[23] In the Proposed Rule, CMS also points to recent examples of states voluntarily adopting this policy as

[20] *See Henderson ex rel. Henderson v. Shinseki*, 562 U.S. 428, 439 (2011) (citation and alteration omitted).
[21] *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 43 (1983).
[22] 88 Fed. Reg. at 27983.
[23] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy, *State Wage Pass-Through Legislation: An Analysis Workforce Issues: No.1* (Dec. 2002), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//40596/wagepass.pdf.

support for its decision that a Federal standard is necessary. However, as discussed below, the examples CMS cites are not at all analogous to the proposal, calling into question their usefulness in terms of allowing stakeholders to adequately evaluate impact. Therefore, CMS has arguably not presented any information or data that would support its assertion that this type of policy will have its intended effect of attracting more workers to the direct care workforce and increasing access for Medicaid beneficiaries.

III. The Proposed Rule May Have Failed to Satisfy the APA's Notice and Comment Requirements

CMS may have also violated the APA's procedural requirements by failing to provide the necessary data to stakeholders to evaluate the agency's proposal, thereby depriving stakeholders with the opportunity to meaningfully comment on the proposal's merits. Under the APA, an agency must publish a notice of proposed rulemaking that includes "either the terms or substance of the rule or a description of the subjects and issues involved."[24] The notice must "include sufficient detail on its content and basis in law to allow for meaningful and informed comment."[25] "[A]n agency cannot rest a rule on data that, in critical degree, is known only to the agency. The most critical factual material that is used to support the agency's position on review must have been made public in the proceeding and exposed to refutation."[26]

As an initial matter, CMS uses generalized terms for certain services that may fall under a variety of different categories depending on the individual state HCBS program. Specifically, CMS says that this proposal will only apply to homemaker, home health aide, and personal care services, without providing detailed definitions for these terms. This is potentially problematic, because these terms are not used uniformly in every state Medicaid program. As such, stakeholders across the country may not be able to adequately weigh the impact of this proposal on their operations in their individual state.

Furthermore, CMS states that this proposal is "based on feedback from States that have implemented similar requirements" and have reported to the agency that these requirements "have had their intended effect of ensuring that a sufficient portion of the payment for Medicaid HCBS goes to compensation for the direct care workforce."[27] CMS also provides that these "States have also indicated an 80 percent threshold is an appropriate threshold that takes into account the expected portion of payments that are necessary for provider administrative and other costs" and that "our research indicates that some States have successfully implemented other thresholds."[28] Notably missing from the Proposed Rule, however, is any information and data states have reported to CMS regarding similar policies, including the impact of these policies on HCBS provider agencies and whether these policies had their intended effect of attracting more workers to the direct care workforce and increasing access to care. CMS also does not make available its "research" indicating that these thresholds are sufficient to allow providers to meet their administrative and other costs.

[24] 5 U.S.C. § 553(b)(3).
[25] *Am. Med. Ass'n v. Reno*, 57 F.3d 1129, 1132 (D.C. Cir. 1995).
[26] *Shands Jacksonville Med. Ctr. v. Burwell*, 139 F. Supp. 3d 240, 262 (D.D.C. 2015).
[27] 88 Fed. Reg. 27983-84.
[28] *Id*. at 27984.

Instead, CMS cites to a few examples where states have voluntarily established minimums for payments authorized under their HCBS programs. However, as mentioned above, the examples CMS cites are not at all analogous to the proposal, calling into question their usefulness in terms of allowing stakeholders to evaluate the proposal's impact. For example, CMS cites to state activities to enhance, expand, or strengthen HCBS under section 9817 of the American Rescue Plan Act ("ARPA").[29] However, this example is not analogous to CMS's proposal, because ARPA section 9817 provided states with additional funds that states then used to *increase their payment rates* to HCBS providers, with the condition that HCBS providers allocate a certain percentage of the increase to the direct care worker providing the service. Here, CMS is not proposing to implement any sort of corresponding mechanism to ensure that states will increase their reimbursement rates along with the 80/20 policy.

Furthermore, CMS also cites to a Minnesota law requiring a minimum percentage of revenue generated by the state's Medicaid payment for its "Community First Services and Supports" (CFSS) program be allocated to support worker wages and benefits.[30] However, the 72.5 percent requirement is less stringent than the 80 percent requirement being proposed by CMS (and below the range of "alternative options" CMS solicits comment on[31]), and the CFSS program has not yet been implemented in Minnesota.[32] The only other example cited by CMS comes from an Illinois requirement for providers participating in the state's Community Care Program to expend 77% of total revenues from the state's Medicaid payment on direct service worker costs.[33] However, Illinois' Community Care Program is narrower in scope than CMS's proposal, as it provides home-based services only to the state's senior population.[34] Furthermore, the state's view of "direct service worker costs" is broader than CMS's proposed definition of direct care worker "compensation", allowing for more costs, like transportation, to be included in the required percentage allocation.

It should also be noted that CMS does not include any analysis or discussion on the actual impact of these laws. CMS does not include any discussion on the impact of the Illinois law on direct care workforce participation, although the law has been in place for several years. Furthermore, there is not yet evidence of the impact of ARPA funds in this context, as many of these ARPA-specific programs are still ongoing. Nor is there evidence of the impact of the Minnesota law cited by CMS, *as it has not yet been implemented*. It will likely take several years to fully evaluate the impact of these laws on direct care workforce participation.

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[29] Pub. L. No. 117-2; see also Centers for Medicare & Medicaid Services, *Strengthening and Investing in Home and Community Based Services for Medicaid Beneficiaries: American Rescue Plan Act of 2021 Section 9817*, https://www.medicaid.gov/medicaid/home-community-based-services/guidance/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817/index.html.

[30] *See* Minn. Stat. § 256B.85, https://www.revisor.mn.gov/statutes/cite/256B.85/pdf.

[31] In the Proposed Rule, CMS "request[s] comment on the following options for the minimum percentage of payments that must be spent on compensation to direct care workers for homemaker services, home health aide services, and personal care services: (1) 75 percent; (2) 85 percent; and (3) 90 percent." 88 Fed. Reg. at 27984.

[32] Minnesota Department of Human Services, *Community First Services and Supports*, https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/cfss.jsp.

[33] 89 Ill. Adm. Code 240.2040.

[34] Illinois Department on Aging, *Community Care Program*, https://ilaging.illinois.gov/programs/ccp.html.

IV. Conclusion

In sum, we believe there are several colorable arguments against CMS's proposal. In particular, we believe there is an argument that CMS's proposal may be contrary to law pursuant to the *Chevron* standard of statutory interpretation and agency deference, as well as the arbitrary and capricious standard. We also believe there is an argument that, if finalized, CMS's proposal could be found to have violated the Administrative Procedure Act's (APA's) notice and comment requirement by failing to provide stakeholders with the necessary data to adequately evaluate the impact of its proposal.