



July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically to <http://www.regulations.gov>

Re: CMS-2442-P. Medicaid Program; Ensuring Access to Medicaid Services

Dear Administrator Brooks-LaSure:

AARP, which advocates for the more than 100 million Americans age 50 and over, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on ensuring access to Medicaid services. AARP fights to help older Americans live independently in their homes where they want to be and supports the over 48 million family caregivers who enable them to do so. We believe that the rule's approach to expanding access to Medicaid funded home care or home- and community-based services (HCBS), improving their quality, and providing program input and transparency advances the goal of living at home by empowering older adults and people with disabilities, their family caregivers, and advocates with greater access to services and information.

We offer our comments below to address some of the questions posed, offering suggestions on selected aspects of the rule that we believe will assist in its successful implementation, support individuals receiving care at home and their family caregivers, and further the desired outcomes.

Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG)

AARP strongly supports proposals to facilitate engagement from enrollees with lived Medicaid experiences and their family caregivers, and we applaud the inclusion of a wide and diverse range of voices, including those from different geographical areas and those who are age 50 and over.

AARP supports the proposal to require states to establish a public Medicaid Advisory Committee (MAC) that must also have a dedicated Beneficiary Advisory Group (BAG), with BAG members on the overall MAC, and the requirement that the MAC and BAG would advise on matters of concern related to policy development and effective administration of the Medicaid program. The MAC and BAG provisions can also play an important role in giving individuals who have received or are receiving Medicaid long-term care services (including HCBS) and their family

caregivers a voice in policy development and effective administration of the Medicaid program, including home care. They will provide important insights to state agencies regarding current obstacles to accessing Medicaid HCBS programs and the program enhancements required.

It will be important for states to work with state stakeholders, including advocates for older adults, people with disabilities, and family caregivers. In the proposed rule, at least one of the MAC members must come from this category: (A) State or local consumer advocacy groups or other community-based organizations that represent the interests of, or provide direct service to, Medicaid beneficiaries. We suggest that CMS reword the regulatory text to ensure that a minimum number of state or local consumer advocacy groups are members of the MAC, including those that focus on long-term care (LTC)/long-term services and supports (LTSS). We appreciate the inclusion in the BAG membership of "...individuals with direct experience supporting Medicaid beneficiaries (family members or caregivers of those enrolled in Medicaid) ...", especially family caregivers of Medicaid beneficiaries.

AARP strongly supports increased consumer voices in a "comfortable, supportive, and trusting environment that facilitates beneficiaries' ability to speak freely on matters most important to them," both from Medicaid enrollees and their caregivers. We also support the proposal to continue to provide the State with discretion on how large the overall MAC and BAG should be. It is in this spirit that we question if 25 percent is enough of a makeup to ensure beneficiaries' voices are not drowned out or overruled, as proposed in § 431.12 (d)(1). We encourage CMS to consider increasing the makeup of the BAG members on the MAC. Further, we urge CMS to require public reporting on the feedback from the BAG/MAC and how it is being used to improve access to Medicaid services, especially HCBS.

The proposed rule states that CMS plans "to expound on best practices for engaging beneficiary participation in committees like the MAC in future guidance." We support the requirement for states to offer in-person and virtual attendance options to maximize member participation, and that at a minimum, states will need to provide a telephone dial-in option for MAC and BAG meetings.

In addition to the current provisions of the proposed rule, CMS may wish to consider making consumer advocate members of the MAC, or similarly qualified consumer advocates available to members of the BAG, to help provide technical assistance and support to navigate the complexities of federal and state policies and programs that are brought up during meetings. This would also provide an opportunity for Medicaid beneficiaries and their caregivers to express instances where they desired access to a care service but were not aware of its offering through the State plan. We also encourage CMS to consider the population and the diverse range of backgrounds, education levels, ages, mobility levels, experiences with public entities and abilities to engage, and to provide resources and technical assistance to help States convene these forums.

Person-Centered Planning Process

AARP supports the person-centered planning requirements in the proposed rule, including that the individual or their authorized representative (if applicable) will help guide the service

planning process, and that the service plan will be reviewed, and revised, as appropriate, based on the reassessment of functional need at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

We also appreciate the inclusion of reporting requirements on minimum performance at the state level. However, we urge CMS to set a 100 percent performance standard or compliance rate for completing a reassessment of functional need at least every 12 months and reviewing and revising, as appropriate, the person-centered service plan, based upon the reassessment of functional need, at least every 12 months for all individuals continuously enrolled in the waiver for at least 365 days. Such needs reassessments and service plan revisions are important to ensure that individuals receive their due process rights. We understand that there may be circumstances when the reassessment may not be possible, such as if an individual is in the hospital. A 100 percent threshold could be designed with an allowance for such factors and limited circumstances beyond the state's control. However, we believe that the proposed 10 percent blanket allowance for delayed or missed annual reassessments is unlikely to reflect the true number of appropriate annual review exceptions and will fail to hold states accountable for attaining a 100 percent compliance rate where possible. We believe that setting a 100% goal for annual service plan reviews, with exceptions available for appropriate beneficiary considerations outside of the state's control, is the best way to ensure that this foundational element of care is in place whenever possible and better serves the intent of the rule.

Regarding the rule's proposal to allow random sampling of beneficiaries to confirm compliance with the service plan review requirement, we are concerned that this approach adds complexity to reporting and requires statistical expertise to calculate correctly. AARP believes that deriving the report from all individuals continuously enrolled in the waiver program for 365 days will provide a more accurate compliance measurement and suggest that it should be the eventual standard, with an interim use of random sampling to allow any state system enhancements required for reporting derived from all qualified beneficiaries.

AARP urges that the requirement be implemented within the first year or so of the rule's effective date, as all beneficiaries should already have an up-to-date person-centered service plan. CMS should consider application of this provision to other Medicaid HCBS authorities.

Finally, in the context of beneficiary assessments and reassessments, AARP believes there is an important opportunity to strengthen support for family caregivers of those receiving Medicaid HCBS. Family caregivers play an essential role supporting loved ones and enabling them to live in their own homes, including providing an estimated \$600 billion in unpaid labor annually and saving taxpayer dollars. The 1915(i) Medicaid HCBS state plan option includes a provision at § 441.720(a)(4), "Include in the assessment the individual's physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service and housing options, and if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment." AARP urges CMS to modify this provision to read "..., and if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a culturally inclusive caregiver assessment." Making this modification would help ensure that family caregiver assessments better assess the needs, strengths, capacity, and family caregiving situation of all family caregivers to better target and provide or connect family

caregivers more efficiently and effectively with the supports that best meet their individual needs. This change is also consistent with the CMS focus on health equity. CMS should clarify that the caregiver assessment provision also applies to beneficiary reassessments, and not solely the initial enrollee needs assessment. Importantly, we also urge CMS to expand this modified culturally inclusive caregiver assessment provision to other Medicaid HCBS authorities. Ensuring the provision of family caregiver support (e.g., education, training, support groups, counseling, and respite) based on a caregiver assessment not only supports the family caregiver, but can also impact the outcomes, quality of care, and quality of life for the beneficiary.

Grievance System

AARP strongly supports the proposed rule's requirement that states establish a grievance system for fee-for-service (FFS) beneficiaries, their authorized representatives, or other individuals or entities to whom a beneficiary or authorized representative provides written consent to file a grievance on behalf of the beneficiary. We appreciate that these provisions would allow a beneficiary to provide written consent to a family caregiver to file a grievance on their behalf. We particularly applaud the proposed requirements in the rule for state assistance to file a grievance and expedited resolutions when there is a substantial risk that resolution within standard timeframes will adversely affect the beneficiary's health, safety, or welfare.

We recommend that CMS add a provision requiring states to issue an annual and publicly available report on the grievances received in the previous 12 months, categorized by issue, severity, and resolution or lack of resolution. The report should be presented in a format that protects the anonymity of the filer and beneficiary. Such a report would enhance transparency and could assist with quality improvement by providing states, providers, and consumer advocates with insight into grievance patterns and trends.

Incident Management System

AARP supports the rule's proposed incident management system, including requirements for the definition of a critical incident, mandatory provider reporting of critical incidents, use of other data sources to capture unreported critical incidents (including claims and fraud data), and the investigation and resolution of critical incidents. We believe that the already strong critical incident system proposal can be enhanced through the following additions and modifications:

1. Adding missed or delayed provision of services identified in the person-centered plan to the list of critical incidents that must be reported and resolved, whether or not they result in obvious or immediate harm. Missed or delayed services, especially a pattern of missed or delayed service appointments, can lead to poor outcomes.
2. Increasing the compliance standard for critical incident timeframes, resolution, and completion of required corrective actions from 90 percent to 100 percent. As with the service planning review standards discussed previously, we believe that for an issue of this importance to beneficiary outcomes, setting a 100 percent goal for compliance, together with an exception provision for appropriate beneficiary considerations or other circumstances outside of the state's control, is the best way to ensure that this important quality assurance function will be rigorously implemented.

3. Expand and amend the reporting provision to include that the required public report of critical incidents be from the last 12 months, be categorized by issue and, for those substantiated, by severity and resolution. The information reported should be presented in a format that protects the anonymity of the beneficiary and filer. We suggest that a separate section of the public report should provide information on substantiated critical incidents by provider, including the service provider's owner and the name that they are doing business under (i.e., doing business as (DBA) name).

HCBS Payment Adequacy

The proposed rule addresses the role of payment adequacy in accessing Medicaid services in two related areas. The first is the adequacy of state Medicaid rates to attract sufficient qualified providers to serve the needs of beneficiaries. The second is the adequacy of the compensation paid by Medicaid providers to direct care workers to attract and retain sufficient workers to meet the current and growing demand for HCBS. Both issues are important elements in enhancing access to HCBS and AARP supports the proposed rule's focus on them.

Provider Payment Adequacy

In addition to reporting requirements, the proposed rule requires that the state form and facilitate an interested parties' advisory group to advise the state on Medicaid provider rate adequacy every two years, including payments made to direct care workers under self-directed programs and agency directed HCBS. The rule requires that the recommendations of the interested parties' advisory group are made public and that the group include direct care workers, beneficiaries, authorized representatives of beneficiaries, and other interested parties (which may include beneficiary family members and advocacy organizations). The proposed rule also requires personal care, home health aide, and homemaker services provided by individual providers and providers employed by an agency be included in the payment rate disclosure requirements.

We believe that, collectively, the reporting, disclosure, transparency, and advisory group requirements will help provide critical rate and outcome information necessary to inform rates that are sufficient to enhance access to HCBS and help ensure a viable reasonable choice of services, settings, and providers. We believe that the provisions can be further enhanced by specifying that qualified consumer advocates are required members of the interested party advisory group in order to assure that an expert technical assistance resource is available to inform group discussions. CMS may want to consider rate adjustments if the various measures of rate adequacy prescribed in the proposed rule indicate that they are below an acceptable threshold. Given the benefits of these provisions for assessing HCBS rate adequacy, we recommend that they be extended to all state Medicaid HCBS programs.

Direct Care Worker Payment Adequacy

AARP agrees with the proposed rule's focus on the direct care workforce (DCW) shortage as a key challenge to expanding access to HCBS as well as the rule's identification of uncompetitive compensation and job-related stress as major challenges for increased DCW recruitment and retention. The proposed rule addresses direct care worker compensation adequacy through a

provision requiring that at least 80% of all Medicaid payments for personal care, home health aide, and homemaker services must be spent on direct care worker compensation. This includes important services that help people live in their homes. The rule does not address how to mitigate job related stress on DCW retention. We encourage CMS to consider future opportunities to address this issue where possible and appropriate.

For the definition of compensation, we suggest that CMS also consider the transportation expenses/travel time that direct care workers often have as they are travelling to and from different clients and providing services to them. We strongly support the proposal's goal of raising direct care worker compensation to address equity and access goals. We encourage CMS to require staffing studies on a regular basis, such as every few years, to look at what wages are needed to be paid to attract sufficient workers to meet the aggregate needs of all HCBS beneficiaries. We also agree with the proposed rule's observation that, together with increasing the DCW, "the supply of HCBS providers has a direct and immediate impact on beneficiaries' ability to access high quality HCBS."

Assuming CMS adopts the minimum 80 percent or another percentage or amount of payments for specific services that must be spent on direct care worker compensation, CMS should include a mechanism to evaluate the impact of establishing that particular amount of compensation for the DCW. Collecting and evaluating data after implementation would help provide important information about how well the policy is working and if any adjustments are needed. Payments should provide for appropriate compensation of the workforce and help attract and retain HCBS providers needed to maintain and expand access to these critical services. It is also important to ensure accountability for use of public dollars and ensure that funding intended for DCW compensation is actually used for that purpose. Oversight and monitoring are important to ensure accountability. CMS may want to encourage or require states to conduct a rate study to identify an appropriate rate that supports a living wage for direct care workers and increases quality provider participation in Medicaid funded HCBS or home care, all to increase beneficiary access to these important services. The MAC and BAG could also provide feedback to inform such studies.

HCBS Quality Measure Set

AARP generally supports the proposed rule's requirement for state implementation and reporting on the standardized HCBS Quality Measure Set and related provisions. This includes CMS approved state quality improvement goal setting, the use of evidence-based measures, CMS and public reporting requirements, data stratification requirements, and updates to the quality measures with strong consumer, DCW, and provider input. We applaud this important advance in federal oversight of HCBS quality assurance, including standardized measures and web-based reporting that will allow beneficiaries, their family caregivers, and advocates to easily access, understand, and utilize the information. Data on the quality measures should be communicated in a consumer-friendly and easy-to-understand manner.

In § 441.312(f)(6) regarding the list of interested parties the Secretary must consult with on the HCBS Quality Measure Set, we urge CMS to amend it to read, "Consumers and national organizations representing older adults, children and adults with disabilities, individuals with

complex medical needs, and family caregivers.” This modified version includes family caregivers as an important stakeholder and user of quality measures. We also urge CMS moving forward to include measures regarding family caregiver experience of care, family caregiver assessment, and support for family caregivers in the HCBS Quality Measure Set.¹ We encourage CMS to require annual updates to and reporting of the HCBS quality measures in the future. Regarding stratification, and in particular, public reporting of stratified measures, we also refer you to [AARP’s recent comments](#) on the Medicare skilled nursing facility payment proposed rule.

Website Transparency

AARP strongly supports the proposed rule’s requirement for states to create an easily navigated, publicly accessible web page containing key access, quality, and payment adequacy reports required under the proposed rule. Easy access to this information will empower consumers, their family caregivers, and their advocates with valuable information for their personal service needs and policy advocacy. AARP’s only suggested addition to this provision of the rule is to clarify that the public, web-based reporting is required for all state plan and waiver service reports regarding access, quality, and payment adequacy produced under the requirements of the proposed rule (i.e., not limited to those in §441.311). This includes the public grievances data report recommended under our discussion of the grievance system and any potential rate setting study a state might conduct as mentioned in the HCBS Payment Adequacy section above.

Waiver Waiting Lists

AARP strongly supports the proposed rule’s requirement for states with waiver program waiting lists to annually report on how they maintain the waiting list. This report should include how many people are on the waiting list, the average length of time that people are on such list, initial screening practices, and rescreening frequency. This information is extremely valuable to beneficiaries and family caregivers seeking service options as well as to consumer advocates working to improve access. However, it is also important for consumers, family caregivers, and care recipients to understand what a waiting list means and does not mean. That context is also necessary to understand the information the proposed reporting requirements would provide. The lack of waiting lists and related data for the states and HCBS programs that do not maintain waiting lists also creates a gap in our understanding of need for these services.

There is also wide variation in how waiting lists are maintained, so the numbers may not fully or accurately represent the need for HCBS and are not comparable across states. Individuals may need services, but not appear on any waiting list. In some states, waiting lists for HCBS are created for individuals who have already been preliminarily screened or found to be eligible, while in others, they are more like interest lists and may include people who are not likely to qualify. Greater transparency on waiting lists is important. Greater standardization of relevant wait list variables or criteria, audits, and/or rescreening or reassessment might also inform who is on waiting lists, whether or not they need services, and may be helpful for CMS to consider. Individuals on waiting lists for waiver programs or services should not have to go into a nursing home to get the services they need and also potentially risk not getting out of one. CMS could

¹ See AARP’s [2020 comments](#) on the request for information on a recommended measure set for Medicaid-funded HCBS.

also consider adding a requirement for all state Medicaid HCBS programs with waiting lists to include screening, level of care, risk of institutionalization ranking, and related reporting provisions. This would help provide transparency where waiting lists exist now. As with all the reports required in the proposed rule, the waiting list reports should protect the identity of those enrolled.

Presumptive Eligibility

While presumptive eligibility for Medicaid HCBS is not addressed in the proposed rule, AARP believes it is worthy of CMS' consideration. Typical Medicaid application requirements and timelines limit access to HCBS due to the practical realities that individuals encounter assembling required documentation combined with state processing constraints, especially under stressful circumstances—an unexpected hospitalization or a rapid deterioration of health at home. In these situations, timely access to HCBS can mean the difference between someone remaining in their community or entering a nursing home, perhaps for the rest of their life.

Nursing facilities regularly admit and initiate services for someone after hospital discharge or from the community even while their Medicaid eligibility is evaluated. Presumptive eligibility for HCBS allows applicants to temporarily access HCBS when an urgent need arises and before the formal administrative process to determine Medicaid eligibility is completed. It is only currently available in a few states. AARP believes that adding financial incentives to the proposed rule to encourage states to implement presumptive eligibility programs for HCBS would be a strong complement to the other proposed access enhancements in the rule, potentially significantly increasing Medicaid access for the most at-risk HCBS applicants.

Financial incentives would help prioritize presumptive eligibility implementation, cover start-up costs, and overcome state concerns related to the financial risks perceived to be associated with the requirement that states repay the federal share of a state's Medicaid payments made during any incorrectly approved presumptive eligibility periods. While research has shown that HCBS presumptive eligibility programs have [low error rates](#), and that state costs associated with errors are likely offset by Medicaid cost savings associated with institutional diversions, the potential risk, combined with the resources required to start-up a program, have limited state take-up.

To promote HCBS access through the wide adoption of HCBS presumptive eligibility, AARP believes that federal incentives are needed to overcome perceived financial risks and start-up cost concerns. Federal incentives for state implementation might include grants to cover start-up costs, grants or waivers to cover any federal share of a state's Medicaid repayments required from the state due to incorrect presumptions as staff gain experience with the program, or on-going federal cost sharing at the federal financial participation (FFP) services rate once the program matures.

Federal Financial Participation

The proposed rule requires important new and enhanced state HCBS administrative and oversight activities. These activities will benefit individuals receiving Medicaid home care and federal oversight of Medicaid funded HCBS programs. Acknowledging the investments of states

to implement and sustain the proposed rule, we encourage CMS to explore opportunities for enhanced federal financial participation (FFP) or other federal approaches to assist states with implementation of the rule. If federal dollars can be provided to offset new state spending required by the rule, we recommend coupling those dollars with a maintenance of effort (MOE) requirement in the rule to be sure that the added federal funding achieves its goal of preventing service reductions.

Conclusion

AARP appreciates the opportunity to comment and your consideration of our feedback. Thank you again for this important work to advance access to and quality of care at home and in the community. Support for family caregivers in this proposed rule and more broadly is also important not only for the family caregiver, but also because it helps sustain them in their caregiving role and enable loved ones to remain in their homes. If you have any questions, please contact me or Rhonda Richards on our Government Affairs staff at r-richards@aarp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner", with a long horizontal flourish extending to the right.

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs