July 3, 2023
Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-0057-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: *Ensuring Access to Medicaid Services, CMS-2442-P*

Dear Administrator Brooks-LaSure:

The undersigned state associations of community providers submit comments in response to the proposed rule, *Ensuring Access to Medicaid Services*. We are grateful for CMS's actions to strengthen the equal access provision and acknowledgment of the dire direct support workforce crisis that threatens the sustainability of Medicaid Home and Community Based Services (HCBS). However, we are concerned that the proposed rule's provision to ensure payment adequacy does not effectively accomplish that, and could have the unintended consequences of diminishing, rather than strengthening, beneficiaries' access to critical home and community-based services.

Direct Support Workforce Crisis

The providers in our network provide critical services for individuals with intellectual and developmental disabilities (I/DD), which empower people to live full, independent lives in their communities. These long-term supports and services include support with skill development and community integration, from assistance with community integration to advanced job training and employment support. But the direct support workforce crisis is hindering the ability of providers to continue to provide these services.
This workforce crisis stems from decades of underinvestment in the HCBS program. Stagnant reimbursement rates and increasing costs of care delivery have left providers unable to offer wages that are competitive with those of hourly-wage industries, such as fast food, retail, and convenience stores. The COVID-19 pandemic exacerbated this crisis to levels that threaten the very existence of community-based services. In 2022, the American Network of Community Options and Resources surveyed its community-based provider network to measure the impact the workforce crisis has had on their ability to provide services. Data from this survey indicates that 83% of providers are turning away new referrals due to insufficient staffing, while 63% of providers have been forced to discontinue programs and services—a staggering 85.3% increase since the beginning of the pandemic.[1]

Payment Adequacy

[1] American Network of Community Options and Resources, *The State of America's Direct Support Workforce Crisis 2022* (Oct. 2022).

We appreciate CMS's recognition of the workforce crisis and the need to raise wages of direct care workers to strengthen access to services. However, the payment adequacy mandate in § 441.302(k)(3)(i) of the proposed rule does not adequately address the underlying issue of funding and rate inadequacy. Moreover, if the payment adequacy mandate were extended to include I/DD habilitation services, it could have the impact of restricting I/DD service providers and reducing access in an already fragile system of services.

The requirement for 80% of the payment rate to be allocated for compensation for direct care workers, while well-intentioned, could lead to devastating consequences for providers. In order to raise wages for workers, there must be commensurate increases in the rate at the state level to account for competitive wages. Without those rate increases, this policy will necessitate cuts from non-compensation expenses—cuts to programmatic and administrative expenses like investments in technology, training, and oversight of direct care staff. By mandating 80% of the rate shift to direct care compensation, this rule will force providers to cap all other costs of providing services at 20%. The broad range of programmatic expenses encompasses critical components of ensuring quality services like supervision, quality assurance, and clinical oversight, as well as essential everyday costs such as transportation, reporting, overtime, capital costs such as housing, vehicles, or home maintenance.

The result will be a reduction in the quality of services, and in some cases, such significant cuts to overhead costs as to force providers to close their operations. This is especially concerning for providers in rural areas or those running small businesses that are unable to shoulder the additional cuts. In fact, in a survey of providers ANCOR found that 35% worried the payment adequacy provision and resulting cuts alone would necessitate them closing services altogether. Such a result runs counter to the intent of the rule, which is meant to strengthen access to home and community-based services.

Because of the impact on providers and unintended consequences of reducing access to services, we ask that CMS remove the payment adequacy mandate and instead add language to require that states review their rates on a routine, specified basis and with opportunities for stakeholder input, to ensure that rates are sound and provide sufficient funding to support competitive wages.

Clarity in Implementation

If CMS were to finalize the payment adequacy provision in regulation, we also have concerns that the rule is unclear and would lead to confusion and inconsistency in implementation at the state level.

The proposed rule contains language requiring a minimum payment adequacy percentage for certain services—personal care services, home health aide services, and homemaking services—requiring states to ensure at least 80% of all payments for these services are spent on compensation. However, states do not consistently report service taxonomy within their waiver applications; often using nonspecific type-of-service codes or unique state-specific codes and classifications. This may make it difficult for states to clearly identify the impacted personal care, home health aide, and homemaking services against identified services with facility or other indirect costs such as adult day health, habilitation, and day treatment. This risks even broader devastation to an already fragile systems of care if the rule were to inconsistently be applied and inappropriately expanded into skill-building services focused on supporting individuals through community integration—a hallmark of habilitation services. As CMS recognized, habilitation services for people with intellectual and developmental disabilities should not be included in the payment adequacy

provision as currently drafted. The impact on these providers, and the people they support, could be devastating.

Conclusion

We appreciate that CMS is focused on ensuring greater access to home and community-based services and are grateful for the positive provisions in this rule such as additional requirements around rate transparency, reporting metrics on waiting lists, and improving grievance processes, and tracking critical incidences. We ask that CMS ensure the intent of this rule is not undermined by a payment adequacy provision that could result in additional restrictions or closures of services.

Sincerely,

Alabama Service Providers Association
Alaska Association on Developmental Disabilities
Alliance Colorado
Alliance for the Betterment of Citizens with Disabilities (New Jersey)
Arizona Association of Providers for People with Disabilities
Association of Developmental Disabilities Community Providers (New Mexico)
Association of Developmental Disabilities Providers (Massachusetts)
Association of Residential Resources in Minnesota
California Disability Services Association
Cerebral Palsy Associations of New York State
Community Residential Services Association (Washington)
Community Provider Association (Louisiana)
Community Providers Association of Oregon
Community Support Providers of South Dakota
Connecticut Community Nonprofit Alliance
DC Coalition of Disability Service Providers
Developmental Disabilities Provider Association (Arkansas)
Florida Association of Rehabilitation Facilities, Inc.
Illinois Association of Rehabilitation Facilities
Indiana Association of Rehabilitation Facilities
Institute on Public Policy for People with Disabilities (Illinois)
InterAgency Council of Developmental Disabilities Agencies, Inc. (New York)
InterHab, Inc. (Kansas)
Iowa Association of Community Providers
Kentucky Association of Private Providers
Maine Association for Community Service Providers
Maryland Association of Community Services
Michigan Assisted Living Association
Minnesota Organization for Habilitation and Rehabilitation
Missouri Association of Rehabilitation Facilities
Nebraska Association of Service Providers
New Jersey Association of Community Providers, Inc.
New York Alliance for Inclusion and Innovation
North Carolina Providers Council

North Dakota Association of Community Providers
Ohio Health Care Association
Ohio Provider Resource Association
Oklahoma Community-Based Providers, Inc.
Oregon Resource Association
PAR (Pennsylvania)
Private Providers Association of Texas
Provider Alliance for Community Services of Pennsylvania
Provider Alliance for Community Services of Texas
Rehabilitation and Community Providers Association (Pennsylvania)
Service Providers Association for Developmental Disabilities (Georgia)
State of Nevada Association of Providers
Tennessee Community Organizations
Utah Association of Community Services
Vermont Care Partners
Virginia Network of Private Providers, Inc.