

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

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Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard,  
Baltimore, MD 21244-1850

*Submitted via regulations.gov*

## **RE: Medicaid Program; Ensuring Access to Medicaid Services CMS-2442-P**

Justice in Aging appreciates the opportunity to comment on the Ensuring Access to Medicaid notice of proposed rulemaking (NPRM) issued by the Centers for Medicare & Medicaid Services (CMS). We strongly support many of CMS's proposals in this NPRM to improve access to Medicaid home- and community-based services (HCBS) and other services that low-income older adults rely on.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable healthcare, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on populations who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency.

### Introduction

Ensuring strong implementation of Medicaid's equal access requirements in fee-for-service (FFS) is especially important to older adults who are dually eligible for Medicare and Medicaid. While Medicaid managed care is growing, older adults and people with complex needs, such as a reliance on long-term services and supports (LTSS), are the primary populations who remain in FFS. Section 1932(a) of the Social Security Act excludes specific populations, including Medicare enrollees and American Indians and Alaska Natives, from mandatory enrollment in managed care.<sup>1</sup> States also have the flexibility to exclude populations who will not be well served by managed care from mandatory enrollment. For example, in California, many individuals who have complex medical conditions are not required to enroll in a managed care plan if their doctor is not contracted with the health plan and the doctor cannot be changed without risking their health.<sup>2</sup> Many states also carve out critical services like LTSS, behavioral health, substance abuse, and dental from managed care and use FFS to provide these benefits to some or all Medicaid enrollees.

HCBS, a major focus of this rulemaking, are also extremely important for low-income older adults. Over one-third of adults age 65 and older have some form of disability,<sup>3</sup> and many need assistance with daily activities such as bathing, eating, toileting, housework, medication management, financial management,

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<sup>1</sup> 42 USC § 1396u-2(a)(2)(B).

<sup>2</sup> 22 CCR § 53887.

<sup>3</sup> ACL, 2019 Profile of Older Americans, at 19 (May 2020), [acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2019ProfileOlderAmericans508.pdf](https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2019ProfileOlderAmericans508.pdf).



and grocery shopping. Of people who are dually eligible for Medicare and Medicaid, 63 percent have three or more chronic conditions and nearly half require assistance with daily activities of living.<sup>4</sup> The dual-eligible population is also diverse: nearly half are people of color, 20 percent were born outside the United States, and 13 percent have limited English proficiency.<sup>5</sup> Thus, access to high-quality, person-centered HCBS is essential to their health and wellbeing.

Our comments focus on how the proposals in this rule will impact older adults and people dually eligible for Medicare and Medicaid. We draw on our expertise and extensive experience with HCBS and other Medicaid services in California and across the country. CMS is rightly focused on advancing equity and improving outcomes and should aim to build robust systems to measure and address disparities from the outset. In addition to supporting the goals and proposed initiatives, we offer recommendations for further improvements.

### ***Other Areas for Rulemaking Consideration***

In the preamble, CMS requests comment on other areas it should consider for rulemaking regarding HCBS access. Throughout our comments, we recommend further actions CMS can take to reduce the institutional bias and improve equitable access to HCBS and Medicaid more broadly both within this rulemaking and in the future. For example, we recommend CMS establish a national HCBS ombuds program. Ombuds are a successful component of many Medicare and Medicaid programs, including residential long-term care. Older adults and people with disabilities living in the community would benefit from a dedicated and well-resourced HCBS ombuds program to provide education, representation, and advocacy support on par with the ombuds support currently available to long-term care facility residents. In addition to strengthening the newly proposed grievance system as discussed below, an ombuds would strengthen HCBS Settings Rule oversight and provide another source of information for CMS, states, and other policymakers to identify and address issues more promptly.

An access barrier that is not addressed in this rulemaking is Medicaid estate recovery. As Justice in Aging and partners explained in an issue brief, this policy perpetuates intergenerational poverty and provides little if any financial benefit to states.<sup>6</sup> The mere existence of this discriminatory policy leads some older adults to forgo or delay needed LTSS because they do not want their loved ones to lose valuable family assets through estate recovery. While statute requires states to pursue estate recovery in certain instances, many states' policies go beyond what is required. We recommend CMS limit the harm of estate recovery by setting minimum standards for hardship waivers, as MACPAC recommends,<sup>7</sup> and implementing other reforms.

#### **A. Medicaid Advisory Committee and Beneficiary Advisory Group (§ 431.12)**

Justice in Aging supports the proposals to create a new Beneficiary Advisory Group (BAG) and to strengthen the role of the Medicaid Advisory Committee (formerly the MCAC). We strongly support the goal of the proposal to ensure the state is receiving input from enrollees and other key stakeholders not

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<sup>4</sup> KFF, [A Profile of Medicare-Medicaid Enrollees \(Dual Eligibles\)](#), 2023.

<sup>5</sup> DHCS, [Cultural and Linguistic Demographics of the California Medicare Population](#), 2023.

<sup>6</sup> Justice in Aging et al, [Medicaid Estate Claims: Perpetuating Poverty and Inequality for Minimal Return](#) (Apr 2021).

<sup>7</sup> MACPAC, Chapter 3: Medicaid Estate Recovery: Improving Policy and Promoting Equity (Mar. 2021), [www.macpac.gov/wp-content/uploads/2021/03/Chapter-3-Medicaid-Estate-Recovery-Improving-Policy-and-Promoting-Equity.pdf](http://www.macpac.gov/wp-content/uploads/2021/03/Chapter-3-Medicaid-Estate-Recovery-Improving-Policy-and-Promoting-Equity.pdf).

only on covered medical services, but also on policies relating to meaningful access to both medical and health-related social needs such as eligibility and enrollment processes, communications, grievances, and quality of care.

We strongly support requiring states to have BAGs composed of individuals with lived experience (enrollees) and Medicaid enrollee representatives (family/caregivers). Information on lived experience is crucial to state Medicaid agencies effectively developing policies and administering the Medicaid program. The BAG will be a valuable resource to provide direct feedback both to the broader MAC and to the state.

The NPRM requires that BAG members be past/present enrollees and/or family/caregivers, but it does not further outline membership requirements. This could lead to some BAGs not being representative of the state's Medicaid populations, interests, demographics, and needs. For example, under the current proposal, a BAG could be composed entirely of members representing children and non-disabled adults and not represent the needs and experiences of older adults and people with disabilities who rely on LTSS. As another example, a BAG that does not include tribal members or people with limited English proficiency would be missing unique perspectives on access. Therefore, **we recommend that CMS require states to: (1) ensure the BAG membership represents all populations served (including people dually eligible for Medicare and Medicaid and people who use LTSS); and (2) consider the demographics of the Medicaid population in their State (including geography, race/ethnicity, tribal membership, and limited English proficiency).**

The NPRM proposed more specific requirements for the MAC membership and asks whether the percentage of MAC members who are also BAG members should be higher than 25%. We do not believe that 25% will ensure equitable representation, as CMS suggests. Given that CMS is not mandating a specific size for the MACs, 25% could mean BAG members are either few in number (limiting how well they represent all enrollees) or not be as influential in a larger group with many perspectives. **Justice in Aging recommends that CMS require BAG members to comprise at least 50% of the MAC membership.** Existing advisory committee models, such as the implementation council for the Massachusetts One Care Medicaid-Medicare integration demonstration and the state developmental disabilities councils, have been successful because they require the majority of members to be people with lived experience and/or program enrollees. This disrupts inherent power imbalances and ensures that the people impacted by the policies and programs are centered in decision-making. In any case, we recommend increasing the percentage to at least 30%, to ensure there is at least one additional person with lived experience regardless of the group size and that BAG members would constitute a plurality in regards to the four categories of required representation for voting members.

With respect to clinical provider representation, we suggest requiring multiple perspectives to include not only medical providers, but also LTSS and others addressing social determinants of health. We also recommend that CMS explicitly require states to meaningfully engage native communities (including meeting tribal consultation obligations) in the MACs.

**To improve meaningful participation by people with lived experience, we recommend the following:**

- Require states to compensate all BAG members for their expertise and time (in addition to providing other financial support necessary to ensure meaningful participation).

- Require states to provide an option for MAC and BAG members to participate by video, in addition to by telephone. We also recommend requiring an online option for members of the public, as some people may have access to the internet but not a phone and vice versa.
- We appreciate that § 431.12(f)(7) requires states to *ensure* MAC and BAG meetings are accessible to people with disabilities. We recommend revising the regulatory language to similarly “ensure” meaningful language access for members with limited English proficiency, as opposed to requiring “reasonable steps.”

Finally, we agree with the proposed one-year implementation timeline. These advisory committees, along with the interested party advisory group discussed later in this comment, will provide very valuable feedback and contributions to Medicaid policy and should not be delayed.

## B. Home and Community-Based Services (HCBS)

As a threshold matter, we recommend CMS expand the scope of these proposals to include state plan HCBS under § 1905(a). These services are common: 37 states offer personal care as a state plan benefit, covering more than 1.2 million people.<sup>8</sup> Another 734,500 people receive mandatory home health services. Some states also provide case management, rehabilitative services, private duty nursing, and other HCBS through their state plans. In total, of the 5.8 million people receiving HCBS in 2020<sup>9</sup>, about 1 in 3 received services through a 1905(a) state plan benefit. We do not see any reason that states cannot or should not be required to apply the relevant provisions of this rule to these sizable populations. The benefit of including all HCBS participants and programs outweighs the burden on states.

Excluding these services from the important quality and access improvements this rule aims to achieve would be inequitable to the people receiving state plan HCBS. State HCBS programs are complex to navigate and generally the individual cannot choose to receive personal care via a waiver versus the state plan, nor should they have to. For example, 46% of California’s In-Home Supportive Services (IHSS) recipients receive IHSS through the state plan option –approximately 271,000 older adults and people with disabilities. The other 54% receive IHSS through the Community First Choice Option.<sup>10</sup> But the enrollee knows no difference. Moreover, not ensuring quality access to these services across authorities could disproportionately harm people who do not have family caregivers, such as older women of color and LGBTQ+ older adults, because they are more likely to rely on personal care services. They and all HCBS participants should receive timely, culturally responsive person-centered care planning, and be able to file a grievance, no matter which HCBS program they are enrolled in.

### 1. Person-Centered Service Plans (42 CFR 441.301(c))

Justice in Aging supports the new, higher minimum threshold of 90% for states to assure that functional needs assessments are conducted at least annually and that person-centered service plans (PCSP) are adjusted accordingly. However, the proposed language as currently written suggests that states will only need to conduct annual assessments for 90% of beneficiaries. CMS should emphasize that states are

<sup>8</sup> KFF, Medicaid Home & Community-Based Services: People Served and Spending During COVID-19, [www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief/](http://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief/).

<sup>9</sup> KFF, 10 Things About Long-Term Services and Supports (LTSS) (Sep. 15, 2022), [www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/](http://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/).

<sup>10</sup> Cal. Dept. of Social Svcs., IHSS Program Data (May 2023), <https://www.cdss.ca.gov/inforesources/ihss/program-data>.

required to conduct functional assessments and service plan adjustments *for every participant* at least every twelve months, or at the individual's request, in accordance with 42 CFR § 441.301(c)(3) and that the 90% threshold does not supersede that requirement.

We also stress that 90% should be an absolute minimum threshold. As CMS notes, enrollees frequently experience fluctuations relating to their disability. Updated service plans based on functional assessments ensure individuals' unique needs are continuously met, which in turn reduces the likelihood of institutionalization.<sup>11</sup> We support CMS's decision not to allow good cause exceptions to the 90% threshold. We agree the 90% threshold provides enough flexibility to address factors outside the state's control. Further, states can utilize emergency authorities, as they did during the COVID-19 public health emergency, if natural disasters or other emergencies prevent them from complying with the requirement.

We support the language clarifying that enrollees may not have an authorized representative and should lead their service planning process when possible.

While we support the proposed changes, they do not address all concerns around functional reassessments and person-centered service plans. Enrollees and advocates have expressed concern about functional reassessments. The process can be incredibly opaque and varies across programs and among beneficiaries.<sup>12</sup> While some degree of subjectivity is unavoidable, CMS and states must do more to ensure assessments are standardized and unbiased. The 90% threshold alone will not be helpful to HCBS participants without improved standards to ensure assessments are objective, unbiased, and fully address the individual's needs.<sup>13</sup>

The PCSP process can be dominated by a medicalized model that prioritizes medical services above beneficiaries' social and environmental needs.<sup>14</sup> In New Jersey, for example, advocates report that managed care LTSS (MLTSS) plans focused primarily on meeting medical needs rather than on assistance with activities of daily living, or meeting the participants' social and environmental needs. To rectify this, **we encourage CMS to expand the evaluative requirements of the PCSP beyond mere completion checks to adequately address the participant's goals and preferences.**<sup>15</sup> These requirements must

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<sup>11</sup> Administration for Community Living, "Promoting Community Living for Older Adults Who Need Long-Term Services and Support," (2016), <https://acl.gov/sites/default/files/triage/Issue-Brief-Promoting-Community-Living.pdf>.

<sup>12</sup> MACPAC, "Functional Assessments for Long-Term Services and Supports," (2016), <https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf>.

<sup>13</sup> See also Justice in Aging, "An Equity Framework for Evaluating California's Medi-Cal Home and Community-Based Services for Older Adults and People with Disabilities," (December 2022), <https://justiceinaging.org/wp-content/uploads/2022/12/An-Equity-Framework-for-Evaluating-CAs-HCBS-System.pdf>.

<sup>14</sup> See National Quality Forum, "Person-Centered Planning and Practice," (July 2020) identifies focus on "clinical terminology and diagnoses" as a barrier to person centered care planning and emphasizes need for assessments that support "open-ended feedback" during eligibility assessments and service planning.

<sup>15</sup> See Mathematica, "Assessment and Care Planning Measures," (2019) <https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-1-assessment-care-planning.pdf> at page 4 "most HCBS assessment and care planning measures evaluate compliance with federal rules that require such processes rather than the content of the assessments or the degree to which care plans reflect participants' goals and preferences."

encompass a thorough assessment of the plan’s content, ensuring its alignment with the HCBS Settings Rule and, more importantly, with the preferences and desires of the individuals themselves.

One opportunity is to strengthen cultural competency requirements in § 441.301. As the NPRM notes, PCSP is a critical tool for ensuring autonomy and input in how individuals’ own services are rendered, yet the existing rules only address materials and language services. As currently written, § 441.301(c) only requires the planning process to “reflect cultural considerations” and provide information in plain language in a manner accessible to people with disabilities and people with limited English proficiency. The regulation cites to 42 CFR § 435.905(b) which includes additional information regarding the communication of materials, including the use of auxiliary aids, translation services, and interpreters. At a minimum, **the proposed regulations should require that PCSP are completed in a culturally-competent manner that considers how the enrollee’s identity could impact how services are delivered.** For example, religious and cultural observances may affect how enrollees dress, how they interact with providers of the opposite sex, and how food is selected and prepared. As these considerations were recently included in the updated Surveyor’s guidelines<sup>16</sup> for long-term care facilities, we recommend including equivalent language with regards to PCSP for HCBS enrollees.

We support applying these changes consistently across FFS and managed care systems. Managed care in particular has been critiqued for being very opaque and inconsistent with assessments.<sup>17</sup> We have heard anecdotally about trends in managed care plans cutting authorized hours during reassessments. More rigorous enforcement of unbiased assessments, coupled with new access measures, will strengthen CMS’s oversight.

In terms of timing, **we propose 18 months for implementation.** Three years is unnecessary. Annual assessments and services plan adjustments have been required for nearly 10 years. This rule only slightly adjusts the monitoring and reporting system requirements from the 2014 guidance. Also, we see no need for delay related to the unwinding of Medicaid continuous coverage and the ending of the public health emergency (PHE). Assessments, both financial and functional, are already conducted by states as part of unwinding. Therefore, the impact of unwinding would be minimal with regard to monitoring and reporting compliance with assessments and service plan adjustments.

We support the application of the revised requirements to 1915(i), (j), and (k) programs to maintain consistency for HCBS beneficiaries. **We recommend CMS extend the proposed rules to 1905(a) state plan benefits and add requirements for annual functional needs reassessments and person-centered care plan adjustments to ensure consistency across all Medicaid programs.** As discussed above, it is inequitable to not apply the same quality and person-centered standards across all HCBS, even if it takes time for states to implement.

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<sup>16</sup> Guidance to 42 CFR 483.10(c)(3)(iii), F553, State Operations Manual, Appendix PP- Guidance to Surveyors for Long Term Care Facilities <https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf>.

<sup>17</sup> GAO, “CMS Should Take Additional Steps to Improve Assessments of Individuals’ Needs for Home- and Community- Based Services” (2017) available at <https://www.gao.gov/assets/gao-18-103.pdf>.

2. Grievance System (§§ 441.301(c)(7), 441.464(d)(2)(v), 441.555(b)(2)(iv), and 441.745(a)(1)(iii))

Justice in Aging appreciates the creation of a grievance system. All HCBS participants, including those in 1905(a) state plan services, need an effective mechanism to better ensure that participants' needs are met in compliance with relevant law. A grievance system complements other quality mechanisms — such as performance measures — because a grievance system can address problems as they happen, thus preventing harm before it can occur.

We note, however, multiple holes in the grievance system as it is described in the proposed regulations. The biggest weakness of the proposed grievance provisions is their limited scope: the proposed grievance system only applies to a relatively narrow list of legal protections, and the proposed regulations provide few tools to obtain adequate resolutions.

***Limited Aspects of Care Subject to Grievance Protections***

Regarding the relevant legal protections, a grievance is defined in the proposed regulations as related only to violations of §§ 441.301(c)(1) through (6). Accordingly, under the proposed regulations, HCBS participants would only have a grievance right in relation to person-centered planning (paragraphs (1)-(3)) and the HCBS settings requirement (paragraphs (4)-(6)).

The grievance provisions as drafted would offer no help to participants in many common and important situations. Consider the types of problems that a HCBS participant is likely to face. A provider might frequently not show up, or might arrive late or leave early. A care provider might handle a HCBS participant roughly, or fail to assist the participant with certain activities of daily living.

In a residential setting, likewise, many common problems would not be subject to grievance rights. For example, the facility staff might fail to assist the resident during the night, or be extremely slow in responding to requests for assistance. The staff might administer harmful antipsychotic medication, or provide such poor personal care services that a bed sore develops.

Notably, under the proposed regulations, the grievance process would allow for a grievance regarding the development of a service plan, but would have little to say regarding whether the service plan actually is honored. This is shortsighted. A service plan by itself does not benefit a participant — the real measure of an HCBS system issue is whether and how well services actually are provided.

We recommend that the regulatory language be rewritten to include a broader right to a grievance, including but not limited to person-centered service planning and the HCBS settings requirements. The grievance right should be expanded to protect participants' health, safety, and welfare. We note that Medicaid Act § 1915(c) refers to safeguards "to protect the health and welfare" of participants. Furthermore, existing regulations require that a State assure "that necessary safeguards have been taken to protect the health and welfare" of participants.<sup>18</sup> This includes "[a]dequate standards for all types of providers that provide services under the waiver" and "[a]ssurance that the standards of any State licensure or certification requirements are met for services."<sup>19</sup> Also, the proposed regulations themselves call for an expedited resolution if normal timelines would "adversely affect the beneficiary's

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<sup>18</sup> 42 CFR § 441.302(a).

<sup>19</sup> 42 CFR § 441.302(a)(1)-(2).

health, safety, or welfare.”<sup>20</sup> All of this existing law supports a grievance right that would include 1) service planning, 2) the HCBS settings requirements, and 3) participants’ health, safety, and welfare.

Expanding the reach of the grievance system is essential, because a grievance often would be the only mechanism available to a participant to protect them from harm. In the current federal model, to a significant extent, health and welfare only is protected through compilation of performance measures. But if HCBS are substandard, it is of little use to a participant that poor performance might be reflected in a performance measure that will be made available years in the future. The participant should be able to access a grievance process that is expansive and forceful enough to stop an injury before it occurs, rather than just documenting it after the participant has received poor care.

### ***Need Tools for Grievance to Compel Compliance by Providers***

Regarding tools for resolving grievances, the proposed regulations have little or nothing to say. This is a significant shortcoming. Given the great detail otherwise in the proposed grievance processes, it is telling that the regulations (and the accompanying Federal Register discussion) do not address how the process will ensure that the participant’s problem will be fixed. “Resolution” in this context is too broad a term because, without more detail, it suggests that a resolution could include a situation where ultimately a participant did not get the requested relief, and the provider continued in providing noncompliant and potentially harmful care.

The regulations should provide the State with more tools to ensure compliance by providers, including appropriate monetary and non-monetary penalties. Otherwise, the State may be put in a position where it finds that the provider is in the wrong, but with no ability to compel the provider to come into compliance. A “resolution” that leaves the participant in the lurch is an improper resolution and should be rejected by CMS.

### ***Other Provisions***

Regarding § 441.301(c)(7)(iii)(B)(2), the proposed regulations require reasonable assistance in filing a grievance. We appreciate this requirement but also contend that assistance with filing is necessary but not sufficient. An HCBS ombuds program could provide broader and more effective assistance. Also, we recommend that CMS set minimum criteria for the “reasonable assistance” in filing a grievance, including but not limited to someone available to meet with the participant in person.

Regarding § 441.301(c)(7)(iii)(B)(3), we believe that “punitive” may not be the best word to describe retaliatory conduct. We recommend a revision to say “retaliatory action” or “retaliatory or punitive action.” Also, we recommend addition of more specific provisions to protect against retaliatory action. Possibilities include a post-grievance follow-up with the participant and/or assessed penalties against a provider who has taken retaliatory action.

Regarding § 441.301(c)(7)(iii)(B)(4), we recommend that language be added to specify that no “magic language” is needed to initiate the grievance process. A demonstrated intent to obtain assistance with an HCBS-related problem should be enough.

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<sup>20</sup> 42 CFR § 441.301(c)(7)(iv)(B).



Section 441.301(c)(7)(iii)(B)(5) requires that a State provide a participant with required notices and information, including general information on grievance rights and how to file a grievance. We recommend that this be more specific. Absent more specificity, the participant probably would merely receive a page about the grievance rights in the initial papers when an application is approved. We propose requiring an explanation of grievance rights in any HCBS-related communication from the State to the participant, and incorporating an explanation of grievance rights into the service planning process. Explanation of grievance processes should include common examples, so that participants are better able to understand the potential utility of the process. Also, the grievance process should be set up with a “no wrong door” process so that (for example) a managed care plan receiving a grievance related to a FFS service would be responsible for forwarding the grievance to the appropriate entity.

We support the proposed language that the State must “ensure that such information is accessible for individuals with disabilities and individuals who are limited English proficient in accordance with § 435.905(b).” We recommend adding the Section 1557 nondiscrimination regulations here, as §§ 92.201 - 92.205 of the 2022 proposed rules would provide additional specificity to these accessibility requirements.

Proposed § 441.301(c)(7)(iii)(B)(6) obligates a State to “[r]eview any grievance resolution with which the beneficiary is dissatisfied.” We believe that “review” is too vague, as is “dissatisfied.” The regulations should specify that the reviewer be someone not involved in the original determination, and the participant should have a process to submit information as to why the original resolution was insufficient. Also, for the State’s benefit, the participant should be required to request review (or appeal) of the original resolution, rather than expecting the State to decide whether the participant is dissatisfied. The notice of the original resolution should inform the participant of this review process and how to initiate it.

Regarding § 441.301(c)(7)(iii)(C)(2), we recommend revision to require explicitly that acknowledgement of the receipt of a grievance be in writing.

Proposed § 441.301(c)(7)(iii)(C)(4) says: “The State must inform the beneficiary of the limited time available for this [submission of information by participant] sufficiently in advance of the resolution timeframe for grievances as specified in paragraphs (c)(7)(v)(B)(1) and (2) of this section.” We suggest deletion of the word “limited” —it is sufficient to say that there must be notice of the time available.

Regarding § 441.301(c)(7)(iii)(C)(5), since grievances are not eligibility appeals, there often will be a need for documents far beyond the participant’s “case file.” We recommend that the regulations require that the State obtain relevant files and other information held by the provider, and then provide that information to the participant. Particularly in cases involving residential providers, provider-maintained information will be relevant and often pivotal.

Regarding § 441.301(c)(7)(v)(B), justice delayed is justice denied. In other words, the grievance process will not be effective if it cannot address participants’ problems in a timely and effective manner. We believe that the proposed timelines of 90 days and 14 days are too long, and suggest that they be reduced by half, to 45 and 7 days, respectively. We also recommend that expedited procedures be extended to the managed care grievance procedures at subpart F of part 438.

We note that § 441.301(c)(7)(v)(A) requires that resolution occur “as expeditiously as the beneficiary's health, safety, and welfare requires, within State-established timeframes that may not exceed the timeframes specified in this section.” That goes partway towards addressing the problem noted in the previous paragraph — but only if there were a way for the state to meaningfully set different time limits depending on the seriousness of the situation. We recommend that the regulations be revised to require that the State solicit more information from participants on the how delay could hurt the participant.

Regarding the format for notifying a participant of a grievance resolution, proposed § 441.301(c)(7)(vi)(A) merely cites § 435.905(b), which only discusses plain language and LEP requirements. We believe this to be wholly insufficient, and recommend that the regulation be revised to require that the notice explain what the grievance is, the information considered, the necessary remedial actions (if any) for resolution, and the ability to request further review. Also, to ensure proper follow-up, we recommend that the regulations specify that grievances and their resolutions be reviewed at the subsequent person-centered planning process.

Under proposed § 441.301(c)(7)(vii)(B), the record of each grievance must include a general description of the reason for the grievance; the date received; the date of each review or, if applicable, review meeting; resolution of the grievance, as applicable; date of resolution, if applicable; and name of the participant for whom the grievance was filed. We recommend that, at a minimum, the regulation should also include all information considered.

These grievance protections will be vital to HCBS participants. We recommend that States be required to come into compliance within 18 months after the effective date of the regulations.

### 3. Incident Management System (§§ 441.302(a)(6), 441.464(e), 441.570(e), and 441.745(a)(1)(v))

Justice in Aging supports improvements to States’ incident management systems, but finds the proposed regulations not focused enough on protecting participants’ well-being. In general, the incident management systems as described in the proposed regulations seem to be unduly focused on *documenting* critical incidents rather than *protecting* HCBS participants who are suffering the consequences of these critical incidents. **The orientation of the regulations should be changed to increase the focus on immediately and concretely addressing situations where participants are suffering harm.** Accordingly, we recommend that proposed § 441.302(a)(6) be revised as follows:

“Assurance that the State operates and maintains an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. Resolution of critical incidents focuses on preventing harm to the participant(s) involved in the critical incident, and addressing provider’s policies and procedures to prevent harm to other participants, now and in the future.”

A related issue is the concept of “corrective action.” Section 441.302(a)(6)(ii) discusses the State’s requirement to comply with timeframes at least 90 percent of the time, and includes the requirement in § 441.302(a)(6)(ii)(C) that the State document that “corrective action” has been taken in a timely fashion in the situations in which corrective action is required. But nowhere in the proposed regulations is it recognized that the State might need to use tools to compel corrective action. The risk here is that it is too easy for a State to “comply” simply by categorizing many cases as not needing corrective action. In

this way, the timeframes might be honored, but only by ignoring a participant’s need for corrective action.

In many ways, this “corrective action” issue, i.e., “resolution” issue, is one of the most important areas in which the proposed regulations fall short. **We recommend that the proposed regulations be revised to ensure that a State has the tools necessary to obtain relief against a noncompliant and potentially recalcitrant provider. We also recommend that the regulations be revised to ensure that a State honestly identify those situations in which corrective action is required.** One good option would be a presumption that corrective action is required, subject to a State’s documentation that there is no useful corrective action to be taken. In these determinations, “corrective action” should be understood broadly, so that a State could require “corrective action” to change a provider’s policy or procedures even though a particular participant may have suffered harm that cannot be erased. Also, consideration of whether corrective action is feasible should assume a willing and competent provider; it would be a perverse result if an uncooperative or incompetent provider could, through its own uncooperativeness or incompetence, avoid a requirement to correct a situation. Consistent with these comments, we recommend this potential language, to be included among the characteristics of an incident management system in § 441.302(a)(6)(i): “The State must: ... Ensure that corrective action is taken as necessary to protect participants’ health and welfare. There shall be a presumption that corrective action is required, subject to documentation that no corrective action is possible. ‘Corrective action’ shall be understood to include not only corrective action to benefit the participant(s) immediately involved, but also corrective action to benefit other participants, now or in the future. Also, the determination of whether corrective action is “possible” shall be made with the assumption of a willing and competent provider, because the consideration of corrective action should not be limited by a specific provider’s uncooperativeness or lack of competence.”

Proposed § 441.302(a)(6)(i)(A) sets forth six minimum situations that must be treated by States as critical incidents. **We recommend that these be revised to include situations of “Physical or emotional harm suffered by participant.”** Under the proposed regulations, this type of harm is not adequately covered, unless the conduct can be classified as physical abuse or neglect, or the participant has died. Otherwise, a definition might not include such critical incidents as (for example) a participant suffering a fall and broken bone due to substandard attention, or an individual provider berating and swearing at a participant.

For similar reasons, **“neglect” should be explicitly defined to ensure that its reach is adequately broad.** “Neglect” is defined in § 483.5 (related to nursing facilities) as “the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.” In the HCBS context, this definition could be adapted so that “neglect” would mean “the service provider’s failure to provide goods or services to a participant that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.”

Proposed § 441.302(a)(6)(i)(C) requires providers to report critical incidents that occur “during the delivery of services authorized under section 1915(c) of the Act and as specified in the waiver participant’s person-centered service plan.” We suggest that this is too narrow, because it invites hyper-technical arguments by providers that, although the critical incident occurred while the service provider was present, it did not occur during services authorized by federal law or the service plan. It would be better to **refer to critical incidents occurring “during delivery of service by the HCBS service provider.”**

(This same comment and proposed revision apply to similar language in proposed §§ 441.302(a)(6)(i)(C) and (D).) This recommended language would be important if, for example, a provider was not authorized to drive the participant somewhere, or to help the participant get on or off the toilet. If an accident were to happen during such unauthorized services, the incident would be during delivery of service but not delivery of HCBS authorized services. The recommended revision appropriately includes such situations as “critical incidents.”

Proposed § 441.302(a)(6)(i)(B) lists minimal requirements for an “information system.” These requirements should include the ability to identify the critical incident by provider. This ability is essential to judging provider competence and identifying appropriate remedial and punitive measures, all with the goal of preventing harm. **We recommend the following additions to the required capabilities of the information system:**

“Enables tracking of critical incident by provider. Enables tracking of critical incident by whether corrective action was needed, whether corrective action was performed, and whether any corrective action addressed a participant’s immediate needs, participants’ future needs, or both. Enables tracking of the type of injury caused or threatened by the critical incident.”

Proposed §§ 441.302(a)(6)(i)(C) and (D) call for critical incidents to be identified by provider self-reporting, claims data, Medicaid fraud control unit data, and data from Adult Protective Services (APS) and similar agencies. We suggest that this requirement is off-target regarding the specified data sources. No monitoring system should depend so heavily on self-reporting. Claims data (generally information about payments made) is unlikely to reveal critical incidents. Also, APS is infrequently involved in these types of situations, and most of this reporting in any case would be much too late to protect the participant involved. **We recommend that grievances and the grievance resolution process be integrated with the critical incident system.** Grievances are likely to be made 1) while the contested action (or inaction) is occurring and 2) by participants or others who are independent of providers.

Proposed § 441.302(a)(6)(i)(E) refers to “critical incidents as defined in § 441.302(a)(6)(i)(A).” But § 441.302(a)(6)(i)(A) does not “define” critical incidents; rather, it lists certain situations that must be included by a State in its definition of “critical incident. **We recommend the following language for (a)(6)(i)(E): “critical incidents as defined by the State, including the critical incidents identified in section 441.302(a)(6)(i)(A).”**

Proposed § 441.302(a)(6)(i)(F) obligates the State to “Separately investigate critical incidents if the investigative agency fails to report the resolution of an investigation within State-specified timeframes.” But there is no similar provision for investigations that do not involve a separate State agency. (Proposed § 441.302(a)(6)(ii) is focused more on time requirements than the investigations themselves.) Also, investigations by other state agencies will not necessarily be focused on protecting the participant or on addressing any problem with HCBS services or the HCBS service provider. **We recommend the following new language for § 441.302(a)(6)(i)(F) to ensure that the system is not overly dependent on “other” investigations: “Investigate critical incidents in compliance with State-specified timeframes. If another State agency is involved in a related investigation, coordinate the investigations to the extent possible.”** (Note that we use the language “another State agency”; the reference to “the investigative agency” in the proposed regulation does not seem specific enough.)

In a related matter, **we recommend that CMS set minimum acceptable timeframes — this should not be left solely to a State.** And, like proposed regulations for a grievance system, the timeframes should set an accelerated schedule when a participant’s health is at risk. We suggest a 45-day window for investigations, and a 7-day window if (in language adapted from the proposed regulations on a grievance system) there “is a substantial risk that resolution within standard timeframes will adversely affect the participant’s health, safety, or welfare.”

4. HCBS Payment Adequacy (§§ 441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi)) Justice in Aging strongly supports CMS taking action in this NPRM to ensure that the direct care workforce who provide HCBS are paid a living wage. As CMS recognizes, the workforce shortage and instability directly contribute to gaps in HCBS access. Put another way, HCBS access cannot be expanded and equal access cannot be achieved without securing competitive compensation for direct care workers. We support both components of this proposed rule aimed to meet this goal: establishing an effective process that produces HCBS payment rates that include competitive, livable wages for direct care workers, and creating a payment pass-through mechanism and minimum federal standard to ensure the workers are actually paid those higher wages.

Given the importance of these actions to securing an adequate workforce and increasing access to HCBS, we strongly urge CMS not to extend the implementation timeline for this payment adequacy proposal beyond four years. As discussed under the payment rate transparency provisions below, the final rule would be strengthened by requiring states to establish the interested party advisory group within one year of the rule being finalized and begin the work to gather data on competitive wages and document payment rates right away. The advisory groups, the states, and CMS need this information to determine both adequate payment rates and competitive wages. Having the competitive wage amounts as targets and a full understanding of other costs that must be included in the payment rate will help ensure success of the pass-through mechanism.

**We support the proposal at § 441.302(k)(3)(i) to require that at the state level, a minimum percentage of all Medicaid payments for homemaker services, home health aide services, and personal care services be spent on direct care worker compensation.** A minimum percentage is a valuable tool to strengthen the rate adequacy provisions and achieve the goal of raising wages to a livable standard. We believe that 80 percent is a valid starting point—especially at the overall state level. Similar to CMS’s rationale for limiting this initial pass-through proposal to homemaker, home health aide and person care services given their relatively low indirect costs, we encourage CMS to consider other distinctions such as provider type and/or provider size, and whether the payments are going through managed care (which uses an 85% medical loss ratio standard).<sup>21</sup> Rather than further limit application of a pass-through, we recommend CMS consider varying the percentage by other factors such as delivery system, service type, provider type, and/or provider size. Some instances—e.g., self-directed services with particularly low indirect costs, or managed care systems and large agency providers with economies of scale—may call for a higher percentage.

We also recommend CMS emphasize the state itself is responsible for meeting this minimum percentage pass-through. CMS should work with states on implementing this requirement to minimize any undue burden on smaller providers to verify they are reaching 80 percent independently.

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<sup>21</sup> 42 CFR § 438.4(b)(9).

CMS asks for comment on whether minimum percentage pass-throughs should be required for other services, such as adult day and facility-based residential services, that have other indirect costs and facility costs. **Justice in Aging supports requiring minimum percentages for facility-based services and recommends requiring separate measurement and reporting from home-based services.** Although the indirect costs for facility-based services may be different than for home-based services, they are likely easier to identify and the types of costs are likely common across providers (e.g., all adult day programs have facility costs and food service costs). In addition, we think requiring at least 80 percent of payments for facility-based settings to go towards direct care worker compensation is appropriate. First, centralized service delivery sites, such as adult day and assisted living, may require fewer direct care workers to serve the same number of participants than for at-home service delivery. Second, with respect to facility-based residential services such as assisted living, as CMS notes, participants pay room and board that covers at least some of these costs. The remaining indirect costs are likely different and may even be less than for home-based services because there is no transportation to and from the service delivery site, and equipment could be utilized for multiple residents in the same day as opposed to needing equipment to be available at multiple service sites as once.

Justice in Aging recommends that CMS closely monitor the impact these pass-through provisions are having on HCBS access. During the first year the pass-through assurances are required, states should report to CMS at least quarterly on HCBS provider numbers, including whether the number of providers is increasing or decreasing in particular areas or for particular services or populations. States should also analyze the access reporting measures data (§ 441.311(d)), HCBS quality measures data (§ 441.312), and reports from the grievance and incidents systems (and HCBS ombuds if created) to look for disparities and changes in access to culturally and linguistically appropriate services.

### ***Definitions***

We support the proposed definition of compensation to focus on the direct financial benefit to the worker, as it is narrowly aimed to achieve the goal of securing competitive compensation. We also support the proposed broad definition of direct care worker, especially to allow for expansion of these proposals to other services. We recommend, however, that any analysis of payment or wage adequacy distinguish among the types of workers. For example, nurses are on a completely different compensation scale than home health aides or personal care attendants. To the extent a nurse is providing the same services as a home health aide, for example, not distinguishing between them would complicate the analysis of whether the pass-through is effective and potentially mask inadequate wages for lower-paid direct care workers. Further, while nursing services are very important for HCBS participants, they are distinct from the scope of personal care, home health, and homemaker services CMS is focused on in this rulemaking. We caution against melding the medical and non-medical services covered by HCBS.

#### **5. Supporting Documentation Required (§ 441.303(f)(6))**

Justice in Aging strongly supports the proposal to require states to report information about the size and processes for their 1915(c) waiver waiting lists. CMS states that one of its goals for waitlist reporting is to ensure states are enrolling individuals up to their approved waiver enrollment cap. We support this as a primary goal. For example, 3,600 older adults are on the waiting list for California's Assisted Living

Waiver even though the state added new 7,000 slots in 2022 and these slots are not filled.<sup>22</sup> We appreciate that CMS is proposing measures to ensure it can adequately monitor waiting lists and address such unauthorized waiting lists.

As of 2018, 42 states used 1915(c) waivers to serve older adults but only 16 of those states maintained waiting lists for those waivers.<sup>23</sup> We believe it is just as important to have public transparency about the waivers that do not have waiting lists as those that do. As explained in Justice in Aging's equity framework for analyzing HCBS, understanding how waiver programs are designed and administered is necessary to improve public transparency and help states identify and correct inequities.<sup>24</sup> To further the goals of increasing transparency around waiver eligibility and enrollment processes, **CMS should consider requiring states with capped enrollment waivers to maintain waiting lists of people already determined eligible.** Requiring states to determine an individual is eligible prior to placing them on the list would ensure these lists are most transparent so that applicants are not waiting for services they are not eligible for. At a minimum, we recommend CMS require states that have capped enrollment waivers without waiting lists to report on their process for accepting applications and processing enrollment when slots open.

Finally, we suggest CMS consider additional measures of and actions to address unmet need. Because HCBS are not mandatory and states are not required to maintain waiting lists for 1915(c) waivers, waiting lists represent only a fraction of unmet need. This is particularly true for older adults because, as mentioned, most states do not maintain waiting lists for waivers that serve them. Waiting lists also do not capture people with LTSS needs who do not know about HCBS programs in the first place. An article in Cal Matters shows how lack of information and public outreach about California's Assisted Living Waiver means fewer people know about it, and therefore fewer people are on the waiting list.<sup>25</sup> And even if a person knows HCBS exists, the complexity around the many different programs, each with names that often do not include Medicaid or HCBS and different eligibility criteria, acts as a barrier to application.

**To better assess and address unmet need, CMS should consider:**

- Analyzing Medicaid-funded nursing facility stays, including the number of people, length of stay, and demographic characteristics.
- Reporting on nursing facility transitions, including comprehensive reporting on Money Follows the Person (MFP) and broader data on how many people have expressed interest in leaving a facility compared to how many have been discharged with HCBS (either MFP or another program).<sup>26</sup>

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<sup>22</sup> Justice in Aging, California's Assisted Living Waiver: An Equity Analysis (March 2023), [justiceinaging.org/wp-content/uploads/2023/03/CAs-Assisted-Living-Waiver-An-Equity-Analysis.pdf](https://justiceinaging.org/wp-content/uploads/2023/03/CAs-Assisted-Living-Waiver-An-Equity-Analysis.pdf).

<sup>23</sup> Justice in Aging, Medicaid Home- and Community-Based Services for Older Adults with Disabilities: A Primer (Apr. 2021), [justiceinaging.org/wp-content/uploads/2021/04/HCBS-Primer.pdf](https://justiceinaging.org/wp-content/uploads/2021/04/HCBS-Primer.pdf).

<sup>24</sup> Justice in Aging, [An Equity Framework for Evaluating and Improving Medicaid Home and Community-Based Services](https://justiceinaging.org/wp-content/uploads/2023/06/An-Equity-Framework-for-Evaluating-and-Improving-Medicaid-Home-and-Community-Based-Services.pdf) (June 2023); see, e.g., [California's Assisted Living Waiver: An Equity Analysis](https://justiceinaging.org/wp-content/uploads/2023/03/CAs-Assisted-Living-Waiver-An-Equity-Analysis.pdf).

<sup>25</sup> CalMatters, 'Operating under water': Families trying to place loved ones in Medi-Cal assisted living program wait years (Sept. 7, 2022), [calmatters.org/health/2022/09/medi-cal-assisted-living/](https://calmatters.org/health/2022/09/medi-cal-assisted-living/).

<sup>26</sup> See, e.g., KanCare Program, Medicaid State Quality Strategy (Sept. 2014), at 112, [http://www.kancare.ks.gov/download/Attachment\\_J\\_State\\_Quality\\_Strategy.pdf](http://www.kancare.ks.gov/download/Attachment_J_State_Quality_Strategy.pdf).

- Requiring states to do more outreach on their HCBS programs and report to CMS on those efforts. This could be a tool for CMS to address “unauthorized” waiting lists.

#### 6. Reporting Requirements (§§ 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

We appreciate the more standardized and meaningful measures and reporting proposed in this NPRM. We emphasize, however, that reporting alone will not lead to better access or higher-quality care. CMS must hold states and managed care organizations accountable both for reporting and for taking action to address issues that the reporting reveals. We urge CMS to consider requiring states to submit implementation plans and to make those plans public. We also urge transparency in addressing noncompliance, so that stakeholders (both within the MACs and more broadly) can understand the implementation issues in their state and contribute to the resolution.

##### *a. Compliance Reporting*

##### **Critical Incidents**

Regarding § 441.311(b)(2), Justice in Aging recommends that critical incident reporting to CMS be revised significantly so that the reporting will facilitate improvements in participants’ health and welfare. In the proposed regulations, unfortunately, the focus is almost exclusively on timeliness: (i) timely initiation of investigations, (ii) timely resolutions, and (iii) timely corrective action. What is missing is a focus on what actually is happening in that State, based on reported critical incidents.

##### **We recommend the following additional items to be reported by States to CMS:**

“The number of critical incidents in each year, categorized by type of incident and extent of injury, whether corrective action was needed; whether corrective action was performed; whether any corrective action addressed the needs of current participants or future participants (or both); and whether corrective action adequately addressed participants’ needs.”

##### **Person-Centered Planning**

Regarding § 441.311(b)(3), we support requiring states to report annually to demonstrate that they are meeting the § 441.301(c)(3)(ii) requirements for PCSP. These metrics are the percentage of HCBS participants for whom a functional needs reassessment was completed within the past 12 months and the percent of participants who had a service plan updated as a result. **As states are required to complete assessments and PCSP updates for every HCBS participant annually, these metrics should be reported for all HCBS participants, not a sample as CMS proposes.** In fact, requiring states to sample would be more burdensome than simply requiring them to report on this data which they are obligated to track for all participants. Most importantly, for the reasons discussed above, enforcing the 90% compliance threshold for reassessments should be an absolute minimum. Random sampling would dilute the minimum compliance threshold and potentially mask whether states are actually meeting it.

In addition, **we recommend requiring states to report on additional metrics to improve transparency and oversight:**

- Both the number and percent of participants whose hours were reduced in the last 12 months.<sup>27</sup>

<sup>27</sup> See, e.g., Memorandum of Understanding Between CMS and Virginia Re Commonwealth Coordinate Care Financial Alignment Model, at 95, <https://www.cms.gov/medicare-medicare-coordination/medicare-and-medicare-coordination/medicare-medicare-coordination-office/downloads/vamou.pdf>.



- The median and average number of total hours authorized per participant and the median and average number of hours that changed over the last 12 months (whether an increase or decrease).

This information should be reported and analyzed by programs/populations, delivery systems, and demographics to identify disparities.

#### *b. Access Reporting*

Justice in Aging appreciates CMS introducing standardized reporting on HCBS access in this rulemaking. We agree that ensuring timely access to personal care, home health aide, and homemaker services is especially critical to the health and safety of older adults and people with disabilities and that annual reporting is necessary to effectively monitor access. People receiving HCBS may also have unmet needs and experience harm if their authorized service hours are not fulfilled. For example, data from California shows that from 2015 to 2019 the number of IHSS hours that were approved but ultimately not provided to IHSS users increased from 33,000 to 40,000 hours per month.<sup>28</sup> The proposed standardized, annual reporting will help CMS and states take targeted action to address such issues.

We strongly urge CMS to require access reporting for these services across all authorities, including 1905(a). While an initial focus on these services is appropriate, we recommend phasing in access reporting for other services, including facility-based services. In addition to assisting CMS with oversight and targeting technical assistance to state HCBS programs, effective access reporting is also an important tool for identifying and addressing disparities in access. Therefore, we ask that reporting on access measures include disaggregation by HCBS authority and population (including dual-eligibility), delivery system, provider type, and the same demographic characteristics as for the HCBS quality measures.

#### ***Waiting lists***

At § 441.311(d)(1), CMS is proposing to require states to report on how waiver waiting lists are maintained, the number of people on the waiting list, and the average amount of time an individual stays on the waiting list. We support requiring reporting on these elements on an annual basis. As discussed above, this information will greatly improve public transparency about waiver enrollment and be useful to individuals navigating the HCBS application and enrollment processes. We recommend these additional reporting requirements:

- Separate reporting for each waiver, including capped enrollment waivers without waiting lists (as discussed above).
- Collect and report on demographic information for each of the elements.
- Report on the number of people on the waiting list who are enrolled in Medicaid, and the number of those who are receiving other HCBS.<sup>29</sup>

<sup>28</sup> Justice in Aging, California's In-Home Supportive Services Program: An Equity Analysis (June 2023), [justiceinaging.org/wp-content/uploads/2023/06/CA-IHSS-Program-An-Equity-Analysis.pdf](https://justiceinaging.org/wp-content/uploads/2023/06/CA-IHSS-Program-An-Equity-Analysis.pdf).

<sup>29</sup> According to a MACPAC report on waitlist management, "Stakeholders noted that beneficiaries may get their LTSS needs met through state plan services or support from family caregivers while they wait for an HCBS waiver slot to become available. It is difficult to judge how many people on waiting lists are actually going without any HCBS because states do not track how individuals meet their care needs while waiting for waiver services." MACPAC, State Management of Home- and Community-Based Services Waiver Waiting Lists (Aug. 2020),

- Report on the number of people who drop off the waiting list but are not enrolled in the waiver, including numbers of those who enter institutional care and who die.

### ***Access to homemaker services, home health aide, and personal care***

At § 441.311(d)(2), CMS is proposing to require states to report on the average amount of time from when these services are initially approved to when services began and the percent of authorized hours that have been provided within the past 12 months. We support these measures with some recommended clarifications and additions.

First, as discussed previously, we recommend these measures apply to all HCBS, including 1905(a) services, and include demographic information. **We also recommend CMS require complete reporting, rather than allowing states to use a valid random sample.** Using a random sample can mask disparities. With respect to the timeliness reporting, states only have to report on new enrollees that year, lessening the burden. If CMS does permit a random sample, we recommend adding a requirement that the sample ensure the ability to look at disparities by race/ethnicity and population (older adults, people with I/DD, people with physical disabilities, etc.).

**Also, we recommend CMS require states to report on the time from application to assessment and approval.** Currently, many older adults do not have timely access to HCBS. HCBS needs can arise or increase suddenly. A person may experience a disabling medical event like a stroke, or their family caregiver may no longer be able to meet their needs at home (e.g., a spouse may die or a friend may move away). While it is important to measure and understand delays between service authorization and delivery, many people face significant wait times to get services authorized in the first place. For example, the slow processing of applications and assessments is a major reason why the new California Assisted Living Waiver slots have not been filled and the waiting list is not cleared. People with limited resources facing delays simply cannot afford to wait and are often forced to enter a nursing facility.

We also urge CMS to take action to address the barriers to timely access to HCBS. One barrier is Medicaid's coverage start date policy that is biased towards institutional services. The policy allows Medicaid coverage for nursing facility care to start from the first day of service, regardless of when a service plan is completed.<sup>30</sup> HCBS coverage, however, may not start until a service plan is finalized, which often takes months to complete. A potential solution is provisional plans of care discussed in Olmstead Letter #3.<sup>31</sup> As an initial step, **we recommend that CMS affirm that HCBS provisional plans of care are an available option in the preamble to the final access rule and require states to report on usage of such plans.** CMS should take additional steps to further amplify this guidance in

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[www.macpac.gov/wp-content/uploads/2020/08/State-Management-of-Home-and-Community-Based-Services-Waiver-Waiting-Lists.pdf](http://www.macpac.gov/wp-content/uploads/2020/08/State-Management-of-Home-and-Community-Based-Services-Waiver-Waiting-Lists.pdf).

<sup>30</sup> Justice in Aging, [Medicaid's Unfair Choice: Wait Months for In-Home Assistance—or Get Nursing Facility Coverage Today](#) (Sept. 2021).

<sup>31</sup> In [Olmstead Letter #3, Attachment 3-a](#), CMS explains that it “will accept as meeting the requirements of the law a provisional written plan of care which identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility, while a fuller plan of care is being developed and implemented.” During this time, the relevant agencies work with the beneficiary to develop and finalize a “comprehensive plan of care,” which goes into effect as soon as practically possible, and at least within 60 days.

communicating with states, including as part of technical assistance to address timely access issues identified by these new reporting requirements.

With respect to percent of authorized hours that are delivered, **we recommend that CMS clarify in the final rule that states cannot use information about unfilled hours to infer whether or not authorized services are necessary.** There are many reasons why authorized hours are not delivered that have no bearing on need for services. We suggest incorporating a method to capture data on why hours are not provided. CMS should analyze these reports to ensure states are not improperly reducing hours. This could also be a tool for CMS to monitor whether states are improperly compelling family members to provide unpaid assistance.<sup>32</sup>

Finally, **we recommend adding a measure comparing people who have been authorized to receive HCBS to people who actually received services.** Our analysis of California's IHSS program shows why this metric of actual users is important: in the 2021-2022 fiscal year, an average of 665,329 people were authorized to use IHSS, but only 586,627 actually received IHSS services.<sup>33</sup>

### *c. Payment Adequacy*

Justice in Aging supports the proposed reporting requirements for HCBS payment adequacy both for states to demonstrate they meet the § 441.302(k) compensation pass-through requirements and to bring transparency to HCBS payments overall. **We urge this reporting to be broadened to include all HCBS, including 1905(a) services, and all provider types and settings.** Rather than limit this reporting to homemaker, home health aide, and personal care services, we recommend CMS phase in reporting with priority towards these three services across all authorities. We also support adding reporting on median hourly wage and compensation as important to measuring whether the pass-through requirements are, in fact, increasing wages and compensation. To aid the interested party advisory committee's work on rate setting, **we recommend shortening the implementation date to two years for reporting on services that will be subject to the minimum percentage pass-through requirements.**

We also urge CMS to consider requiring states to report the breakdown of the remainder of the payments not going to compensation to improve understanding of other costs such as worker training, equipment, transportation, and administrative expenses. To improve transparency and usefulness of this information, we recommend that states report by additional criteria:

- Delivery system. Within managed care reporting, the data should be disaggregated for individuals dually enrolled in Medicare and Medicaid. Integrated care plans (such as dual-eligible special needs plans (D-SNPs)) are growing and it's important to understand the unique impact on HCBS payment adequacy.
- Program and population (including dual eligibility).
- Setting (at home, residential, facility-based day setting, etc.)
- Service provider type. In addition to reporting by agency vs. self-directed services, as CMS is proposing, it is useful to know if there are differences between assisted living facilities, small group homes, etc.

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<sup>32</sup> Justice in Aging, *Voluntary Means Voluntary: Coordinating Medicaid HCBS with Family Assistance* (May 2016), <http://justiceinaging.org/voluntary-means-voluntary-coordinating-medicaid-hcbs-with-family-assistance/>.

<sup>33</sup> California's In-Home Supportive Services Program: An Equity Analysis, *supra* note 28.

We understand that additional details require some additional work but, without this detail, CMS and states will not be able to identify and address disparities. As CMS notes, providers should be able to readily access much of this information. We believe it is important and more efficient to build the comprehensive reporting structure from the start.

7. Home and Community-Based Services (HCBS) Quality Measure Set  
(§§ 441.312, 441.474(c), 441.585(d), and 441.745(b)(1)(v))

Justice in Aging strongly supports the proposed quality measurement reforms outlined in this proposal, which are integral to advancing health equity among Medicaid enrollees and improving the overall efficiency of the Medicaid program. We also offer recommendations to prioritize equity throughout the development and implementation of HCBS Quality Measure Set and ensure the reporting is as useful in identifying and addressing issues. Our comments in this section address the proposed reporting provisions at § 441.311(c) as well.

***Developing and Updating the HCBS Quality Measure Set***

Justice in Aging supports the proposed collaboration between the Secretary and stakeholders to develop and update the HCBS Quality Measure Set. It is essential that “interested parties” described in § 441.312(g) possess a comprehensive understanding of HCBS and prioritize the perspectives of beneficiaries themselves, and advocates on behalf of older adults and people with disabilities. Their valuable perspectives will help ensure that selected measures are relevant, meaningful, and reflective of the needs and experiences of HCBS users. To enable meaningful participation from beneficiaries, CMS should ensure accessibility (e.g., plain language and translated materials).

Section 441.312(c)(2)(iv) requires that the Secretary ensure that measures “are meaningful for States.” **We recommend more specific criteria to ensure the measures are designed to help states identify problems and potential areas for improvement, and are actionable for subsequent policy changes.**

To prioritize equity in measure selection, we suggest adding “advances equity” as another evaluation category, in addition to prioritizing the “importance of measure” and “usability and use” criteria. Including equity as a selection criterion will force evaluators to consider how each measure evaluates and enable solutions to address disparities in the eligibility, authorization, and utilization of HCBS services. Centering equity in HCBS quality measure selection would also strengthen CMS’s approach to addressing disparities across the health care system and be consistent with the Medicare Advantage equity index, for example.

***Standardized Reporting of HCBS Quality Measures***

Justice in Aging supports requiring standardized reporting of HCBS Quality Measures. This information will advance the understanding of service quality, identify disparities in the quality of services, and equip states and CMS with information to deploy targeted strategies to meet the needs of older adults and people with disabilities. We agree that all states should be required to report the same quality measures to enable quality comparisons across states.

***Performance Targets and Quality Improvement Strategies***

We support establishing performance targets for reported measures to drive continuous improvement in service quality. We recommend CMS establish minimum performance targets for each mandatory

measure; states should be permitted to establish their own performance goals beyond the federal minimums, but standardized performance targets will ensure national quality standards. We encourage CMS to prioritize equity by establishing targets that reduce disparities. We discourage CMS from permitting a compliance threshold exempting states from developing improvement strategies, as all states should be held accountable for providing high-quality care to HCBS recipients.

### ***Disaggregating HCBS Quality Measures***

We recommend CMS establish minimum requirements for disaggregation by the delivery system, provider type, population, and demographic elements. Current data limitations inhibit a meaningful understanding of how well delivery models, such as MLTSS, meet recipients' needs. To identify disparities in HCBS delivery, **we recommend revising § 441.312(d)(5) to require states to disaggregate Quality Measures by HCBS delivery models**, including managed care, fee-for-service, and PACE, to identify the most effective, efficient, and impactful approaches to care delivery. To help states identify problems and make targeted improvements, **we also recommend requiring reporting by provider type--assisted living facility, personal care services agency, case management agency, self-directed care, etc.**

Specific to population type, **we recommend requiring disaggregation of by, at a minimum, older adults, people with physical disabilities, individuals with IDD, and those with serious mental illness.** While we strongly support including disaggregation of data for people dually eligible for Medicare and Medicaid in this analysis, we are unclear about the proposal to include partial duals, as they do not have access to HCBS or any other Medicaid benefits. If CMS does decide to include partial duals, this population group must be differentiated from full-benefit duals. Additionally, **we suggest stratifying for health conditions, specifically Alzheimer's disease and other dementias, as this population is particularly susceptible to institutionalization.**<sup>34</sup>

**We strongly encourage CMS to establish minimum demographic elements for stratification of all HCBS core measures (rather than a subset), including age, disability, race, ethnicity, Tribal status, primary language, sex characteristics, sexual orientation, gender identity, and rural/urban environment.** Recognizing the current quality limitations of the T-MSIS dataset, we support using imputed data to enable such analysis. That said, we strongly encourage CMS to simultaneously implement best practices to improve the self-reporting of demographic information<sup>35</sup> and hold states accountable for improving their T-MSIS data. **We also urge CMS to present this data in a manner that permits manipulation by intersectional identities, as a combination of demographic identities can compound inequities.**

While we acknowledge the need to provide states with sufficient time to update their data infrastructures to enable the stratification of HCBS Quality Measures, we are concerned that by the time the rule is finalized, it will be nearly a decade before states achieve 100% stratification of their Quality

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<sup>34</sup> At age 80, [75 percent of older adults](https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00548) with dementia and Alzheimer's are living in nursing homes compared to just 4% of the general population. Fifty-three percent of individuals 65 and over in a nursing facility have a diagnosis of Alzheimer's or dementia. Ne'eman *et al*, Nursing Home Residents Younger Than Age Sixty-Five Are Unique and Would Benefit from Targeted Policy Making, *Health Affairs* (Oct. 2022), [www.healthaffairs.org/doi/10.1377/hlthaff.2022.00548](https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00548).

<sup>35</sup> MACPAC, "Improving Medicaid Race and Ethnicity Data Collection and Reporting: Review of recommendation and draft chapter for March report," (2023), <https://www.macpac.gov/publication/medicaid-race-and-ethnicity-data-collection-and-reporting-review-of-draft-chapter-and-recommendations-for-the-march-report/>.

Measures. We suggest a four-year timeline for states to stratify their HCBS Quality Measures instead of seven, as discussed in the Consortium for Constituents with Disabilities comment letter.

#### 8. Website Transparency (§§ 441.313, 441.486, 441.595, and 441.750)

We support strengthening public transparency of Medicaid HCBS programs, including by requiring states and CMS to maintain websites with results of newly required HCBS reporting requirements. We disagree with the proposed provision to allow states to comply by merely linking to managed care organizations' (MCOs) and other entities' websites. This places the burden on consumers and the public to find and navigate the information in the way the particular MCO presents it. Rather, **the reported information should be accessible on multiple channels, including both the state's website and the MCO's website.** States should also be required to use various channels to disseminate this information, making it accessible from other places where the public learns about, applies, renews eligibility or otherwise engages with HCBS programs. The information on the state's and CMS's websites should also be searchable, at a minimum, by regions, managed care plan sponsors, waiver/population and provider type.

Simply requiring this reporting information to be posted for the public on websites is insufficient for oversight and accountability. Because of the digital divide and the labyrinth of HCBS programs, this information should be shared more directly with HCBS participants rather than putting the burden on them to find information on access, quality, and outcomes for the programs they participate in. **We recommend requiring MCOs and entities administering waivers to disclose results of the access and quality reporting to new applicants and to current enrollees on a yearly basis.**

Three years for implementation is a long time, considering that some of this data is already collected and is fundamental to service quality and participant safety. In the interest of transparency and accountability, we recommend requiring the webpages to be built and displaying all available § 441.311 reporting results within 18 months.

#### 9. Applicability of Proposed Requirements to Managed Care Delivery Systems

States are increasingly using managed care to deliver some or all of their LTSS. Therefore, we strongly support requiring MCOs to comply with website transparency, person centered plans, grievance procedures, assurances, payment adequacy, and reporting. We support the proposal to add a cross reference to the requirements in proposed § 438.72 to be explicit that States that include HCBS in their MCO, PIHP, or PAHP contracts must comply.

#### C. Documentation of Access to Care and Service Payment Rates (§ 447.203)

##### 1. Fully Fee-for-Service States

We support adopting timeliness standards for FFS that are the same as required in managed care. These standards should also apply to FFS services that are carved out from managed care. Many FFS benefits carved out of managed care are benefits that are particularly critical for older adults and people with disabilities including LTSS, behavioral health, and dental.

##### 2. Payment Rate Transparency (§ 447.203(b))

Justice in Aging supports the proposals to increase payment rate transparency as a means to ensuring payments are sufficient to ensure provider participation and availability across the state. As CMS notes, payment rates are a key driver of provider participation in Medicaid, and, in turn, a key driver of access.

With respect to § 447.203(b)(1), we support requiring states to publish Medicaid FFS payment rates on a public, accessible website in a manner that a member of the public can readily determine the amount that Medicaid would pay for a given service. We particularly support requiring identification of the amount for each component of bundled payments and showing varied payment rates for the same service by population, provider type, and geographical location, as applicable. Given that most states already publish some of their FFS rates, as CMS notes, we recommend an earlier implementation date of one year after the rule becomes effective (i.e., January 1, 2025 instead of 2026).

At § 447.203(b)(2) and (b)(3), CMS proposes to require states to develop and publish a comparative payment rate analysis for primary care, obstetrical and gynecological services, outpatient behavioral health services, and a payment rate disclosure for personal care, home health aide, and homemaker services. We support requiring comparative rate analyses and disclosures and urge CMS to add more services in the future.

We agree that Medicare payment rates can be a reliable benchmark. However, we urge CMS not to limit services subject to comparative analysis to those that Medicare covers. Medicare does not cover many services that older adults and people dually eligible need, including HCBS, dental, vision, and hearing. Thus, Medicaid is the primary payer and the only source of coverage for this population with low incomes. Inadequate payment and providers mean people dually eligible cannot access these critical services,<sup>36</sup> leading to worse health outcomes and unnecessary institutionalization.

For services that do not have a comparable Medicare FFS rate, comparison to private insurance rates could be useful. **We recommend CMS consider using Medicare Advantage (MA) as an alternative point of comparison for dental, vision, and hearing.**

For HCBS, we support the approach CMS is proposing to create the interested party advisory committee and process to review rate changes, as discussed below. We caution against using Medicare home health benefits as comparison given that these services are much more medicalized than Medicaid HCBS. A potential future source of comparison are MA supplemental benefits, which can cover services such as personal care, respite and other caregiver supports, and adult day. Currently, the data about who is receiving these benefits is far too limited and the availability of these benefits is too varied to be reliable. However, with the growth of MA plans offering these supplemental benefits, we urge CMS to collect data and consider it as a future source for analysis of HCBS rates.

To ease the burden on states, CMS should explore its authority to require payment rate disclosures, particularly for Medicare Advantage. For example, CMS could require Medicare Advantage plans to disclose payment rate data through their D-SNP contracts with states.

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<sup>36</sup> “In 2014, the average Medicaid fee-for-service reimbursement rate was 40.7 percent of commercial dental insurance charges for adult dental care services in states that provide at least limited adult dental benefits in their Medicaid program. The available evidence strongly suggests that increasing Medicaid reimbursement rates for dental care services, in conjunction with other reforms, increases provider participation and access to dental care for Medicaid enrollees.” AAPD, (Oct. 2014), A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services, [www.aapd.org/assets/1/7/PolicyCenter-TenYearAnalysisOct2014.pdf](http://www.aapd.org/assets/1/7/PolicyCenter-TenYearAnalysisOct2014.pdf). See also Milliman, Medicaid Adult Dental Reimbursement (May 2019), <https://assets.milliman.com/ektron/medicaid-adult-dental-reimbursement.pdf>.

### ***Interested Parties Advisory Group***

At § 447.203(b)(6), States are required to establish an interested parties advisory group to consult on HCBS payment rates. We support this proposal to bring people with lived experience to the decision-making table as a necessary step to both promoting transparency and determining adequate payment *and* wages for the HCBS direct care workforce. Requiring such advisory committees and structure around the HCBS rate setting process will build on the work that states started using with American Rescue Plan Act (ARPA) funds. However, to achieve the goal of ensuring access and adequate wages, **we recommend that CMS clarify and significantly strengthen the advisory group’s role.** Our specific recommendations are to *require* states to:

- Consult the advisory group prior to making any payment rate changes.
- Engage the advisory group in discussion before finalizing rate change proposals that do not adopt the advisory group’s recommendations.
- Provide a written explanation to both the advisory group and to CMS of how and why its proposed rates differ from the group’s recommendations.

**We also recommend that CMS provide more guidance to states on the types of data sources they should be using to arrive at HCBS payment rates.** For example, examining the payment rate for self-directed services could be a helpful starting point for states as those self-directed services tend to have less overhead and may be easier to analyze. CMS could provide data such as PHI’s competitive wage analysis<sup>37</sup> and Bureau of Labor Statistics data on wages for comparable jobs to help inform the rate setting process and reduce the burden on states. We also recommend that CMS share information and best practices across states about the many ARPA-funded initiatives to improve provider payment, such as rate increases (32 states), requirements for funds to be passed on to direct care workers (20 states), and conducting studies on new rate structures (23 states).<sup>38</sup>

We recommend that CMS clarify in the final rule that the advisory group is not to be subsumed in the MAC. The advisory group’s work is significant and important and therefore requires its own entity and focused meetings. Given the central role of HCBS participants and workers in the advisory group, we do support allowing overlap of MAC membership and advisory group membership. Encouraging states to include advisory group members in their MACs would help ensure that older adults and people with disabilities, including HCBS participants, are represented in the broader MAC work.

### ***Lesser-of Payment Policies***

For dually eligible Qualified Medicare Beneficiaries (QMBs), state Medicaid programs have an obligation to reimburse Medicare providers for deductibles and co-insurance after the Medicare program pays its share. States are permitted, however, to limit those payments to the lesser of the Medicaid rate for the service or the Medicare co-insurance amount. Forty-two states have adopted this “lesser-of” policy for physician services and are therefore only responsible for reimbursing Medicare providers up to the Medicaid rate.<sup>39</sup> Low Medicaid payment rates mean that Medicare providers often do not receive any

<sup>37</sup> PHI, [Competitive Disadvantage: Direct Care Wages are Lagging Behind](#) (2020).

<sup>38</sup> ADvancing States, ARPA HCBS spending plan analysis (2023), [www.advancingstates.org/sites/nasuad/files/u34188/3-28-2023](http://www.advancingstates.org/sites/nasuad/files/u34188/3-28-2023).

<sup>39</sup> Roberts, *et. al.*, New evidence of state variation in Medicaid payment policies for dual Medicare-Medicaid enrollees, *Health services research*, 55(5), 701–709, (2020), <https://doi.org/10.1111/1475-6773.13545>.



reimbursement from the state for the 20% Medicare coinsurance.<sup>40</sup> In other words, because of “lesser-of” payment policies, providers are often paid less per service to treat dually-eligible individuals than they would be paid to treat Medicare-only enrollees.<sup>41</sup>

The result is that many providers refuse to take dually-eligible individuals as patients, limiting access to care. A recent analysis from the Congressional Budget Office “found that lesser-of policies were associated with a 5 percent reduction in the number of new primary care visits and a 7 percent reduction in the likelihood of such visits among QMBs. Both the number and the likelihood of total and established patients’ primary care visits fell by about 3 percent.”<sup>42</sup>

The proposals in this rule to ensure adequate Medicaid payment rates that are more on par with Medicare rates will certainly help rectify this access issue. We urge CMS to work with states to eliminate their lesser-of policies and pay the full amount of Medicare cost-sharing.

### 3. State Analysis Procedures for Rate Reduction or Restructuring (§ 447.203(c))

We appreciate that CMS acknowledges the importance of strong administrative review of Medicaid payment rates to ensure adequate provider participation and enrollee access to care. As an example of where stronger CMS administrative review would have prevented a rate change and subsequent precipitous decline in access to care, we point to the 2021 lawsuit, *Brown v. Becerra*. This lawsuit arose out of California’s submission of a state plan amendment to reduce rates for periodontal treatment for residents of skilled nursing facilities and intermediate care facilities in California.<sup>43</sup> Specifically, California’s Medicaid agency reduced the amount of reimbursement for periodontal scaling and root planing by 58% for procedures performed specifically in nursing facility settings. In the 19-month period following implementation of this rate standard, there was an 88% decrease in periodontal scaling and root planing procedures performed and reimbursed in these settings.

In the decision to vacate California’s approved State Plan Amendment (SPA) effectuating the rate reductions, the Court found that despite the requirements for states to submit comparative data, CMS did not require this of California and therefore did not consider this data when making a decision to approve the SPA.<sup>44</sup> We are therefore encouraged that CMS has acknowledged in this rulemaking its important role to conduct administrative review of rate changes to ensure continued access.

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<sup>40</sup> CMS, “Access to Care Issues Among Qualified Medicare Beneficiaries (QMB),” (July 2015), [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-MedicaidCoordination/Medicare-Medicaid-CoordinationOffice/Downloads/Access\\_to\\_Care\\_Issues\\_Among\\_Qualified\\_Medicare\\_Beneficiaries.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-MedicaidCoordination/Medicare-Medicaid-CoordinationOffice/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf).

<sup>41</sup> Keohane & Hwang, Payment Policy and The Challenges Of Medicare And Medicaid Integration for Dual-Eligible Beneficiaries, *Health Affairs* (Oct. 20, 2022), [www.healthaffairs.org/doi/10.1377/hpb20220923.93608?utm\\_medium=email&utm\\_source=hasu&utm\\_campaign=policy+brief&vgo\\_ee=3yrLynNBmvg0cwRpX0ffrCIP%2B%2Fc0AXGNFO%2BmwxtReuQ%3D](https://www.healthaffairs.org/doi/10.1377/hpb20220923.93608?utm_medium=email&utm_source=hasu&utm_campaign=policy+brief&vgo_ee=3yrLynNBmvg0cwRpX0ffrCIP%2B%2Fc0AXGNFO%2BmwxtReuQ%3D).

<sup>42</sup> Congressional Budget Office, “Lesser-of” Payment Policies and the Use of Physicians’ Services Among Dual-Eligible Beneficiaries (Jan. 2023), <https://www.cbo.gov/system/files/2023-01/57843-Working-Paper-2023-01.pdf>.

<sup>43</sup> U.S. Dist. Ct., *Brown v. Azar*, Nov. 17, 2021, available at [https://www.aarp.org/content/dam/aarp/aarp\\_foundation/litigation/2021/brown-v-becerra-decision.pdf?eType=EmailBlastContent&eld=c599b33d-0522-4959-a8dd-bf31d8fb0a4d](https://www.aarp.org/content/dam/aarp/aarp_foundation/litigation/2021/brown-v-becerra-decision.pdf?eType=EmailBlastContent&eld=c599b33d-0522-4959-a8dd-bf31d8fb0a4d); See also, Amicus Curia Brief of Justice in Aging, et al., (Aug. 17, 2021), available at <https://justiceinaging.org/wp-content/uploads/2021/08/amicusBrownVAzar.pdf>.

<sup>44</sup> Id.

We also support the proposed changes to strengthen and clarify requirements for the analysis for reductions in rates or restructuring of provider payments outlined in § 447.203(c)(2). We, however, have concerns about comparing access solely to Medicare rates, as discussed previously.

### Conclusion

Thank you again for the opportunity to comment on this rulemaking. We appreciate CMS's thoughtful attention to ensuring equal access to Medicaid FFS benefits and HCBS broadly. These benefits and services are incredibly important to the low-income older adults we advocate for.

If any questions arise concerning this submission, please contact Natalie Kean, Director of Federal Health Advocacy, at [nkean@justiceinaging.org](mailto:nkean@justiceinaging.org).

Sincerely,



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