



This document is scheduled to be published in the Federal Register on 11/09/2016 and available online at <https://federalregister.gov/d/2016-27040>, and on [FDsys.gov](https://fdsys.gov)

CMS-2404-NC

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 440

[CMS-2404-NC]

RIN 0938-ZB33

Medicaid Program; Request for Information (RFI): Federal Government

Interventions to Ensure the Provision of Timely and Quality Home and Community Based Services

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for information.

SUMMARY: This request for information seeks information and data on additional reforms and policy options that we can consider to accelerate the provision of home and community-based services (HCBS) to Medicaid beneficiaries taking into account issues affecting beneficiary choice and control, program integrity, ratesetting, quality infrastructure, and the homecare workforce.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [Insert date 60 days after date of publication in the **Federal Register**].

ADDRESSES: In commenting, refer to file code CMS-2404-NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to **<http://www.regulations.gov>**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2404-NC,
P.O. Box 8013,
Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2404-NC,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW.,
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

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

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Melissa Harris, (410) 786-3397.

Jodie Anthony, (410) 786-5903.

SUPPLEMENTARY INFORMATION: Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Introduction

The Centers for Medicare & Medicaid Services (CMS) and states have worked for decades to support increased availability and provision of quality home and community-based services (HCBS) for Medicaid beneficiaries. HCBS provide individuals who need assistance such as personal care, respite care, and many other services the opportunity to receive those services in their own homes or in the community versus institutional settings. Over time, the provision of HCBS has increased significantly, to the extent that

Medicaid spending on HCBS now exceeds spending on institutional services. Efforts by the Department of Health and Human Services' (HHS') Office for Civil Rights (OCR) to enforce the community integration mandate of the Americans with Disabilities Act (ADA), the Supreme Court's interpretation of the ADA in Olmstead v. L.C., 527 U.S. 581 (1999)¹, the creation of additional HCBS statutory options for states, and grant programs such as the Money Follows the Person Rebalancing Demonstration, have been central factors driving this progress. In addition, we have promulgated regulations to adopt requirements for HCBS settings that incorporate community integration principles², established a new quality oversight framework for HCBS waivers, and promoted quality measurement and other innovations related to HCBS through new initiatives such as the Testing Experience and Functional Tools (TEFT) grant and the Balancing Incentive Program.

Through this RFI, we seek input from the public on ways that CMS can, through its statutory authority, accelerate this progress. We also seek input into how best to ensure high quality HCBS that promote the health and well-being of beneficiaries, enhance policies that ensure the integrity of such services and protect beneficiaries from harm, and address workforce challenges particular to this set of services, such as wages, training and retention. This is a request for information only. Respondents are encouraged to provide complete but concise responses to the questions outlined in section II. of this RFI. Please note that a response to every question is not required. This RFI is issued solely for information and planning purposes; it does not constitute a Request for

¹ https://www.ada.gov/olmstead/olmstead_about.htm

Proposal, application, proposal abstract, or quotation. This RFI does not commit the Government to contract for any supplies or services or make a grant award. Further, we are not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request. Please note that we will not respond to questions about the policy issues raised in this RFI. We may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become Government property and will not be returned.

To assist the public, the RFI provides background on the history and current status of HCBS, the dynamics that affect the provision of HCBS, and actions we have taken to

²The State Plan and Home and Community-Based Services, 5-Year Period for Waivers, etc. final rule (79 FR 2947) can be found at: <https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider>

implement HCBS in the context of expanded Medicaid authority and increased public demand. In addition, it solicits input on the following general topic areas, described in more detail later in this RFI, to inform the agency's future decision-making on actions to be taken within its statutory authority:

- What are the additional reforms that CMS can take to accelerate the progress of access to HCBS and achieve an appropriate balance of HCBS and institutional services in the Medicaid long-term services and supports (LTSS) system to meet the needs and preferences of beneficiaries?

- What actions can CMS take, independently or in partnership with states and stakeholders, to ensure quality of HCBS including beneficiary health and safety?

- What program integrity safeguards should states have in place to ensure beneficiary safety and reduce fraud, waste and abuse in HCBS?

- What are specific steps CMS could take to strengthen the HCBS home care workforce, including establishing requirements, standards or procedures to ensure rates paid to home care providers are sufficient to attract enough providers to meet service needs of beneficiaries and that wages supported by those rates are sufficient to attract enough qualified home care workers.

II. Background

A. Historical Advances

From the beginning of the Medicaid program in 1965, states were required to provide medically necessary, nursing facility care for most eligible individuals 21 or

older³. Coverage for what is now considered HCBS was generally not included. Personal care services became an option for states to cover under their state Medicaid plans in 1975. In 1981, the Social Security Act (the Act) was amended to provide authority under section 1915(c) of the Act for the Secretary to waive certain provisions of the Medicaid statute to allow states to provide HCBS to eligible individuals who would otherwise require institutional services. Medicaid HCBS authority was expanded in 2005 and 2010, with the addition of an optional state plan HCBS benefit under section 1915(i) of the Act and the optional home and community-based attendant services and supports under section 1915(k) of the Act.

Using these authorities, states, in partnership with the federal government, have developed a broad range of HCBS to provide alternatives to institutionalization for eligible Medicaid beneficiaries. Consistent with the preferences of many beneficiaries of where they would like to receive their care, the evolution of HCBS provision has been driven by federal statutory and policy changes, court decisions, and state initiatives as described later in this RFI.

HCBS are a critical component of the Medicaid program, and are part of a larger framework of progress toward community integration of older adults and persons with disabilities that spans efforts across the federal government. Through a combination of state plan personal care services and home health services, and waivers in Medicaid, over 3.2 million beneficiaries received HCBS in calendar year (CY) 2012⁴ including individuals who are elderly and individuals with a developmental disability, physical

3 Wenzlow, Audra, Steve Eiken and Kate Sredl. 2016. Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014. Retrieved from <https://www.medicaid.gov/medicaid/ltss/downloads/evolution-ltss-expenditures.pdf>

4 <http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2012-data-update/>

disability, traumatic brain injury, or behavioral health condition. This is a growth of almost 1 million individuals since 2002. In 2012, a total of 764,487 people received home health state plan services (in the 50 states and the District of Columbia (DC)); 944,507 received personal care state plan services (in the 32 states offering the benefit at that time); and almost 1.5 million were served through section 1915(c) waivers (in 47 states and DC). Likewise, HCBS expenditures have grown from less than 10 percent of approximately \$13 billion in federal and state expenditures in fiscal year (FY) 1986 for all Medicaid LTSS, including nursing home expenditures,⁵ to more than 25 percent of Medicaid LTSS expenditures by the late 1990s. By FY 2014, 53 percent of the \$152 billion spent nationally on Medicaid LTSS was for HCBS.

As noted previously, coverage of HCBS was included in statutory waiver authority in 1981 under section 1915(c) of the Act to permit states to provide an alternative to care provided in institutions. The Secretary may waive certain Medicaid requirements and permit states to offer HCBS to meet the needs of people who would otherwise require institutional care. States have used HCBS waiver programs to provide numerous services designed to support beneficiaries in their homes and communities consistent with their person-centered plans of care. As a result of receiving waiver services, many beneficiaries have been able to achieve greater independence and community integration and have been able to exercise self-direction, personal choice, and control over services and providers.

Considerable flexibility exists for states when proposing 1915(c) HCBS waivers.

⁵ Wenzlow, Audra, Steve Eiken and Kate Sredl. 2016. Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FYs 1981-2014. Retrieved from <https://www.medicaid.gov/medicaid/ltss/downloads/evolution-ltss-expenditures.pdf>

They can seek approval to offer services in only defined geographic areas of the state, "cap" enrollment of beneficiaries at a certain number, and maintain waiting lists. Further, services can be targeted based on the populations the state makes eligible for the waiver, such as individuals with a developmental disability, individuals who are elderly, or individuals with a physical disability or traumatic brain injury. HCBS waiver services specifically authorized under the statute include case management (that is, supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that the Secretary may approve, including services that can assist in diverting or transitioning individuals from institutional settings into their homes and community. The statute requires that average estimated per capita expenditures for services provided under the waiver cannot exceed the average amount that would have been spent on waiver enrollees in institutions, absent the waiver.

HCBS waiver authority has been pivotal in assisting beneficiaries to achieve community living goals. The passage of the ADA of 1990 and the Supreme Court's interpretation of the ADA in Olmstead v. L.C., 527 U.S. 581 (1999) resulted in increased provision of Medicaid HCBS, as states sought to comply with those authorities. The ADA clarified that the "Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." In Olmstead, the Supreme Court held that Title II of the ADA prohibits the unjustified segregation of individuals with disabilities, and public entities are required to provide community-based services to persons with disabilities when-- (1) such services are appropriate; (2) the affected persons do not oppose

community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. These obligations apply to states and, while the Medicaid program is not the sole avenue for a state to comply with these mandates, Medicaid provides states broad opportunities to obtain federal funding to support the offering of services and supports in home and community-based settings, within programmatic requirements.

Significant progress in the realm of HCBS also occurred through the Deficit Reduction Act of 2005, (Pub. L. 109-171) with the creation of two new state plan options under the new section 1915(i) and (j) of the Act, as well as the Money Follows the Person Rebalancing Demonstration⁶ Grant (MFP). Section 1915(i) of the Act provides states the ability to furnish HCBS to individuals who require less than an institutional level of care (LOC) and who would otherwise not be eligible for HCBS under section 1915(c) waivers; section 1915(i) of the Act also allows states to provide state plan HCBS to those who are eligible for section 1915(c) waivers, under the eligibility group defined at section 1902(a)(10)(A)(ii)(XXII) of the Act. Section 1915(j) of the Act built upon the successes of the Cash & Counseling Demonstration and Evaluation that began in the late 1990s, allowing states to offer participants the ability to self-direct either state plan personal care services or state selected section 1915(c) waiver services without needing the authority of a section 1115 demonstration project. With the history and strength of the Real Choice Systems Change⁷ grants as a foundation, which provided states with resources for administrative, program, financial, and regulatory infrastructure to increase community

⁶ Section 6071 of the Social Security Act can be accessed at https://www.ssa.gov/OP_Home/comp2/F109-171.html

service provision, MFP assisted states in their efforts to reduce reliance on institutional care while developing community-based long-term care opportunities for individuals transitioning from institutional settings to homes in the community. With the passage of the Affordable Care Act of 2010, section 1915(k) of the Act (Community First Choice) was added⁸, offering increased federal matching funds for the provision of statewide home and community-based attendant services and supports. Services can be provided through an agency or a self-directed model. The Affordable Care Act also extended MFP⁹, enhanced the 1915(i) state plan option¹⁰, and established the Balancing Incentive Program¹¹, which provided financial incentives in the form of enhanced federal reimbursement to States to increase access to non-institutional LTSS.¹²

B. Present Status of HCBS

The shift in funding to HCBS accounting for a majority of LTSS spending represents an important achievement, with a doubling of the percentage of LTSS provided in the community since 2000. However this statistic masks significant differences in spending by population. HCBS spending for individuals with intellectual and/or developmental disabilities represented approximately three-quarters of Medicaid LTSS spending in 2014. This far surpasses the HCBS spending percentage for older adults, individuals with physical disabilities, and individuals with serious mental illness/serious emotional disturbances, which is only 41 percent of total LTSS spending.¹³ Thus, there is still work to be done by all levels of government and stakeholders to ensure that all

7 <https://www.medicaid.gov/medicaid/lts/real-choice/index.html>

8 <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/2-28-11-Recent-Developments-In-Medicaid.pdf>

9 <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/2-28-11-Recent-Developments-In-Medicaid.pdf>

10 <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10015.pdf>

11 <http://www.cms.gov/smdl/downloads/11-010.pdf>

12 It is important to note that the Money Follows the Person and the Balancing Incentive Program initiatives are time-limited, and require Congressional action to continue their authorization. Specifically, Federal funding under the Balancing Incentive Program ended September 30, 2015, and MFP expired on September 30, 2016 (unused portions of state grant awards made in 2016 are available to the state until 2020).

Medicaid beneficiaries who wish to remain in their homes and communities have the services, workforce and supports to enable them to do so.

Additional information on LTSS, including program information and expenditure reports, is available at www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/long-term-services-and-supports.html. A comprehensive state-by-state analysis of utilization patterns and cost for community versus institutional long-term care is available at <http://www.longtermscorecard.org>. This latter analysis by several collaborating organizations uses data from CMS as well as many other sources to quantify the unique long-term care service patterns in each state.

In recognition of the shift to community-based care and based on the experience and understanding of the challenges in overseeing such programs, in the January 16, 2014 **Federal Register** (79 FR 2947), we issued final regulations for the 1915(c) HCBS waiver authority, as well as the 1915(i) HCBS and the 1915(k) Community First Choice state plan authorities, to ensure that services provided under these HCBS regulatory authorities are truly home and community-based. The State Plan Home and Community-Based Services, 5-Year Period for Waivers, etc. final rule (79 FR 2947) (hereinafter referred to as the HCBS final rule) represented the culmination of over 5 years' worth of stakeholder input and addressed the key challenges associated with the provision of HCBS. While statutory authority for coverage of HCBS required services to be provided in a "home and community-based setting", there was no definition of what that phrase meant. This lack of a definition resulted in HCBS Medicaid funding for services in some settings that bore similarities to institutions (for instance, in terms of regimented schedules or isolation

from the larger community or both). The regulations sought to change that by outlining the criteria for residential and non-residential home and community-based settings.

The principle of community integration, and the requirement that coverage of HCBS be based on person-centered service plans that outline how individuals wish to exercise choices, are at the heart of the home and community-based settings criteria. Given the scope of the changes mandated by the rule, we provided states with a transition period (through March 2019) to bring existing programs into compliance with the HCBS setting requirements. During this transition period, states are working with providers, managed care entities, advocacy organizations, beneficiaries and family members, and other stakeholders to complete assessments of existing HCBS provision and to determine how to implement needed revisions to ensure adherence with regulatory requirements.

In July 2014, we also established the Medicaid Innovation Accelerator Program (IAP) which seeks to improve the care and health for Medicaid beneficiaries and reduce costs by supporting states' ongoing payment and delivery system reforms through targeted technical support. Promoting Community Integration through Long-term Services and Supports is one of four program areas of focus for IAP. It is supporting a number of states with planning and implementing strategies for incentivizing quality and outcomes in HCBS and with developing Medicaid and housing-related services and partnerships. As part of this work, state Medicaid agencies and Federal and state housing partners are building on the collaborative work of the CMS and the U.S. Department of Housing and Urban Development (HUD) as part of the Obama Administration's Year of Community Living Initiative (established in June 2009 to mark the 10th anniversary of the Olmstead decision).

We are also actively engaged in efforts to improve the quality of care provided to individuals receiving HCBS. In addition to the ongoing monitoring of quality requirements embedded in the various HCBS authorities and programs and the quality work being done through IAP, we have developed an experience of care survey, developed under the Testing Experience and Functional Tools (TEFT) grant, which has been awarded the Consumer Assessment of Healthcare Providers and Systems (CAHPS) trademark. The CAHPS HCBS Survey is now available¹⁴ to states to elicit feedback on beneficiaries' experience with the services they receive in Medicaid HCBS programs. Results will be used to assess and further improve program quality.

Our quality efforts are guided by the CMS Quality Strategy,¹⁵ which seeks to provide better care, achieve healthier people and communities, and ensure smarter spending for care. The CMS Quality Strategy was built on the foundation of the CMS Strategy¹⁶ and the HHS National Quality Strategy (NQS),¹⁷ which was established as part of the Affordable Care Act to serve as a catalyst and compass for a nationwide focus on quality improvement efforts and approach to measuring quality, including in HCBS.

We believe that these strategies and efforts underway across CMS to achieve strategy goals will drive change as called for by the Commission on Long-Term Care and highlighted in the recent National Quality Forum (NQF) report released in September 2016, entitled Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement.¹⁸ The NQF report was

14 <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html>

15 <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html>

16 <https://www.cms.gov/about-cms/agency-information/cms-strategy/>

17 <http://www.ahrq.gov/workingforquality/>

18 PNQF Project Page - http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx

developed by a multi-stakeholder committee to recommend and prioritize opportunities to address gaps in HCBS quality measurement. The report represents 2 years of work by NQF, the Committee, and an HHS Federal team, and contains its final set of recommendations for how to advance quality measurement in HCBS through the development, testing, and endorsement of HCBS quality measures at par with those used across the healthcare system.

For more information on quality and performance measures, as well as many relevant past and present public-private efforts pertaining to HCBS quality, please see Appendix A of this RFI.

Finally, in support of achieving additional progress toward broadening access to HCBS , the President's FYs 2016¹⁹ and 2017²⁰ budgets have included proposals to strengthen HCBS provision, such as expanding eligibility for the Community First Choice Option and the 1915(i) state plan services options. These and other proposals are summarized in Appendix B of this RFI. A particularly notable proposal, is the "Pilot Long-Term Care State Plan Option", which would create a comprehensive long-term care state plan option for up to five states. Participating states would be authorized to provide equal access to home and community-based care and nursing facility care and the Secretary would have the discretion to make these pilots permanent at the end of 8 years.

This brief background cannot capture all of the important developments that have shaped the current long-term care landscape. Critical contributions from persons with disabilities, advocates, providers, and states in partnership with these CMS efforts have created opportunities that may not be reflected.

¹⁹ <http://www.hhs.gov/about/budget/budget-in-brief/cms/medicaid/index.html>

C. Key Factors that Affect the Provision of HCBS

Despite the many creative and effective HCBS programs developed by states and the shift in Medicaid payments toward such services, several factors present unique challenges to states seeking to expand access to HCBS. These include the following:

- State budgets play a critical role in shaping the HCBS landscape within a state.

States may face fiscal constraints as they make decisions about the optional services to offer, along with any limitations on how services are offered and to whom to provide them. Economic downturns can negatively impact a state's ability to offer a robust array of optional services, including HCBS, precisely when more individuals are enrolling in the program. In order to stay within appropriated state budgets, HCBS authorized under 1915(c) waivers may have enrollment caps and geographic boundaries. This provides budgetary certainty but can lead to significant variations within and across states in terms of the benefits offered, the number of individuals served, and waiting lists for those services. It also means that if a state is not able to add funding to its HCBS waivers, increases in programmatic expenses are frequently accompanied by offsetting reductions in other areas of the waiver or other Medicaid program expenditures.

- Provider availability is key to ensuring that individuals have access to needed Medicaid services. Availability can be impacted by several factors including the ability to attract a sufficient mix of providers in urban and rural areas of a state and how rates of reimbursement affect provider willingness to accept Medicaid beneficiaries. We issued the Access to Medicaid Covered Services final rule on November 2, 2015 (80 FR

67575)²¹. In implementing these regulations, we are engaged in activities to assist states in determining that fee-for-service (FFS) payment rates are sufficient to attract enough providers to ensure that Medicaid beneficiaries have access to covered Medicaid services to address their needs. The November 2015 final rule requires states to complete access monitoring review plans (AMRPs) for specified services, including home health services. In addition, it requires states submitting state plan amendments that would reduce payment rates to providers or restructure provider payments if the change could result in diminished access, to provide to us an analysis of the expected impact of the reduction on provider participation. The requirement to provide such an analysis applies to all state plan services, including the 1915(i) HCBS state plan option and the 1915(k) Community First Choice state plan option, but does not apply to 1915(c) HCBS waivers. In conjunction with the November 2015 final rule, we released a request for information to solicit comments on additional approaches the agency and states should consider to ensure better compliance with Medicaid access requirements. This included comments on the potential development of standardized core measures of access, access measures for long-term care and home and community based services, national access to care thresholds, and resolution processes that beneficiaries could use in facing challenges in accessing essential health care services. We note that we received comments confirming that access to HCBS should be measured differently than access to primary and acute care services, and we continue to analyze the comments to determine potential paths forward.

- The presence of managed care arrangements in a state's Medicaid program can also impact how beneficiaries receive services. Through contracts with managed care

21 <https://www.federalregister.gov/documents/2015/11/02/2015-27697/medicaid-program-methods-for-assuring-access-to-covered->

organizations, states determine the array of Medicaid services to be provided under a managed care delivery system. Over the past decade, managed care has been used with increasing frequency in the delivery of Medicaid-funded LTSS, including HCBS. Almost 390,000 beneficiaries received LTSS in a managed care delivery system in 2012, and today an even larger number of beneficiaries are receiving LTSS through managed care.

As managed care organizations administer and coordinate contracted benefits, they are continually balancing the parallel goals of containing costs and facilitating the provision of needed services, which can impact the delivery of service on a daily basis. Under Medicaid regulations, plans can implement utilization criteria that influence service provision, such as prior authorization requirements or requiring the use of a particular drug or therapy before access to a more expensive treatment is authorized. However, the use of managed care should not negatively impact a beneficiary's access to covered services, as managed care plans must offer all services they are under contract to provide. In addition, services available under a managed care delivery system should be no less in amount, duration and scope as the services provided under a FFS payment system. Through managed care authorities, plans can also provide additional services not otherwise available in that state, either as a value-added service that the plan chooses to provide, or by offering a service in lieu of a covered service under the state plan if it is medically appropriate and cost effective (although use of the "in lieu of" authority does not relieve a state or managed care organization (MCO) from providing access to all state plan services).

Given the unique characteristics of LTSS, protections such as provider continuity

and beneficiary education, were incorporated into the May 6, 2016 managed care final rule (81 FR 27498). Specific protections include requiring that a state establish a beneficiary support system that accounts for the unique needs of individuals receiving LTSS, person-centered planning processes to ensure medical and non-medical needs are met and that individuals have the quality of life and level of independence they desire, and standards to evaluate the adequacy of network and availability of services for all MLTSS programs.

- Recent CMS and other federal agency policy changes are shaping program implementation. The HCBS, Access to Medicaid Covered Services, and Medicaid Managed Care rules established new policies for states and managed care organizations that will have significant impact on states and HCBS providers. For example, the settings provisions in the 2014 HCBS final rule require states to develop and submit statewide transition plans detailing how the state will operate its HCBS waivers or state plan benefits and including all elements approved by the Secretary. Guidance as to the elements required in the transition plan²², indicates that among these elements are in-depth assessments and development of resulting remediation plans to ensure compliance with the regulation's community integration requirements by the end of the transition period.

Recently, the Department of Labor (DOL) issued two rules, one that took effect in October 2015 extending minimum wage and overtime protections to most home care workers, and the other taking effect in December 2016, which updated the salary threshold below which white collar salaried workers, including managers, are entitled to

²²<https://www.medicaid.gov/medicaid/ltss/downloads/statewide-transition-plan-toolkit.pdf>

overtime pay when they work more than 40 hours in a week. Both of these rules are implementing necessary reforms, and both will require time, effort, and financial resources to ensure compliance.

From the beginning, the DOL has emphasized the importance of implementation in a manner that protects both workers and consumers. States have a number of options for coming into compliance with these regulations. For example, in response to the Home Care final rule (78 FR 60453), some states are planning to increase funding for home care programs such that workers receive overtime compensation for hours worked over 40 in a work week. Others are planning to limit overtime work but create exceptions processes so that certain consumers are permitted to receive care from a single home care worker in excess of the general cap on worker hours.

Actions taken by states to implement these regulations have real implications for beneficiaries and service providers. Some states anticipate challenges in being able to secure funding to accommodate overtime payments incurred in the delivery of HCBS by providers in response to the two DOL regulations, and are taking actions such as implementing caps on the number of hours worked by home care workers to avoid incurring overtime expenses. These caps can necessitate beneficiaries who require a significant number of hours of service needing to find additional workers. Many stakeholders, such as labor organizations and beneficiary advocates have expressed concerns that hard caps and low wages are likely to hamper recruitment and retention efforts to secure a consistent workforce.

We issued guidance²³ on the availability of Medicaid reimbursement for costs

23 <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-01-08-16.pdf>.

associated with complying with these two DOL rules. As of the drafting of this RFI, only a handful of states have submitted filings to CMS to embed overtime costs in the rate methodology of applicable services. In late 2014, the Department of Justice (DOJ) and the HHS OCR issued joint guidance²⁴ stressing that to remain compliant with Olmstead, "states need to consider reasonable modifications to policies capping overtime and travel time for home care workers, including exceptions to these caps when individuals with disabilities otherwise would be placed at serious risk of institutionalization." We remain available to provide technical assistance on this issue.

- Workforce stability is impacted by many of the considerations discussed previously, and is a key factor in sustaining the growth of HCBS. States are grappling with providing a sufficient homecare workforce to meet the growing demand for LTSS. This is a particular challenge in states working to shift their long-term care service delivery systems toward HCBS and away from institutional care.²⁵ LTSS are by their nature extremely labor intensive and direct service workers—a paid workforce of about 3 million nationwide in 2009—constitute the main input into these services and supports. This workforce has been demonstrating signs of workforce instability, including high turnover and vacancy rates for some time. As demand for HCBS assistance grows, so too will the need for an engaged and dedicated workforce.²⁶ According to the Bureau of

24 Vanita Gupta and Jocelyn Samuels, Joint Dear Colleague Letter on Companionship Rule Implementation, US Department of Justice, Civil Rights Division and U.S. Department of Health and Human Services, Office for Civil Rights, December 2014 <http://acl.gov/NewsRoom/NewsInfo/docs/2014-FLSA-Dear-Colleague-ltr.pdf>.

25 Edelstein, Steven, and Dorie Seavey, February 2009. "The Need for Monitoring the Long-TermCare Direct Service Workforce and Recommendations for Data Collection". Retrieved from: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/workforce/workforce-initiative.html>

26 Edelstein, Steven, and Dorie Seavey, February 2009. "The Need for Monitoring the Long-TermCare Direct Service Workforce and Recommendations for Data Collection". Retrieved from: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/workforce/workforce-initiative.html>

Labor Statistics²⁷, personal care aides and home health aides are the occupations with the first and third largest projected job growth from 2014 through 2024 (BLS projects demand for an additional 806,500 jobs in these occupations). Further, employers with job openings in these occupations will be competing for workers with employers who have job openings in other occupations that have similar education and training requirements, e.g., cashiers and retail salespersons. BLS projects demand for an additional 1.2 million jobs from 2014 through 2024 in these sectors. To attract engaged and dedicated workers to fill home care jobs will require wages that are competitive with what potential home care workers would receive in these and other alternative occupations.

CMS created the National Direct Service Workforce (DSW) Resource Center in 2005 to respond to the shortage of workers who provide direct care and personal assistance to individuals who need LTSS. These workers include direct support professionals, personal care attendants, personal assistance providers, home care aides, home health aides, and others (described collectively in the remainder of this document as the home care workforce). The DSW Resource Center created a number of important resources designed to assist states in developing home care workforce capacity, as well as to improve recruitment and retention efforts associated with the home care workforce. These resources included an inventory and analysis of the various core competency sets used across and within LTSS sectors.

While the DSW Resource Center concluded in December 2014, important resources funded through this initiative are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term->

²⁷ <http://www.bls.gov/ooh/most-new-jobs.htm>

Services-and -Supports/Workforce/Workforce-Initiative.html. Included in these resources is a toolkit that was developed in 2013 to discuss strategies to address workforce challenges, which contains a chapter dedicated to the unique characteristics of self-directed programs that are prevalent in the provision of HCBS. Self-directed programs place decision-making authority in the hands of the beneficiary or their representative, and can vary according to structure and scope. Across the various Medicaid authorities, almost every state offers beneficiaries the option to receive HCBS through some type of self-directed model. Understanding the parameters of self-directed programs operating in a state, such as the ability to hire family members and friends and the ability to set wages for home care workers, is key to understanding implications these models have on the ability to maintain an engaged and dedicated homecare workforce of sufficient size. As discussed later in this RFI, enhancing the stability of this workforce also involves ensuring that reimbursement rates support wages that are sufficient to attract enough qualified workers

D. The Role of Medicaid in Helping States Comply with ADA and Olmstead Requirements

On May 20, 2010, we issued a State Medicaid Director (SMD) letter to provide information on new tools to support community integration, as well as to remind states of existing tools articulated in past "Olmstead" letters that remain strong resources in states' efforts to support community living as a choice for Medicaid HCBS beneficiaries. With the issuance of this 2010 letter, we reaffirmed our commitment to the policies identified in previous Olmstead guidance. We also expressed an interest in working with states to continue building upon earlier innovations and encouraged states to identify new

strategies to improve community living opportunities. However, while Medicaid provides a powerful tool to states in fulfilling ADA and Olmstead responsibilities, the program cannot serve as a state's sole compliance strategy. The following are several reasons why this is the case:

- Separate roles for CMS, DOJ, OCR – CMS collaborates regularly with federal partners including the HHS OCR and DOJ. The three agencies discuss developments occurring in states to ensure awareness and to determine if there are cross-agency implications, but each agency has different areas of oversight responsibility. CMS implements Title XIX of the Act, working daily in partnership with states to operate the Medicaid program under the parameters of Title XIX that dictate CMS governance. DOJ implements and enforces certain provisions of the ADA. Its enforcement activities can include filing litigation against public entities not abiding by responsibilities under the ADA, including the statute's integration mandate, as interpreted by Olmstead. HHS OCR enforces non-discrimination laws that apply to health care or human services providers, including Title II of the ADA, section 504 of the Rehabilitation Act of 1973, and section 1557 of the Affordable Care Act, and laws related to health information privacy. Together, the three agencies form a strong partnership in ensuring the provision of quality healthcare, but each has a separate scope of influence.

- Provision of Institutional Services –The statute (Title XIX of the Act) requires the provision of medically necessary services in institutions such as hospitals and nursing facilities for most eligible beneficiaries. At state option, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) may be covered. However, mandatory provision of some institutional services and optional provision of most HCBS does not

facilitate states' efforts to provide Medicaid services in a manner more consistent with ADA or Olmstead as the statute results in states having to devote budget resources to institutional options and having less flexibility to reallocate resources to home and community-based alternatives. While many states are working hard to operate their Medicaid programs in ways that further community integration, further progress is needed. For example, states have made less progress in reducing use of Medicaid-funded long-term stays in nursing facilities.

- CMS review of state reimbursement methodology – Some stakeholders have encouraged CMS to ensure that sufficient wages are available for home care workers to avoid shortages. We have also been encouraged by stakeholders to view state ratesetting methodologies through an Olmstead lens, under which HCBS rates would need to be sufficient to avoid unnecessary institutionalization. Their specific suggestions have included approving only methodologies that guarantee home care workers a salary that is above the prevailing minimum wage for their locality, that is higher than wages paid to similarly-qualified workers in nursing facilities, and that takes into account wages paid in occupations that compete for workers with similar levels of education, training, and experience.

Historically, we have reviewed states' proposed waiver and state plan reimbursement methodologies to determine compliance with regulatory requirements and with the statutory requirement found in section 1902(a)(30)(A) that payments be "consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Based on provisions of the 2015 Access to Medicaid Covered Services final regulation, this review now includes a review of the state's determination that any proposed payment reductions for state plan services, including HCBS provided through the state plan, will still result in sufficient beneficiary access to providers. Our review also includes the state's analysis of any concerns expressed over the proposed reduction from affected stakeholders. However, we have not interpreted the statute and regulations to support an analysis of payment methodologies down to the level of wages paid to individual home care workers. For example, while we review how a state proposes to reimburse a provider agency for the provision of personal care services, this review does not extend to analyzing how the provider agency compensates home care workers and whether that rate is sufficient to cover wage costs. It also does not include a review of whether compensation of home care workers is sufficient to attract needed workers, a key component of which would be a review of how home care worker wages compare to the wages paid to workers in occupations that compete for workers with similar levels of education and training.

III. Provisions of the Request for Information

To assist us in determining how to advance access to HCBS for beneficiaries in both FFS and managed care and how to enhance the quality and integrity of HCBS provision under existing authorities, we are soliciting public input on the following general topics:

A. What are the Additional Reforms that CMS can take to Accelerate the Progress of Access to HCBS and Achieve an Appropriate Balance of HCBS and Institutional services in the Medicaid LTSS system to meet the needs and preferences of beneficiaries?

Although HCBS expenditures account for a majority of total spending for LTSS in Medicaid, we are interested in making additional progress in rebalancing the Medicaid long-term care system. Statutory changes such as the ones proposed in the President's FYs 2016 and 2017 budgets would most likely provide the fastest and most meaningful acceleration of progress (see Appendix B). However, we are soliciting input on actions within our authority to promote access to Medicaid HCBS. These include suggestions for improved benefit design, payment and financing reforms, and stakeholder engagement. In addition, we are open to proposals with respect to all existing Medicaid authorities, both state plan and waiver.

Section 1115 demonstrations give states broad authority to implement reforms in their Medicaid program, such as by waiving specific provisions of the Social Security Act, or by allowing states to cover services and/or populations not typically covered by Medicaid. In the context of HCBS delivery, an 1115 demonstration could provide interested states with the authority to offer a more streamlined continuum of LTSS, similar to the Pilot Comprehensive Long-Term Care State Plan Option legislative proposal referenced in Appendix B. We seek input on the state interest and feasibility of such an approach, along with the following comments and questions:

- We are interested in receiving comments on the following potential interpretation of current law. The term "nursing facility" is defined in section 1919(a) of the Act. Under this definition, a nursing facility must be primarily engaged in providing skilled care and rehabilitation to residents with medical necessity for those services. In contrast, nursing facilities provide health-related care and services, that is, those services that are not skilled nursing or rehabilitation services, "to individuals who . . . require care

and services . . . which can be made available to them only through institutional facilities". In other words, the statutory nursing facility service definition could provide a basis for states to offer the mandatory nursing facility benefit only to individuals eligible for nursing facility coverage whose assessed need cannot be met by HCBS. If the individual's needs can be met by HCBS, Medicaid reimbursement would not be available for health-related care and services provided in a nursing facility in those circumstances. Because this concept intersects with other requirements such as institutional eligibility rules and the choice of institution as an option for section 1915(c) waiver participants, the idea may best be implemented under the flexibility of a section 1115(a) of the Act demonstration authority.

- Are there particular flexibilities around Medicaid requirements for LTSS that states would be interested in using 1115 authority to support? How could 1115 authority be structured to streamline the provision of LTSS across authorities, while adhering to budget neutrality requirements?

- What types of eligibility flexibility and controls, including level of care and utilization, could be used to encourage access to HCBS?

- What types of benefit redesign (such as a package of benefits) would improve the provision of LTSS?

- What resource needs, including differences between urban and rural areas, and variations in providing services to different HCBS populations, would need to be taken into account to ensure access to HCBS?

B. What Actions can CMS take, Independently, or in Partnership with States and Stakeholders, to Ensure Quality of HCBS and Beneficiary Health and Safety?

As the number of beneficiaries receiving Medicaid HCBS has increased, so has the need to ensure that federal and state quality efforts are maintained and strengthened to ensure the provision of services in ways that improve health outcomes of beneficiaries. Toward that end, we made extensive revisions to the quality oversight structure of the 1915(c) HCBS waiver program, which culminated in guidance released in 2014²⁸. At the heart of this framework is the reporting on state-developed performance measures designed to reflect the operations of the waiver across important domains that CMS defined such as beneficiary health and welfare, financial accountability, and service provision and delivery.

As states increasingly turn to managed care to deliver LTSS including nursing home and HCBS to older adults and people with disabilities enrolled in Medicaid, we have sought additional approaches to quality and beneficiary protections, while also allowing state flexibility in program design and administration. As one example, the Medicaid managed care final rule specifically incorporated "managed" long-term services and supports, referred to as MLTSS, elements into several areas of CMS' quality measurement and improvement framework. States must have mechanisms for the identification of enrollees who need LTSS or enrollees with special health care needs, and managed care plans must have mechanisms to assess the quality and appropriateness of care furnished to beneficiaries enrolled in managed care and receiving LTSS, including an assessment of care between care settings and a comparison of services and supports received with those set forth in the enrolled beneficiary's treatment or service plan. Managed care plans must also participate in efforts by the state to prevent, detect, and

28 <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/3-cms-quality-memo-narrative.pdf>

remediate critical incidents that adversely impact enrollee health and welfare, and the state must identify standard performance measures, including performance measures relating to quality of life, rebalancing, and community integration activities for those beneficiaries receiving LTSS.

As we solicit ideas for the expansion and promotion of HCBS, it is critical that the infrastructure surrounding service provision be sufficiently robust to ensure that beneficiaries receive needed, quality services, while also ensuring the health and safety of those beneficiaries. Currently, there is an absence of a formal federal oversight framework for the provision of HCBS such as what exists for services provided in institutions such as nursing facilities and hospitals. Instead, CMS and the states partner to ensure the collection of data is sufficient to both articulate the experience of individuals receiving HCBS and to inform the actions to be taken when necessary to improve that experience. Therefore, we are soliciting feedback on the following:

- What is the appropriate role for CMS versus the states in ensuring quality of care for Medicaid beneficiaries receiving HCBS? How could CMS and states best monitor quality and beneficiary safety? What actions should CMS take when HCBS are not being delivered according to federal requirements? What evidence would be required to determine when CMS takes these actions?
- Should there be an oversight structure with conditions of participation in HCBS similar to that of institutions and home health agencies, in which state surveyors report survey findings directly to CMS?
- What can CMS do to support standardized performance measures for HCBS, including in Medicaid waivers and state plans?

- What other quality measurement activities could CMS undertake to strengthen the provision of HCBS across any Medicaid authority? What data, reporting and system resources would be necessary to support those activities?

- What other quality measurement activities should CMS require or do to support states and other stakeholders to strengthen the provision of quality HCBS across any Medicaid authorities?

C. What Program Integrity Safeguards Should States have in Place to Ensure Beneficiary Safety and Reduce Fraud, Waste, and Abuse in HCBS?

Program integrity expectations apply to providers of HCBS as they do to all other Medicaid services and providers. Program integrity results in Medicaid paying the right provider for furnishing the right services to the right beneficiary at the right price.

Without strong program integrity safeguards, HCBS funds are at risk of being misspent, beneficiaries in need of HCBS are at risk of receiving substandard quality of care that may result in beneficiary harm, and institutionalization may be used in situations where it would otherwise be unnecessary.

Personal care services (PCS), are a critical component of HCBS, and there is evidence of program integrity vulnerabilities in their provision. The Office of Inspector General (OIG) recently issued an Investigative Advisory²⁹ that identifies PCS fraud issues encountered during the course of OIG investigations that have resulted in misspent funds (such as through timecard falsifications), and examples of beneficiary abuse and services furnished by unqualified providers. We have not required states to adopt a standardized set of minimum qualifications for PCS attendants. Currently, some states require PCS

²⁹ <https://oig.hhs.gov/reports-and-publications/portfolio/ia-mpcs2016.pdf>.

attendants to enroll in Medicaid as providers, including undergoing a criminal background check, and assign each attendant a unique provider number. However, many states do not have such procedures in place, and we have not issued minimum Federal qualifications for PCS attendants. OIG has strongly encouraged CMS to undertake actions establishing minimum federal qualifications and screening standards for PCS attendants, including background checks; and require states to enroll or register all PCS attendants and assign them unique numbers for purposes of tracking claims.

Given the nature of these services, focusing on activities of daily living (ADLs) such as eating, bathing, toileting, and transferring, and instrumental activities of daily living (IADLs) such as money management and meal preparation, community-based provider qualifications have tended to be less formal than care more focused on skilled nursing or licensed therapies. Many states have adopted personal care provider qualifications such as minimum age requirements, possession of a valid driver's license, and completion of training required by the state and specific training required by the beneficiary.

When evaluating how best to ensure the provision of quality person-centered services by a sufficient pool of qualified providers, we are weighing competing stakeholder viewpoints. As an example, standardized worker training requirements may be supported by entities focused on home care worker engagement and program integrity safeguards, but are generally not supported by disability rights organizations and self-advocates, who favor more flexible programs that base training requirements on individual beneficiary circumstances. We believe that ensuring both interests are

included as part of the overall delivery of HCBS is important to successful delivery of high quality HCBS to Medicaid beneficiaries.

We are particularly interested in the operational feasibility for states of these recommendations and the implications for beneficiary choice and control. We also seek input into the feasibility and implications in each of two different service delivery models: agency-directed PCS (including “agency with choice” models in which the provider agency and the beneficiary are co-employers of the PCS attendant) and self-directed PCS. HCBS have a long history of utilizing consumer-directed/self-directed models of service delivery, a facilitation of beneficiary choice and control that CMS supports. These include models through which a range of services and supports are planned, budgeted, and directly controlled by an individual (with the help of representatives, if desired) based on the individual’s needs and preferences that maximize independence and the ability to live in the setting of the individual’s choice. Even in more traditional models of HCBS delivery, in which agencies are utilized, there has been movement over time to incorporate beneficiary expectations of participating in training and determining the qualifications of workers that are most relevant to individual needs and preferences.

The use of minimum qualifications and screening and enrollment requirements may create administrative implications, increase costs and impact beneficiary choice and control. On the other hand, a lack of adequate program integrity safeguards could pose risk to both Medicaid beneficiaries and successful stewardship of Federal and state funds. The successful delivery of PCS to Medicaid beneficiaries must ensure that both individual needs and preferences are met and that the program has adequate safeguards in

place. To better ensure the successful delivery of PCS, we are soliciting feedback on the following:

- What are the benefits and consequences of implementing standard federal requirements for personal care workers in agency-directed and/or self-directed models of care?

- What would standardized qualifications look like in terms of the following:

- ++ Educational requirements

- ++ Minimum age requirements

- ++ Screening requirements

- Should standardization include the expectation that certain circumstances require more than the standard, or different standards?

- What role could state-administered home care worker registries play in facilitating access to HCBS? What issues should be addressed in the creation of home care worker registries?

- What issues should be considered in requiring criminal background checks? In the states that are utilizing fingerprinting and background checks already, what lessons can be learned from implementation and experience with these approaches?

- What role can home care worker organizations play in providing training to support implementation of federal qualification standards? What regulatory or policy provisions would either support, or inadvertently disadvantage, home care worker organizations?

- Should states be required to enroll or register all PCS attendants and assign them unique numbers for purposes of tracking claims?

- What is the feasibility for state Medicaid programs of including home care worker identity on claims submitted for Medicaid reimbursement?
- What other program integrity safeguards should be put in place, either as an alternative to, or in addition to, the controls recommended by OIG, for agency-directed PCS? For self-directed PCS?
- Are the program integrity safeguards that are appropriate for agency-directed personal care services also appropriate for self-directed personal care services?
- How can program integrity safeguards be developed and implemented to support key HCBS programmatic objectives such as choice and self-direction?

D. What Specific Steps Could CMS take to Strengthen the HCBS Home Care Workforce?

To determine the specific steps that we could take to strengthen the HCBS home care workforce, we are soliciting feedback on the implications of establishing requirements, standards or procedures to ensure rates paid to providers are sufficient to attract enough providers to meet service needs of beneficiaries and that wages supported by those rates are sufficient to attract enough qualified home care workers.

As indicated previously, and as described in the Informational Bulletin dated August 3, 2016,³⁰ there are several factors that can impact the availability of a sufficient pool of home care workers necessary to provide HCBS relied upon by beneficiaries to remain in the community. Moreover, these access and availability challenges are likely to increase as the population ages and more and more people seek to remain in their homes and communities. Some stakeholders have approached us to intervene and use our

³⁰ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib080316.pdf>

approval authority of rate methodologies as a mechanism to strengthen the provider infrastructure and ensure beneficiary access to services. This may include using the rate approval process to address the competitiveness of worker wages, encourage entry of new providers, support enhanced workforce training and professional development, or improved administrative/IT infrastructure of providers. With respect to wages, for example, some stakeholders have suggested that CMS only approve state reimbursement methodologies for provider rates that will result in sufficient wages for employees to attract and retain a high quality workforce and that relate to the broader labor market within the state to ensure that wage rates are competitive with other industries that employ workers with similar levels of education and experience. As noted previously, historically, our review of ratesetting methodologies has not encompassed this level of specificity. How agencies compensate employees or contractors has been outside of the CMS review. We are soliciting comment on whether we should play a larger role in ensuring the sufficiency of rates at both provider agency and individual worker levels, taking into account that the federal role is to ensure an effective program, not to directly regulate business matters (that is, states operate the Medicaid programs). Specifically, we are interested in feedback on the following:

- What if any actions could CMS take to better ensure adequate beneficiary access to safe HCBS services provided by qualified individuals, across both urban and rural locations and across disparate populations?
- What are positive and negative consequences of such actions, including the implications under the Fair Labor Standards Act and state wage and hour laws, if state ratesetting approaches result in specified wages at an individual worker level?

- Should CMS expand its ratesetting approval authority to support provider infrastructure and the HCBS workforce?
- What effect would an increase in payment rates necessitated by a CMS rate review process that focuses on home care worker wages have on funded slots or services, particularly given budget limitations and cost neutrality requirements inherent in many Medicaid authorities?
- How could CMS determine whether an increase in home care worker wages results in an increase in the quality of services provided and an increase in the size of the workforce such that it will be more likely to meet future industry needs?
- What sources of information, including data from the DOL, would be most useful to CMS in making sure that reimbursement rates appropriately take into consideration wages and benefits for home care workers? How would CMS best use these sources?
- What role could state-administered home care worker registries play in facilitating access to HCBS? What issues should be addressed in the creation of home care worker registries?
- What other actions could CMS consider to strengthen the home care workforce such as assessing training needs, developing career ladders, etc.?

IV. Collection of Information Requirements

This request for information constitutes a general solicitation of public comments as discussed in the implementing regulations of the Paperwork Reduction Act at 5 CFR 1320.3(h)(4). Therefore, this request for information does not impose information collection requirements, that is: reporting, recordkeeping or third-party disclosure

requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Dated: November 2, 2016.

Andrew M. Slavitt,

Acting Administrator,

Centers for Medicare & Medicaid Services.

BILLING CODE 4120-01-P

APPENDIX A

Quality Measurement

Performance measures are used across the healthcare delivery system and across payers to improve outcomes, experience of care, population health, and health care affordability through improvement, with the goal of improving processes and outcomes.

In clinical and behavioral health care, measurement has been associated with improvements in providers' use of evidence-based strategies and health outcomes. However, there is no national quality measure set for HCBS.

Quality measures are tools that help evaluate or quantify healthcare processes, outcomes, individual perceptions/experiences, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, person-centered, equitable, and timely care. CMS uses quality measures in its quality improvement, public reporting, and pay-for-reporting programs for specific healthcare providers.

Other Quality Initiatives

- CMS is working on developing quality measures and maintenance programs serving individuals who are enrolled in both Medicare and Medicaid, as well as individuals only enrolled in Medicaid who use HCBS as part of the work in the IAP. The objectives of this project are to identify and prioritize measures and measure concepts, develop and refine measure specifications for priority measures, conduct field testing to evaluate measure importance, feasibility, usability, and scientific validity and reliability, submit validated, reliable measures to the National Quality Forum (NQF) for endorsement, and assist CMS with an implementation strategy. Eight measures in development apply to beneficiaries enrolled in managed long-term services and supports programs, and one measure, for community integration is specific to HCBS.

- CMS has developed a standardized system for developing and maintaining the quality measures used in its various accountability initiatives and programs. Known as

the Measures Management System (MMS), measure developers (or contractors) should follow this core set of business processes and decision criteria when developing, implementing, and maintaining quality measures. Best practices for these processes are documented in the manual, Blueprint for the CMS Measures Management System (the Blueprint).³¹ CMS uses the standardized processes documented in the Blueprint to ensure that the resulting measures form a coherent, transparent system for evaluating quality of care delivered to its beneficiaries.

- The National Quality Forum's (NQF) Measures Application Partnership (MAP) is a multi-stakeholder public/private partnership that guides HHS on the selection of performance measures for Federal health programs. Its Dual Eligible Beneficiaries Workgroup has identified opportunities for improvement in measurement areas including quality of life, screening and assessment, structural measures, mental health and substance use, and care coordination. The MAP Workgroup noted significant gaps in the availability of measures for HCBS, and in a final report to HHS identified potential measures worthy of attention.³² To cite potential HCBS measures, the MAP Workgroup reviewed "Environmental Scan of Measures for Medicaid Title XIX Home and Community-Based Services" (2010), "Raising Expectations: A State Scorecard on LTSS for Older Adults, People with Disabilities, and Family Caregivers" (2011), and the National Balancing Indicator Project (2010).

31 Additional information on the Blueprint is available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.html>

32 National Quality Forum. Measures Application Partnership. Measuring Healthcare Quality for the Dual Eligible Beneficiary Population. June 2012. Available at: http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/Measure_Applications_Partnership_Submits_Recommendations_for_Dual_Eligible_Beneficiaries_to_HHS.aspx

- HCBS are a focus of HHS's Multiple Chronic Conditions Strategic Framework.³³
- The National Alzheimer's Plan recommends the development of dementia quality measures across care settings.³⁴
- Section 6086(b) of Deficit Reduction Act of 2005, "Quality of Care Measures," directed HHS's Agency for Health Care Research and Quality (AHRQ) to develop measures of program performance, client functioning, and client satisfaction with HCBS under Medicaid; assess the quality of Medicaid HCBS outcomes and those of the overall system, and disseminate information on best practices.³⁵
- CMS sponsored development of a HCBS taxonomy³⁶ to provide a common language for describing and categorizing HCBS across Medicaid programs.
- CMS's Money Follows the Person demonstration program developed a quality of life survey (QoL) for persons transitioning from institutional to community settings which provided valuable insight into the use of an experience of care survey. Through the CMS Testing Experience and Functional Tools (TEFT) demonstration grant, the HCBS Experience of Care Survey was tested and recently received the CAHPS® trademark, and was recommended for endorsement by NQF's Person and Family Centered Care Committee.

33 U.S. Department of Health and Human Services. Multiple Chronic Conditions: A Strategic Framework. Available at: http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf.

34 Department of Health and Human Services. National Plan to Address Alzheimer's Disease: 2013 Update. Available at: <http://aspe.hhs.gov/daltcp/napa/natlplan.pdf>.

35 Agency for Health Care Quality. Project methodology available at: <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/methods/index.html>. Environmental scan at: <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/hcbsreport/index.html> and <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/hcbsreport/index.html>. Measures meeting a numeric threshold are at: <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/hcbsreport/hcbsapv1b.html>, <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/hcbsreport/hcbsapv2b.html>, and <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/hcbsreport/hcbsapv3ab.html#tabav3b>. Details of individual measures are available at: <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/hcbsreport/hcbsapiii.html>.

- CMS’s TEFT initiative is working on a HCBS Functional Assessment Standardized Items (FASI), based on the HCBS CARE tool, and development of standards for electronic and personal health records, or “eLTss Plan.”³⁷
- The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires reporting of quality measures in Skilled Nursing Facilities, Home Health, and across other settings and requires standardized assessment data, data on quality measures, interoperability, and person-centered care.
- The Medicare Access and CHIP Reauthorization Act (MACRA) includes a quality assessment and improvement strategy for Medicare managed care, and the Merit-Based Incentive Payment System (MIPS) offers financial incentives for eligible professionals to provide care that advances the goals of a healthier system.
- The Affordable Care Act included a requirement for CMS to establish voluntary care sets for adult and child quality measures.
- HHS’s Administration for Community Living’s National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) is presently implementing a Rehabilitation Research and Training Center grant to develop, test, and gain NQF approval for HCBS quality measures.
- Under certain Medicaid statutory authorities states must develop and integrate a continuous quality assurance, monitoring, and improvement strategy for HCBS

36 Peebles V, Bohl A. The HCBS Taxonomy: A New Language for Classifying HCBS. August, 2013. Available at: https://www.cms.gov/mmrr/Briefs/B2014/MMRR2014_004_03_b01.html

37 Centers for Medicare & Medicaid Services. Available at: <http://www.medicare.gov/AffordableCareAct/Downloads/TEFT-FOA-7-13.pdf>

programs.³⁸ CMS's final rule on HCBS and related guidance, CMS 2249-F, provides further insight regarding appropriate characteristics of HCBS settings.³⁹

- The Government Accountability Office has issued a series of reviews of HCBS provided through the Medicaid program since 1982, the year after HCBS were first added to Medicaid as an optional benefit, and many address quality issues⁴⁰. The HHS Office of the Inspector General has also made HCBS program integrity a focus of its efforts, with particular attention to personal care services.⁴¹

- There are synergies in HCBS quality in CMS's State Innovation Models Initiative in the states that have received Model Testing Awards,⁴² in the Agency's Community-Based Care Transitions program, the Independence at Home model, and the Accountable Health Communities model.⁴³

APPENDIX B: Summary of Administration's President Budget Proposals to

Advance the Provision of HCBS

1. Pilot Comprehensive Long-Term Care State Plan Option

This 8-year pilot program would create a comprehensive long-term care state plan option for up to 5 states. Participating states would be authorized to provide equal access to home and community-based care and nursing facility care. The Secretary would have the discretion to make these pilots permanent at the end of the 8 years. This proposal

38 Centers for Medicare & Medicaid Services. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html>

39 Government Printing Office. Federal Register Vol. 79, No. 11. January 16, 2014. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>

40 Government Accountability Office. Available at: <http://www.gao.gov/search?q=medicaid+home+and+community+based+services>

41 HHS Office of the Inspector General. National Home and Community Based Services Conference. September, 2013. http://nasuad.org/documentation/HCBS_2013/Presentations/9.11%204.00-5.15%20Washington.pdf

42 Centers for Medicare & Medicaid Services. Available at: <http://innovation.cms.gov/initiatives/State-Innovations-Model-Testing/index.html>

works to end the institutional bias in long-term care and simplify state administration.

2. Expand Eligibility Under the Community First Choice Option

This proposal provides states with the option to offer categorical Medicaid eligibility to individuals who would be eligible under the state plan if they were in a nursing facility and who meet the coverage requirements for, and will receive, 1915(k) services ("Community First Choice" services). Under the current statutory framework, states have the option to extend full Medicaid coverage to individuals who are generally not otherwise eligible for Medicaid but who meet the coverage criteria for a 1915(c) waiver or 1915(i) benefit available under the state Medicaid program. A similar option does not exist for the 1915(k) benefit. This proposal provides an eligibility pathway into Medicaid for individuals otherwise eligible for the 1915(k) benefit and provides states with additional tools to manage their long-term care home and community-based service delivery systems.

3. Expand Eligibility for the 1915(i) Home and Community-Based Services State Plan Option

This proposal increases states' flexibility in expanding access to home and community-based services under section 1915(i) of the Social Security Act. Currently, an individual who meets the coverage and targeting criteria for a 1915(i) benefit available under his or her state's Medicaid program but whose income is above 150% of the federal poverty level (FPL) may only qualify for Medicaid if the individual also meets the coverage and targeting criteria for a 1915(c) waiver approved as part of the state's Medicaid program. This proposal removes this limitation, which we anticipate will

reduce the administrative burden on states and increase access to home and community-based services for the elderly and individuals with disabilities.

4. Allow Full Medicaid Benefits for Individuals in a Home and Community-Based Services State Plan Option

This proposal provides states with the option to offer a larger package of Medicaid services to medically needy individuals who access home and community-based services through the state plan option under section 1915(i) of the Social Security Act. Currently, individuals who qualify as medically needy based on the unique financial deeming rules many states use in providing 1915(i) coverage may only receive 1915(i) services, instead of the other services available to medically needy individuals under the state's plan. This option will provide states with more opportunities to support the comprehensive health care needs of medically needy individuals who are eligible for 1915(i) services.

5. Provide Home and Community-Based Waiver Services to Children Eligible for Psychiatric Residential Treatment Facilities

This proposal provides states with additional tools to manage children's mental health care service delivery systems by expanding the non-institutional options available to these Medicaid beneficiaries. By adding psychiatric residential treatment facilities to the list of qualified inpatient facilities in 1915(c), this proposal provides access to home and community-based waiver services for children and youth in Medicaid who are currently receiving services in these settings and/or meet this institutional level of care. Without this change to provisions in the Social Security Act, children and youth who meet this institutional level of care do not have the choice to receive home and community-based waiver services and can only receive Medicaid-covered services for the

type of care they need in an institutional setting where residents are eligible for Medicaid.

This proposal builds upon findings from the 5 year Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant Program authorized in the Deficit Reduction Act of 2005 that showed improved overall outcomes in mental health and social support for participants with average cost savings of \$36,500 to \$40,000 per year per participant.

[FR Doc. 2016-27040 Filed: 11/4/2016 4:15 pm; Publication Date: 11/9/2016]