NYLAG
New York Legal Assistance Group

June 30, 2023

VIA ELECTRONIC TRANSMISSION

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

Dear Administrator Brooks-LaSure:

The New York Legal Assistance Group (NYLAG) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule, Ensuring Access to Medicaid Services.

New York Legal Assistance Group (NYLAG) uses the power of the law to help New Yorkers experiencing poverty or in crisis combat economic, racial, and social injustice. We address emerging and urgent needs with comprehensive, free civil legal services, financial empowerment, impact litigation, policy advocacy, and community partnerships. We aim to disrupt systemic racism by serving clients, whose legal and financial crises are often rooted in racial inequality. Access to Medicaid eligibility and services, especially community-based long term care services, is a priority. We launched the Managed Long Term Care ("MLTC") Data Transparency Project last year to use data to illuminate systemic failures in achieving rebalancing goals in New York State and the need for more transparency on quality and rates. See website at https://nylag.org/MLTCdatatransparency/ and full Project Report and recommendations at https://nylag.org/wp-content/uploads/2022/09/MMCOR-Report-FINAL.3.pdf.

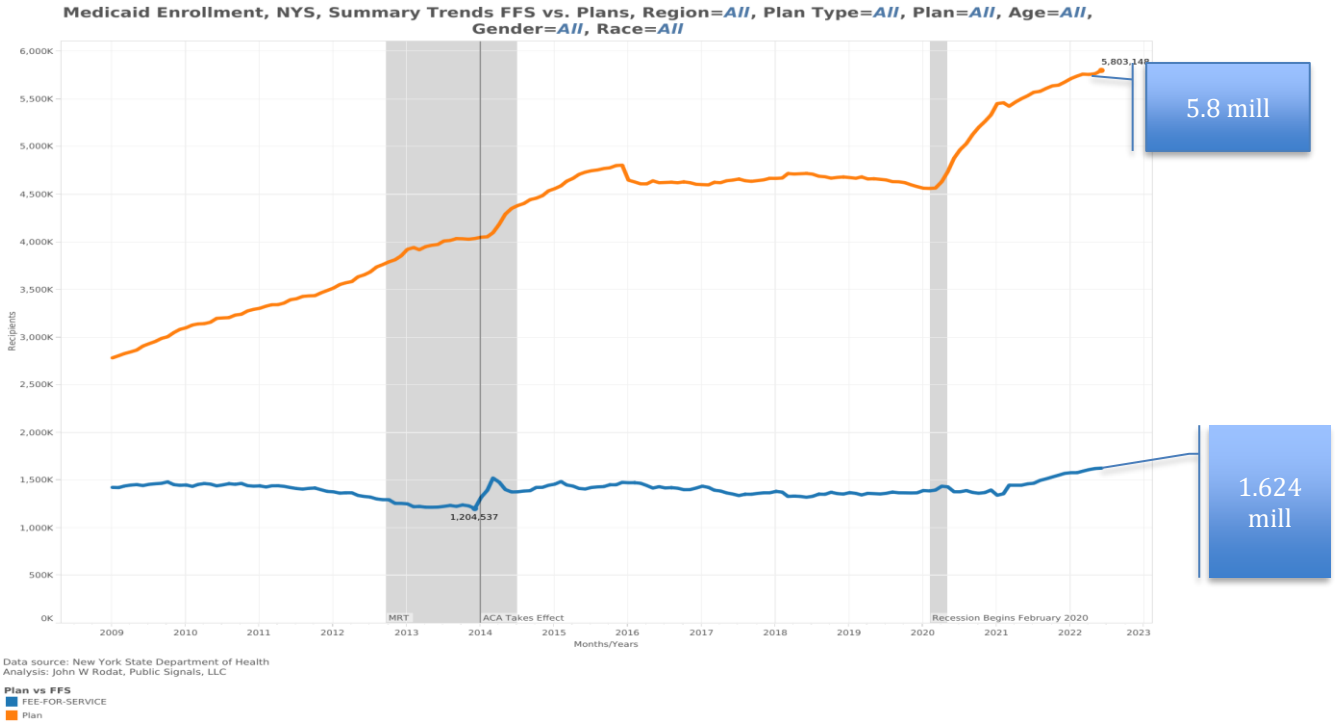
1. All Proposed Requirements, including but not limited to those on Quality, Transparency, Reporting, Rates, and HCBS Access Must Apply to Section 1115 Managed Care Programs.

The regulatory language needs to be amended to carry out the intent stated in the preamble -- that the new requirements will apply to HCBS services provided through 1115 programs. The preamble states in part, "… The proposed requirements for section 1915(c) waiver programs and section 1915(i), (j), and (k) State plan services included in this proposed rule, if finalized, **would apply to such services included in approved section 1115 demonstration projects**, unless we explicitly waive one or more

of the requirements as part of the approval of the demonstration project." p. 27971[1] (emphasis added), and later, "We are proposing to apply the requirements at §§ 441.301(c)(3), 441.302(a)(6), 441.302(k), 441.311, and 441.313 to both FFS **and managed care delivery systems**…." p. 27996 (emphasis added). Yet the next sentence restricts application only to "…a managed care delivery system to deliver services authorized under section 1915(c) waivers and section 1915(i), (j), and (k) State plan authorities…." And the proposed amendment to section 438.72 omits any mention of services authorized under Section 1115, and should be amended as recommended below.

5.96 million or **79 percent of all 7.7 million** NYS Medicaid recipients receive Medicaid services including HCBS through the 1115 waiver (excludes PACE).[2] For the proposals on quality, rate transparency, etc. NOT to apply to 1115 waiver programs would leave out 79 percent of NYS Medicaid recipients, and the vast majority of those who depend on Medicaid for HCBS. Table 1 below shows that only 22 percent of all Medicaid recipients received services FFS (June 2022).

Table 1: Number Enrolled in 1115 Waiver Managed Care vs. Fee for Service – June 2022



SOURCE: NYS DOH Open Health Data, https://health.data.ny.gov/, above summary is available at https://nylag.org/medicaid-plan-enrollment/.

[1] Page numbers are to the rule published at 88 F. R. 27960 (May 3, 2003)(here just p. 27985).

[2] 7.7 million figure from NYS DOH "Public Health Emergency Unwind: Eligibility & Enrollment" presentation May 11, 2023 (excerpt attached as an Exhibit); number enrolled in 1115 waiver programs in May 2023 from DOH Medicaid Managed Care Program Update (June 8, 2023)(excerpt of presentation attached as Exhibit, including slides showing figures shown in Table 2 of number enrolled in individual 1115 programs).

Table 2 – Number of Enrollees in Different 1115 programs and 1915(c)

1115 Waiver program	**Enrolled 5/2023**
"Mainstream" managed care (non-duals)	5,573,316
HARP –managed care for non-duals with behavioral health needs	167,225
HIV-SNP – managed care for non-duals with HIV/AIDS	16,535
FIDA-IDD – Integrated care for Duals with Developmental Disability	1,720
MAP – Medicaid Advantage Plus – fully capitated integrated care for dual eligible who need HCBS (optional alternative to partial cap MLTC)	38,510
MLTC – Partial Capitation – provides solely Medicaid not Medicare services – enrollment mandatory for dual eligible adults who need HCBS/LTSS	264,715
TOTAL 1115 (excludes 9,007 in PACE that is not in 1115 waiver)	6,062,061
1915(c) waivers (2018) see n. 2 – 90% are in OPWDD waiver for Developmental Disabilities	97,136

Source: 1115 data--see footnote 2; 1915(c) data–see Mathematica data in fn 3.

Just looking at HCBS, NYS delivers HCBS services to 2 - 3 times as many people through the various 1115 waiver programs in Table 2 than through 1915(c) or other 1915 authorities. As shown above, in May 2023, **303,225 adults,** mostly dual eligibles, received HCBS from Managed Long Term Care (MLTC) or MAP plans through the 1115 waiver.[3] While MLTC plans and other MCO's under the 1115 waiver in NYS may provide section 1915(k) State plan services, their HCBS services are primarily 1905(a) State plan services such as Personal Care Services – both the traditional version and the consumer-directed version – and Home Health services, along with Private Duty Nursing services.

[3] **97,136** New Yorkers participated in 1915(c) waivers in **2018** (90% of whom were in the waiver for people with Developmental Disabilities). Mathematica, *Long-term Services and Supports Expenditure Reports Project* (Dec. 2021), available at Appendix B tables, available at https://www.mathematica.org/-/media/publications/pdfs/health/2021/sec1915crep_17-18_appb_tables.xlsx, and full report at https://www.mathematica.org/publications/medicaid-section-1915c-waiver-programs-annual-expenditures-and-beneficiaries-report, last accessed 6/19/2023.

In the same year, in Dec. 2018, **236,688** New Yorkers were in 1115 waiver MLTC or Medicaid Advantage Plus plans (excluding PACE). NYS Dept. of Health, *Medicaid Managed Care Enrollment Reports*, available at https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/. "MLTC" is the name used in NYS for the Managed Long Term Services and Supports (MLTSS) program, and includes Medicaid Advantage Plus (MAP) –fully integrated MLTSS plans for dual eligibles.

While 1115 waiver MLTC/MAP enrollment increased by over 20 percent from 2018 to **303,225** in May 2023, we strongly doubt that 1915(c) enrollment has increased proportionally in NYS in that time. Moreover, the other 1915 waivers would not add to the total receiving 1915 services. NYS does not have 1915(i) or (j) waivers. NY does not have a separate 1915(k) program; instead it uses 1915(k) to fund the cost of CFCO services provided through 1115 or 1915(c) waivers or fee for service (FFS). Also, thousands of consumers receive HCBS through the 1115 waiver aside from those in MLTC plans -- "mainstream" MCO's for non-dual eligibles, also under the 1115 waiver, are responsible for providing state plan 1915(a) HCBS services. The number receiving these services is not publicly available, but we believe it is 50,000 - 100,000.

As CMS states several times in the preamble,

> "….section 2402(a)(3)(A) of the Affordable Care Act requires States to improve coordination among, and the regulation of, all providers of Federally and State-funded HCBS programs to achieve a more consistent administration of policies and procedures **across HCBS programs**. In the context of Medicaid coverage of HCBS, it should not matter whether the services are covered directly on a FFS basis or by a managed care entity to its enrollees. The requirement for 'consistent administration' should require consistency between these two modes of service."

Proposed regulation, pp. 27974, 27977, 27981. For this goal to be carried out, the new requirements must apply to 1115 waivers. Moreover, the "effective date" paragraphs of each requirement all section 1115(a) as well as 1915(a) and (b), suggesting that the regulations were intended to cover section 1115 waiver programs. *See, e.g.* § 441.311(f). This must be made clear.

RECOMMENDATION: The proposed § 438.72 should be amended to specifically include services authorized under an **1115 waiver**. Part 438 is the home of all regulations that apply to Section 1115 waivers – from enrollee rights to the grievance and appeal process to rate-setting and medical loss ratio standards. This would not be the only section in Part 438 focused specifically on Long Term Services and Supports (LTSS). See § 438.71(d) and 438.816 (Beneficiary Support System) and § 438.70 (stakeholder engagement when LTSS is delivered through a managed care program). Suggested additions are **bolded and underlined** below.

> § 438.72 Additional requirements for long-term services and supports.
> (a) [Reserved]
> (b) Services authorized under section 1915(c) **and section 1115** waivers and section 1915(i), (j), and (k) State plan authorities. The State must comply with the review of the person-centered service plan requirements at § 441.301(c)(1) through (3), the incident management system requirements at § 441.302(a)(6), the payment adequacy requirements at § 441.302(k), the reporting requirements at § 441.311, and the website transparency requirements at § 441.313 for services authorized under section 1915(c) **and section 1115** waivers and section 1915(i), (j), and (k) State plan authorities.

2. HCBS Payment Adequacy - 80% direct care compensation requirement – Should apply to 1115 waivers and State Plan services, and be used to set a floor for rates paid by Managed Care plans to home care contract agencies

We applaud CMS for acknowledging the brutal impact of COVID on the home care workforce, and recognizing the severe shortages even before the pandemic. The national aide shortage has been acute in New York State as well.[4] Throughout the pandemic we have filed numerous complaints with plans and

[4] Gail Robinson, *What's Driving the Shortage of Home Healthcare Workers in NY? Low Wages, Advocates Say,* City Limits, Dec. 17, 2021, available at https://citylimits.org/2021/12/27/whats-driving-the-shortage-of-home-healthcare-workers-in-ny-low-wages-advocates-say/, last accessed 6/21/23 ("Mercer, a consulting firm, has projected the state will face a shortage of 83,000 home health workers in just three years, the worst such shortage in the country."); Sarah Taddeo, *Home care crisis leaves New Yorkers without aides and families face burnout,* Democrat & Chronicle, June 2, 2022, updated Jan. 11, 2023, available at https://www.democratandchronicle.com/story/news/2022/06/02/new-yorkers-without-aides-face-burnout-during-

with the State because of lack of staffing by MLTC plans and mainstream MCO's – both operating in the 1115 waiver – a problem that could at least be in part ameliorated by the proposed national benchmark of 80% of payments that must be paid as compensation. We have the following comments and concerns.

A. Amend Sec. 441.302(k)(2) to include Services Under 1115 Waivers

Despite the explicit statement in the preamble that §441.302(k) is one of many revised regulations that would apply "to both FFS and managed care delivery systems" (p. 118), the regulation requires States only to meet the requirement for services "that are delivered by direct care workers and authorized under section 1915(c) of the Act." In NYS, omission of the 1115 waiver from this requirement would deny this protection to over 300,000 older people and people with disabilities in MLTC/MLTSS plans – and as many as 100,000 more non-duals who depend on "mainstream" managed care organizations ["MCO"] to receive HCBS services. See Tables 1-2 and n. 2-3.

- **RECOMMENDATION**: Amend 441.302(k) to include services "authorized under section 1915(c) **or section 1115** of the Act." Also, as said above, include section 1115 waivers in the revision to § 438.72.

B. The 20% Benchmark Must Include Section 1905(a) State Plan Home Care Services

Comment was requested about whether to apply the 20% benchmark to section 1905(a) State plan services. We strongly urge that the benchmark be applied to State plan services. In states like New York, the benchmark will be essentially meaningless *unless* it is applied to State plan home health and personal care services, which in NYS also include consumer-directed personal assistance (CDPAP) services. Whether delivered Fee for Service or, more commonly, through Medicaid MCO's and MLTC plans in the 1115 waiver, these are the core home care services that enable older people and people with disabilities to live safely in their homes and avoid institutionalization. As stated below, private duty nursing is also a State plan service in NYS.

The preamble says, with some ambiguity discussed above, that the requirements apply to managed care. "We believe that this proposal supports the economy, efficiency, and quality of HCBS authorized under section 1915(c) of the Act, by ensuring that a sufficient portion of State FFS **and managed care payments for HCBS** go directly to compensation of the direct care workforce." p. 27983 (emphasis added). However, managed care in NYS is entirely under section 1115. The primary HCBS services that both MLTC and mainstream MCO's provide in the 1115 waiver are State plan 1905(a) personal care, CDPAP, and home health services. To be sure, NYS's Traumatic Brain Injury and Nursing Home Transition & Diversion (NHTD) 1915(c) Waivers do include some waiver services that are not in the State Plan, such as Home and Community Support Services (HCSS),[5] or some waiver services in the

home-care-crisis/9458825002/ (reporting "New York has the one of the worst projected shortages of the home health aides in the nation, followed closely by other mid-Atlantic and Midwest states like Michigan, Ohio and Pennsylvania. In New York, 74% of seniors and people with disabilities were unable to retain home care staff in 2021, according to a report by the Consumer Directed Personal Assistance Association of New York").

[5] https://www.health.ny.gov/health_care/medicaid/redesign/tbi_nhtd_service_comp.htm.

waiver for people with Developmental Disabilities. Certainly the 20% benchmark should apply to those waiver services, but to exclude State Plan services from the benchmark will render it meaningless, at least in New York.

In excluding personal care services (PCS) and home health aide state plan services, the preamble asserts, "the vast majority of HCBS is delivered under section 1915(c), (i), (j), and (k), while only a small percentage of HCBS nationally is delivered under section 1905(a) State plan authorities." Yet Mathematica confirms that "…personal care expenditures accounted for the majority of HCBS spending in New York in FY 2019."[6] It seems CMS may be conflating the t**ype** of service –State plan vs. "waiver" service – with the **model for delivery** of that service –Fee for Service vs. managed care. State plan services can be and are delivered in NYS both through managed care plans (MLTC or MCO's in NYS) and Fee for Service. People in 1915(c) waivers do also receive State plan HCBS services outside of the waiver – whether FFS or through an MCO.

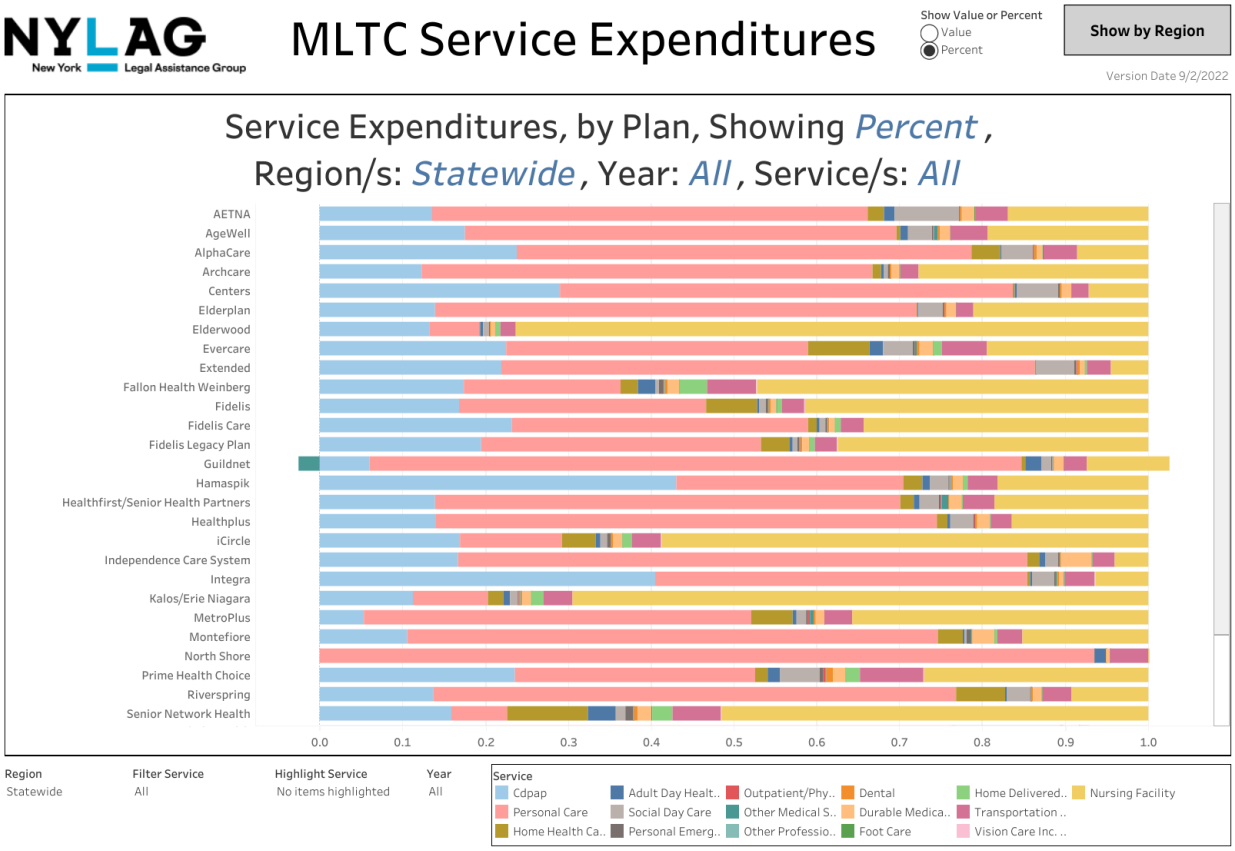
As discussed above at footnote 3, nearly 2.5 times as many NYS consumers received HCBS in 1115 waiver MLTC plans in 2018 as in 1915(c) plans, and that disparity has likely grown since. Moreover, even those in 1915(c) waivers often also receive State plan services outside of the waiver. Those in NYS's Developmental Disabilities 1915(c) waiver may receive State plan HCBS services through a "mainstream" MCO in the 1115 waiver, or through Fee for Service. Those in the TBI and NHTD waivers often receive core State Plan HCBS services Fee for Service, supplemented by the waiver services. In fact, CMS requires that if a service can be authorized under the state plan, it may not be authorized under a waiver.[7]

To illustrate the high percentage of all services delivered by Section 1115 MLTC plans that are State plan HCBS services, Table 3 below breaks down expenses paid by MLTC plans in 2018 for each different service, each color-coded. The three color blocks on the farthest left side represent three types of State plan home care services -- starting from the left -- personal care (blue), consumer-directed personal assistance (pink – a variation of personal care), and home health care (brown). Except for a few upstate plans which used excessive amounts of nursing home care for their members (shown by the gold block on the far right), most MLTC plans spent between 50-85% of all service expenses on these three State plan home care services.

[6] Mathematica, Medicaid LTSS Annual Expenditure Report FFY 2019 (CMS Dec. 9, 2021), available at https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf, at P. 25

[7] CMS, Application for a §1915(c) HCBS Waiver -- Instructions, Technical Guide and Review Criteria, January 2019, available at https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf.

Table 3. MLTC Percent of Service Expenditures for Each Service - 2018



Source: NYS DOH Medicaid Managed Care Operating Reports (MMCOR) 2018, Schedule B, posted online at https://nylag.org/mmcor-service-expenditures/.[8]

CMS reported as the reason for declining to include State plan services in the 20% benchmark, "State feedback that they do not have the same data collection and reporting capabilities in place for section 1905(a) services as they do for section 1915 …programs and … services. Further, the vast majority of HCBS is delivered under section 1915 … authorities, while only a small percentage of HCBS nationally is delivered under section 1905(a) State plan authorities." p. 27975. CMS did not specify whether states reported that they lacked data about section 1905(a) services provided on Fee for Service basis or through managed care plans. Either way, we are surprised by States reporting lack of data and reporting capabilities, given that they must obtain and review data for rate-setting and other oversight. If they do

[8] All MLTC plans and other MCO's in NYS file MMCOR reports with the State quarterly and annually per state regulation. Title 10 NY Code of Rules & Reg. § 98-1.16(a - h). The reports are only publicly available through a Freedom of Information request, and then in a format that makes comparison of plans and regions impossible for the consumer or advocate. Our organization, NYLAG, posted interactive visualizations of selected MLTC MMCOR data for 2017 and 2018, with the user able to compare many data points by regions and plans. https://nylag.org/MLTCdatatransparency/. Our 2022 MLTC Data Transparency Project report recommends making this data public in an interactive format. See https://nylag.org/wp-content/uploads/2022/09/MMCOR-Report-FINAL.3.pdf. The report reviews and critiques the current publicly available reports on rebalancing and quality, including the State's reports to CMS under the 1115 waiver, which are woefully lacking.

lack such capabilities, the expanded reporting capabilities and rate transparency requirements in the proposed regulations will remedy that problem. In New York, for 1905(a) Personal Care services provided on a Fee for Service basis, the state sets or approves the rates. See https://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/. MLTC and MCO plans in the 1115 waiver report costs to the State through MMCOR reports discussed above at fn. 8. If needed, these reports could be adjusted to include the additional data.

For these reasons, the 20% overhead benchmark should be applied to 1905(a) state plan services.

C. Require States to set minimum rates that MCO's must pay their home care contract agencies to ensure adequate payment for workers and overhead needed

The 20% standard is important not only as a cap on overhead and profit, but also as a floor for payments by the State to fee for service providers or payments by managed care plans to their contract providers. The regulation at § 441.302(k)(1)(i) defines the term "Compensation," but the regulation does not define "Payment." In the managed care context, is it the State's capitation payment to the MCO or the MCO's payment to the home care provider agency? We defer to home care providers as to whether 20% is a fair estimate for the overhead costs of Medicaid home care agencies. However, the MCOs also take overhead costs as well as profit from the capitation payments paid by the State. While limiting the overhead for provider agencies is commendable, CMS should require states to set a minimum rate that MCOs must pay their home care contractors, to ensure that the contractors can pay the locally required wages and benefits to direct care workers and still have sufficient overhead to avoid insolvency, using the 20% figure.

New York, like many other states, has set the minimum wage above the federal minimum wage.[9] CMS should require states to set a minimum payment rate that MCOs must pay that is sufficient for their contractors to pay direct care workers the state-mandated wages, benefits and payroll taxes and to retain the allowed 20% overhead. New York has expressed reluctance to intrude on payment arrangements between Medicaid MCOs and their contractors, but without such rate mandates, MCOs have historically failed to pay adequate rates, undermining the intended workforce protections and threatening the financial stability of the home care agencies. For example, New York has traditionally paid MCOs extra payments supplementing the regular capitation rates to cover added costs for Recruitment and Retention of the direct care workforce, and increases in the minimum wage. See Table 4 below showing minimum wage supplements paid to MLTC plans in 2018. Recently, ARP funds were used for extra payments. However, the MCO's have reportedly failed to pass on the extra payments to the home care agencies, depriving these providers of the funds needed to pay worker compensation or for their own overhead.[10]

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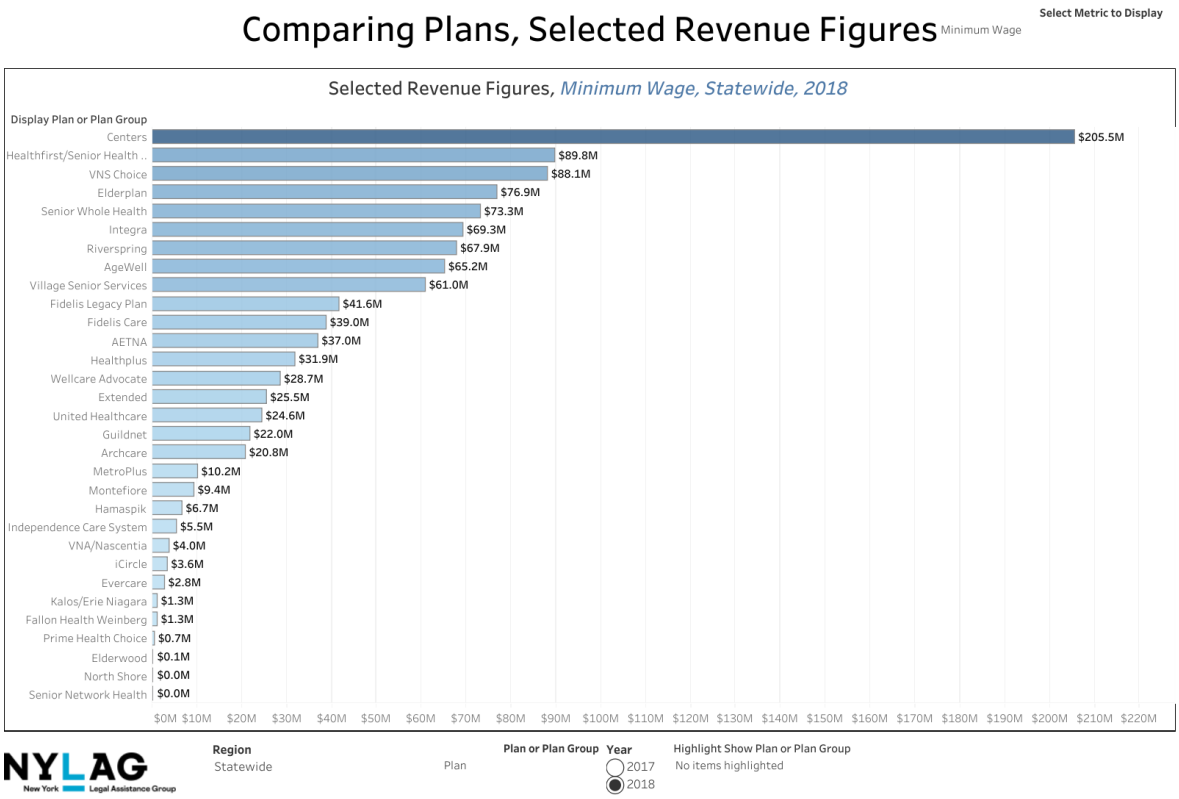
[9] See https://dol.ny.gov/news/new-york-state-department-labor-announces-minimum-wage-increase-home-care-aides (Oct. 2022). There are other "prevailing wage" and "living wage" requirements at a state and local level in NYS.

[10] See, e.g., *News10NBC Investigates: NYS gives homecare aides a raise but insurance companies keep most of it*, April 18, 2023, available at https://www.whec.com/top-news/news10nbc-investigates-nys-gives-homecare-aides-a-raise-but-insurance-companies-keep-most-of-it/.

Table 4. MLTC Plan Revenue from Minimum Wage Add-on 2018



Source: NYS DOH Medicaid Managed Care Operating Reports (MMCOR) 2018, Schedule B - Revenue and Expense statement, obtained through Freedom of Information request, posted online at https://nylag.org/mmcor-consolidated-finance-table/. Online table is interactive, allowing user to select and visualize many other revenue or expense variables.

- **RECOMMENDATION:** The regulations should require States to set a minimum payment rate by MCOs or other entity that pays home care agencies that in turn pay direct care workers for services authorized by the plan or other program. The minimum rates should be set at a level to pay workers the locally required minimum wage and other compensation as defined in the regulation, and for the home care agency to reserve 20% overhead needed to stay afloat.

D. We support inclusion of nurses who do direct care in the 20% benchmark.

We support proposed § 441.302(k)(1)(ii), which includes nurses who provide direct care and excludes those performing supervision or administrative tasks. New York includes as a State plan service "private duty nursing," for those consumers with frequent skilled needs that may not be performed by a home care aide. N.Y. Soc. Serv. Law § 365-a, subd. 2(l). Given the nursing shortage and the advanced training for nurses, their compensation must be higher than wages for aides, and the agencies that employ them must receive enough to pay the compensation and their own overhead. Consumers who

need this service would be forced into nursing homes without this service, so inclusion of nurses is important for *Olmstead* goals.

E. We support setting the 20% benchmark for all direct care workers, regardless of the type of employment or contractor arrangement and including self-directed care.

We strongly support inclusion of those "delivering services under a self-directed service model," along with workers in other employment or contractor arrangements. Proposed § 441.302(k)(1)(ii)(G). Given the dire worker shortage, NY's CDPAP plays an indispensable role in ensuring coverage of service plans in Fee for Service, in managed care Section 1115 and 1915(c) programs. See Table 3 above showing that CDPAP is for many plans the primary HCBS service provided. If regional rather than statewide data is used, the critical role of CDPAP is even greater due to the shortage of personal care workers in rural areas of New York State. Access to this service must be ensured with adequate rates, not only to promote consumer choice and autonomy, but because plans and government agencies alike depend on this service to ensure LTSS coverage. The problems cited above with plans failing to pay home care agencies adequately (see n. 10 above) occur with the same or even greater frequency for CDPAP agencies.

Comment was specifically requested on "whether we should exempt, from these requirements, services delivered using any self-directed service delivery model under any Medicaid authority." p. 27985. For the above reasons, we strongly oppose exempting any self-directed services from this benchmark.

3. ACCESS REPORTING – 441.311(d)(2)

We support, with recommended tweaks, CMS' proposal to require States to track the amount of time from when services are authorized until they are provided and the percentage of authorized hours that are actually provided over a 12-month period. §441.311(d)(2).

In part because New York relies less on 1915(c) waivers than other states, New York does not have the problem of waiting lists faced by other states. However, the lack of waiting lists in no way means there are no problems with access in NYS. See fn 4. In August 2022, the NYS Comptroller issued a report finding that $2.8 billion was paid to MLTC plans that *provided little or no services to their members*.[11] The report made a concerning finding that the—

> … Department [of Health] does not perform reviews to identify instances where MLTC members remain in MLTC but receive few services during their enrollment period…The Department should consider a process to determine the reasons such limited services were received, and ensure members are receiving the required level of care as well as determine if members were properly assessed.[12]

[11] Office of the New York State Comptroller, "Medicaid Program — Oversight of Managed Long-Term Care Member Eligibility," Aug. 5, 2022, *available at* https://www.osc.state.ny.us/files/state-agencies/audits/pdf/sga-2022-20s52.pdf ["NYS OSC Report"]

[12] NYS OSC Report at p. 13.

Our organization joined with other consumer advocacy organizations in responding to this report, calling on the State to do more robust oversight and monitoring of plans' actual provision of services.[13] This is one of the many "Service fulfillment standards" recommended in CMS' 2022 "Managed Long Term Services and Supports Access Monitoring Toolkit"[14] that we urged New York to adopt.

We recommend these changes:

- As said above, these requirements must be applied to 1115 waiver programs – including both managed care for non-duals and MLTC/MAP programs for dual eligibles determined to need HCBS. This application can be made clear through amending § 438.72 as recommended above.

- Tracking the **average** amount of time from when services are authorized to when they are actually implemented **can mask key performance problems**. Instead, as recommended in the CMS LTSS Access Monitoring Toolkit, supra n.14 at pp. 36-38, states would set a target for timeliness (e.g. Texas set 7 days) and measure the **percentage** of all cases in which the wait time exceeded that target, with subsets for the percentage exceeding the target by different buckets of days (i.e 8-14 days, 15-21 days, etc.).[15] The state would track data by requiring plans to submit a Monthly Unstaffed Case Report or a Late & Missed Visit report, and MCO's should face sanctions for their own performance with respect to the targets.[16]

- Whether using average time or percentage of cases showing delays, **it is not enough to track and report a statewide figure.** In a 2019 report, Mathematica warned, "**Aggregate state-level rebalancing measures mask differences across populations and regions within states**."[17] Timeliness of providing HCBS services is an important rebalancing measure. Tracking and reporting regional variations – and variations between specific MCOs -- is critical. In NYS, though staffing issues are severe in New York City, they are more dire in rural areas and small towns, which is much of the rest of the state, where there is less public transportation and aides lack the income to have their own car. Therefore, the

[13] Consumer statement available at https://medicaidmattersny.org/wp-content/uploads/2022/11/OSC-MLTC-report-consumer-advocates-statement-11.2.22-final.pdf (Nov. 2, 2022).

[14] CMS, *Promoting Access in Medicaid and CHIP Managed Care: Managed Long Term Services and Supports Access Monitoring Toolkit*, June 2022, *available at* https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-access-toolkit.pdf [hereinafter "CMS LTSS Access Monitoring Toolkit"]; see also http://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html.

[15] *Id.*

[16] CMS LTSS Toolkit, p. 36.

[17] Deborah J. Lipson, *Measures of State Long-Term Services and Supports System Rebalancing: HCBS Quality Measures issue Brief,* Mathematica, Nov. 2019, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-3-rebalancing.pdf, p. 6, ["Mathematica HCBS Quality Measures"].

regulation should require states to report metrics for each region of the state. New York collects but does not post publicly data from MCOs and MLTCs by region (see fn 8 re MMCOR data).

- Measuring the percentage of authorized hours that are actually provided is one measure of this unmet need, and we support its inclusion. On this indicator as well states should report both regional data as well as statewide data, for the reasons stated above.
- In addition to reporting the access data to CMS, states should compile it by region and, where services are provided by MCOs/MLTC plans, by plan, and report that data publicly. The plan-specific data should also be reported regionally.

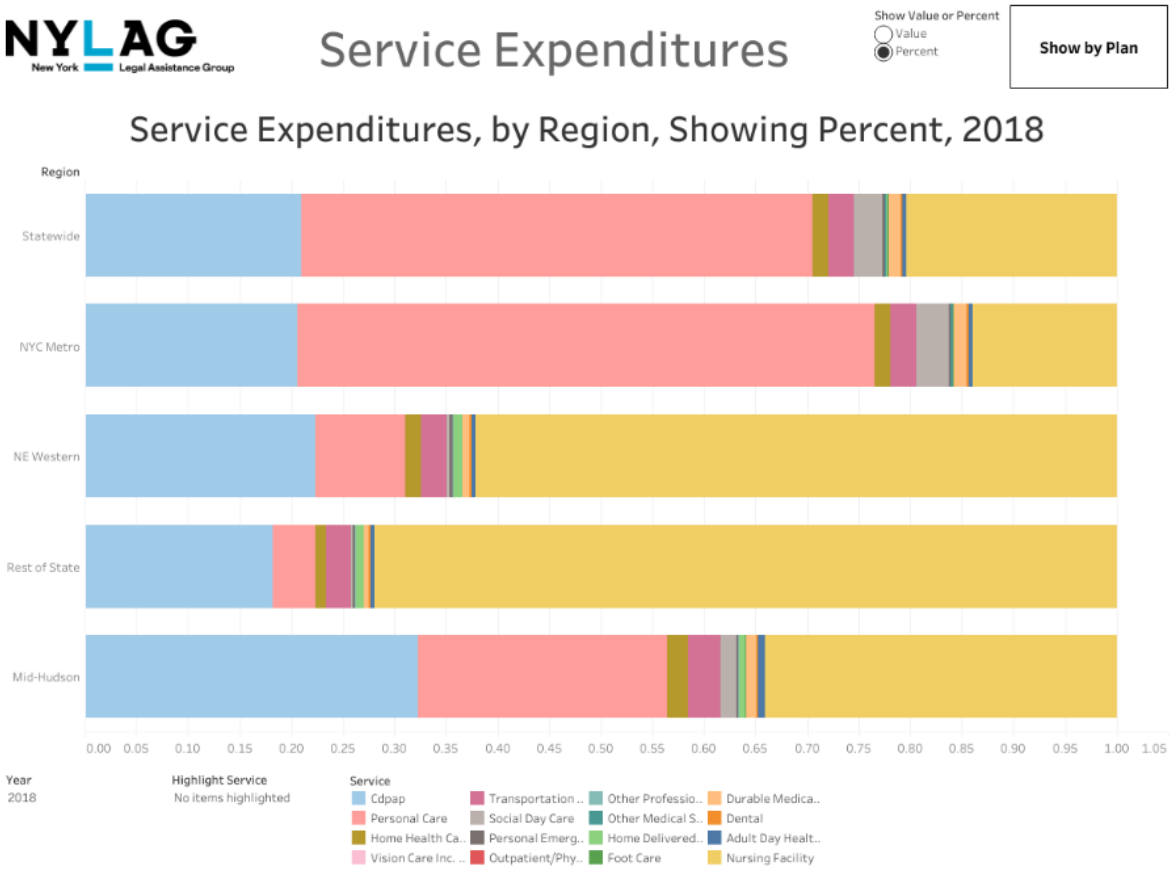
As an illustration of the telling difference between statewide and regional data, Table 5 below shows, statewide and for each of four regions, the percentage of expenditures by MLTC plans on each type of long term care service in 2018. The first row shows Statewide data, and the next four rows show four regions in the state. The gold block on the right represents the percentage of MLTC plan service expenditures on nursing home care in 2018. If only the statewide percentage (20.35% of service expenditures on nursing home care)(percentages appear if view graph online) was reported, one might conclude that NYS is doing well with rebalancing. But the third and fourth rows represent the two upstate regions that include 48 of the 62 counties in the state.[18] In these two regions, 62.16% and 71.96% of all service expenditures were for nursing home care. Thus, even in these MLTC plans designed to provide COMMUNITY-BASED LTSS, rebalancing is a distant goal.

In addition to these metrics, it is also important to track the most common reasons why such services were not provided. Reasons may include lack of home care providers, lack of transportation for home care aides, lack of cooperation by consumer or their informal caregivers, or bureaucratic delays within the plan or State systems.

As noted above in comments on HCBS Payment Adequacy, and for the same reasons, these provisions should also apply to 1905(a) state plan services for home health aides and personal care services and to services delivered through 1115 waivers. Again, if state plan services are left out, and/or if section 1115 waiver services are left out, few New York consumers will benefit from this new oversight. The problems documented by the NYS Comptroller above would continue unchanged.

[18] See NYS DOH, *Medicaid Managed Care Benefit Regions for the MLTC Program*, Appendix A of MMCOR Report template (2021), available at https://nylag.org/wp-content/uploads/2022/09/Upload-B-REGIONS-by-county-PDF.pdf. (the list of counties in each region was the same in 2017 and 2018).

Table 5: Regional Differences in Percentage of Service Expenditures by MLTC Plans on Nursing Facility Services - 2018. *SOURCE: MMCOR Data 2018 - https://nylag.org/mmcor-service-expenditures/*



GOLD is Nursing Facility care, blue is CDPAP and pink is personal care.

Source: NYS DOH MMCOR 2018, Schedule B, https://nylag.org/mmcor-consolidated-finance-table/.

4. GRIEVANCE PROCESS

CMS requested comment on whether a grievance requirement should be established for section 1905(a) State plan personal care and home health services. We enthusiastically say YES. CMS understandably declined to establish a grievance process for managed care enrollees since Part 438 establishes a grievance process. However, CMS is establishing the new grievance process because it recognizes the disparity for FFS HCBS beneficiaries, who do not have a "venue to raise concerns about issues …which are not subject to the fair hearing process" (p. 27975). The same disparity applies to those receiving State plan services on a FFS basis who are not enrolled in 1915(c) plans. While they have the right to request a fair hearing, they need a grievance process for issues not subject to the fair hearing process.

Both the proposed HCBS grievance process and one that we urge be established for State Plan FFS recipients should include issues regarding timeliness, quality and effectiveness of services, which are not issues that can be heard in a fair hearing. For HCBS, this would be in addition to the HCBS setting requirements and person-centered care planning. The lack of a grievance system in New York for this population leaves consumers with nowhere to complain if FFS personal care services are not initiated

for weeks after they were authorized. Many of our clients in New York City have waited weeks and even months for the local New York City Medicaid agency to initiate services it approved after a lengthy assessment process. There is simply no office within the State Medicaid agency (NYS Department of Health) that hears complaints about delays or other quality or service issues for those not in managed care plans.

CMS acknowledges that the proposed grievance system for 1915(c) enrollees would include problems in accessing *State plan services* in the person-centered service plan. P. 27975. In New York, 1915(c) enrollees access state plan services such as personal care or CDPAP the same way that many people not in 1915(c) waivers access them – by applying to the local county Medicaid agency. These are people who are excluded or exempt from enrolling in an MLTC or Medicaid managed care plan, such as those enrolled in home hospice. It would create yet another disparity to offer a grievance process only to some people accessing personal care through these local county offices—those in 1915(c) waivers – but not to others accessing the very same services from the same government agencies.

We support the proposal to implement a grievance process for individuals to express dissatisfaction with the State or a provider's compliance with the person-centered planning process and the home and community-based settings rule. Individuals in fee-for-service Medicaid must have a way to express concerns about compliance with these two linchpins of HCBS service delivery.

5. MEDICAID ADVISORY COMMITTEE (MAC) and INTERESTED PARTIES ADVISORY GROUP FOR RATES PAID FOR CERTAIN SERVICES

NYLAG strongly reports CMS' proposal to significantly strengthen requirements for Medical Care Advisory Committees (MCACs), which would be renamed Medicaid Advisory Committees (MACs) include a new Beneficiary Advisory Group (BAG), and also establish an advisory group for interested parties to advise and consult on HCBS provider rates. Although MCACs have been federally required for nearly 40 years, NYS is among some other states that have seriously underutilized this important opportunity to monitor and improve their Medicaid programs. The closest thing NYS has to a MAC is a Medicaid Managed Care Advisory Review Panel (MCCARP) which has a limited mandate concerning 1115 waivers, and only one consumer representative out of 11 members (9% representation). See (https://www.health.ny.gov/health_care/managed_care/mmcarp/).

We support requiring at least 25% of MAC membership be Medicaid enrollees, their caregivers or families who would also serve as part of the BAG, but also urge CMS to set a 25% benchmark for consumer representatives. These can include legal services providers, consumer assistance programs, beneficiary support systems, Protection & Advocacy program and other disability rights advocates, independent living programs, reproductive justice advocates, elder law organizations, medical-legal partnerships, racial justice organizations, people living with HIV/AIDS, LGBTQIA+ groups, and others who are actively engaged with communities who rely on Medicaid. These advocacy organizations are the eyes and ears on the ground that can identify and report patterns of systemic issues affecting their constituencies.

As a legal service organization and member of various advocacy coalitions, NYLAG routinely brings examples of systemic problems to the attention of the NYS Dept. of Health and its local agency that

administers Medicaid in NYC. For example, even during the Public Health Emergency, when Medicaid should not have been discontinued or reduced for any beneficiary, we helped hundreds of consumers resolve violations of these Maintenance of Effort requirements, and brought the examples to the State and NYC agencies to demonstrate systems problems that needed to be fixed. More of such problems are anticipated in the unwinding – threatening to disrupt HCBS services for 400,000 beneficiaries. Similarly, we report problems with accessing HCBS in myriad settings, and a formal role in a MAC would create more opportunities to report problems and advocate for solutions.

We commend CMS for acknowledging that provider groups and managed care organizations already have a seat at the table, as they and their trade organizations have the resources to engage in lobbying that consumers and their advocates lack. We agree with the proposal to include all such stakeholders but to increase the *representation* of consumers and their advocates to level the playing field

We strongly support the proposed requirement for the State agency to establish an advisory group for interested parties to advise and consult on provider rates with respect to PCS, home health aides, and homemaker services. The group should include direct care workers, beneficiaries and their authorized representatives, and other interested parties. We suggest that at least 25% of seats in the group are reserved for Medicaid beneficiaries and their representatives, and at least another 25% should be reserved for direct care workers and their representatives.

We also encourage CMS to keep the Medicaid Advisory Committee (MAC) and the interested parties advisory group separate. They could have overlapping membership and coordinated meetings, but the work required merits two groups. It would be unreasonable to expect the MAC to fulfill its important obligations overseeing the entire Medicaid program and the particular issues related to the direct care workforce. In addition, while the MAC draws from a very broad cross-section of Medicaid stakeholders, the interested parties advisory group will need to draw from a much more specialized set of stakeholders (for example, stakeholders with disabilities and deep experience with specific HCBS delivered by direct care workers).

In addition to simply making the process by which the State selects group members and convenes its meetings clear, we also support a requirement that the state publicly recruit members. While we support leaving tenure of appointment determinations to the State, group members should serve for set terms and only be removed for cause. Set terms allow members to provide recommendations and constructive criticism of the State's Medicaid program without fear of reprisal, and prevent the State from disbanding an advisory group that disagrees with the rate determination. Similarly, the regulations should clarify that State employees are not permitted to serve on the advisory group. While State employees may provide information and support to advisory group members, allowing State employees to be appointed to the group defeats the purpose of having an independent advisory group.

We also recommend that the advisory group receive sufficient explanations and information as to how any proposed rates were calculated, in addition to the metrics required by the Payment Adequacy and Reporting Requirements sections. This information should include clear, consistent definitions of the cost elements that are considered in establishing a rate.

Rates are often based on rate studies, which are based on specific cost elements involved in providing these services. For example, a rate may be made up of the costs of employee compensation, travel, training, administration, and other components. If the definitions of these components are not clear and the basis for these calculations are not shared with sufficient granularity, then the advisory group will not be able to meaningfully comment. Similarly, if the definitions of the components that go into a rate study for these services vary considerably between rate studies, then meaningful comparisons from year to year or from state to state will not be possible.

Last, the State should be required to publish a public response to the advisory group's recommendations, explaining the evidence used to make their final rate recommendations, whether they accepted the recommendations of the advisory group, and if the rates differ from the recommendations, explaining the State's reasoning.

6. PAYMENT RATE TRANSPARENCY (42 CFR § 447.203(b))

We support the proposals to improve transparency in provider rates. We urge that these rules apply not only to FFS but also to Managed Care – which would require plans to make their rates public since those rates are not set by the state. While we certainly want the benefits of rate transparency for the 1.629 million New Yorkers receiving FFS services, these same protections are needed for the other 5.8 million in managed care. See Tables 1-2. The vast majority of recipients are in managed care and rely on these plans for dental care and other services for which Medicaid rates are notoriously low.

As an example of why rate transparency must be required for managed care as well as FFS, in the last few years, the New York legislature required enhanced rates for private duty nursing for medically fragile children and adults. A fee schedule is published online. https://www.health.ny.gov/health_care/medicaid/redesign/pdn_children/providers/. However, these rates *only apply in FFS* – leaving out most of the medically fragile consumers who need them who are *mandated* to enroll in 1115 waiver managed care or MLTC/MAP plans. See https://www.health.ny.gov/health_care/medicaid/redesign/pdn_children/consumers/. Our organization fights every day for access to these and other HCBS services for children and adults mandated to be in managed care plans or MLTC/MAP plans, which pay rates far below these enhanced FFS rates.

Still, even though NYS is a predominantly managed care state, FFS rate schedules would be helpful to have publicly available. In the private duty nursing example above, for which NYS posts the FFS rates, MCO's can use the FFS schedules as a baseline to set their rates for this service, and the State should compare plan rates with the FFS rates to identify solutions for access problems. Moreover, as discussed above regarding the 20% overhead allowance for HCBS, States should set minimum rates for HCBS and other services delivered by MCOs.

7. QUALITY MEASURES, REPORTING and PUBLIC WEBSITE

We support making parts of the CMS HCBS Quality Measure Set[19] mandatory, and requiring states to stratify data by race and other demographic factors as a means of addressing racial inequity. **Again, we call on CMS to apply these quality measures to MCO's under the 1115 waivers,** which, in New York, provide the vast majority of HCBS services compared to 1915(c) programs. We support the CMS proposal to establish a mechanism for CMS to update the quality measures with public comment.

While beneficiary surveys are important, we believe that the HCBS Quality Measure Set overly relies on those surveys instead of concrete data that reveal access issues. For example, whether "staff come and leave when they are supposed to" is solely tracked as a percentage of participants who report this in a survey. 2022 Quality Measure Set. When NYS MLTC members are surveyed about timeliness of care, the survey question asks whether the home care worker, case manager or visiting nurse were always or usually on time in the last six months. See https://health.data.ny.gov/Health/MLTC-Timeliness-Composite-by-Plan/ngr8-ixax. The timeliness of staff in these different roles should not be conflated in one question, since only a home care worker, not a care manager or visiting nurse, is relied on to assist with basic ADLs. Moreover, there are more accurate ways for plans and DOH to monitor timely access to care. The proposed access standards are an important start for monitoring access, which we urge CMS to expand as discussed above in No. 3.

We urge that the Rebalancing indicators in the 2022 Quality Measure Set be made mandatory for all states for all HCBS services – FFS, 1115 waivers and 1915(c) waivers. These include HCBS-1 and MLTSS-6 (Admission to a facility from the community in MLTSS and FFS), MLTSS-7 (minimizing facility length of stay) and MLTSS-8 (successful transition after long-term facility stay). Again, since most HCBS in NYS is provided through 1115 waivers these measures must apply to these programs.

These rebalancing indicators are particularly important in NYS now that, under a change in the 1115 waiver that CMS approved in Dec. 2019, which NYS implemented in 2020, long-term nursing home care has been "carved out" of the MLTC benefit package.[20] With this change, consumers who depend on home care to stay out of a nursing home, or to return home from a nursing home, are more at risk of being forced into permanent institutionalization. The MLTC plan can avoid paying for expensive home care needed for the consumer to return home simply by waiting out a temporary nursing home placement until three months goes by, and then the consumer is disenrolled from the MLTC plan. Since this 2020 change, well over 20,000 MLTC members have been disenrolled from their MLTC plans in NYS – reducing their chances of returning home. In our MLTC Data Transparency report, infra at p. 1, we called on NYS to strengthen monitoring of the impact of the "carve out" of nursing home care from the MLTC benefit package. We specifically recommended adopting some of the rebalancing measures in the 2022 Quality Measure Set. See NYLAG Report, supra fn. 8.

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[19]CMS, State Medicaid Director Letter No. 22-003, *Home & Community Based Services Quality Measure Set*, available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf [hereafter "2022 Quality Measure Set"].

[20] See Letter from CMS to DOH, Dec. 19, 2019, approving Special Terms & Conditions of 1115 waiver, available at https://www.health.ny.gov/health_care/managed_care/appextension/2019-12-19_cms_stc.htm.

We support the requirement that states build an accessible website to post results of the expanded reporting requirements and other data. We urge that the state website should NOT link to websites of MCOs. If the data is to be reported consistently in the various HCBS programs, as we propose above, the website should be operated and housed solely on one central state webpage. As said above, data should be reported regionally and by racial stratifications – as "Aggregate state-level rebalancing measures mask differences across populations and regions within states." Mathematica, n. 17, infra.

Posting data is not an end in itself. The NYS "Open health data" website[21] is extremely difficult to navigate even for professionals. Searching for MLTC data reveals extensive MLTC plan-specific data that demonstrates the needs of MLTC members – various ADL scores, number living alone, continence, etc. See, e.g. n. 19. However, the reports say nothing about how the plans responded to the documented member needs – whether with nursing home care or HCBS services. Did plans with more members with high needs, shown by a high NFLOC score or a higher percentage who lived alone, provide more HCBS services? Without measuring the plans' response to member needs, and particularly the rate of nursing home placement, federal goals of "rebalancing" cannot be tracked. In NYS, MLTC plans have Quality Incentives that are based on the above indicators, which means *plans are rewarded for the functional needs of their members but not for how they meet those needs*.

8. PERSON CENTERED CARE PLANNING

As said above, the requirement to reassess needs annually and for states to report the results, with demographic stratification, should apply to 1115 waivers as well as 1915(c). In addition to tracking whether assessments are done annually, the HCBS Quality Measure Set, parts of which would now become mandatory (see fn 20), also measures whether "Service plans are updated/revised at least annually or **when warranted by changes in the waiver participant's needs**." MLTSS-1 and MLTSS-4 in CMS 2022 HCBS Quality Measure Set (emphasis added). To that end, states should track and report the percentage of hospitalizations, rehab facility stays, or other critical incidents that were followed by reassessments – within a set standard of time -- to determine a change in need. In MLTC plans under the 1115 waiver, we too often see plans in nYS failing to reassess need after such incidents, even when a request is affirmatively made for an increase in care resulting from the medical incident.

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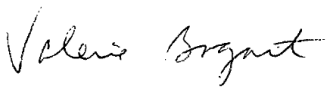
[21] https://health.data.ny.gov/. One of the MLTC charts is https://health.data.ny.gov/Health/MLTC-Activities-of-Daily-Living-by-Plan/uyk3-a9sx.

We have included numerous citations to supporting research, including direct links to the research. We direct CMS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for your attention to these comments. If you have further questions, please contact Rebecca Wallach in the signature below.

Sincerely,



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