Survival Coalition
of Wisconsin Disability Organizations

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The cross-disability Wisconsin Survival Coalition is comprised of more than 20 statewide disability organizations in Wisconsin with a mission of improving services and supports so people with disabilities can fully participate in their communities. We appreciate the opportunity to provide public comment on the Ensuring Access to Medicaid Services rule (file code CMS-2442-P) and the interest CMS has in ensuring state Medicaid LTSS programs are maximizing the use of home and community-based services so people with disabilities can live healthy, safe, community-connected lives. Our experience in Wisconsin demonstrates that to ensure access to appropriate home and community-based long-term care services and supports (LTSS) we need federal regulations and more federal guidance to:

- ensure rates reflect the actual cost of care,
- address the care worker shortage with multiple strategies,
- ensure the provider network can provide the level of authorized services,
- drive states to evolve service systems, lower cost, less staff intensive, more inclusive, and best practice approaches, including community supported living and integrated employment as the first and preferred option,
- significantly improve oversight and monitoring to address abuse and neglect
- Make sure services are person-centered and driven by informed participant choice
- Ensure participants and their families are involved in all aspects of decision-making and policy development of LTSS programs

Ensure rates reflect the actual cost of care

Wisconsin's current capitated rate system and "usual and customary" rates established by the state that participants who self-direct are told they can pay do not begin to reflect the true cost of care. The average direct support provider in WI is making $13.53 an hour and fewer than half have health insurance or paid time off. That compares with a private pay rate of $32/hr and state institution rates for CNAs of $20.82-$22/hr with paid training, $2000 sign-on bonus and full state benefits package.

WI is seeing smaller (often higher-quality) providers going out of business and more providers moving to take private-pay clients only. While WI is technically a no-waiting-list state, the lack of direct support workers and stresses on provider agencies are creating defacto wait lists. One of

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our members, who coordinates her own care, has had as many as two-thirds of her shifts in a given month go unfilled.

Using the previous two years of spending as the mechanism to calculate future rates is insufficient to determine future rates and is a flaw in the current rate methodology, particularly in light of high inflation and other stresses still present from pandemic lock-down.

Survival coalition recommends CMS require all states to include the following factors when determining unmet present need and projecting future needs:

- Changing demographics that increase diversity and acuity of service needs. This calculation should include a breakdown by age, disability status, family caregiver status
- The number and percentage of care plan hours currently being provided by unpaid family caregivers.
- Projection on sustainability of unpaid family caregivers to provide the same level and volume of care.
- Reporting on total authorized and total provided care plan hours by service category to assess current capacity and identify areas where increased capacity is needed.
- Assessment of current number of providers by service category, total amount of authorized care plan hours provided by service category, total number of providers accepting new Medicaid clients.
- Inflation, which can raise supply, equipment, and fuel costs.
- Market forces that impact the ability to recruit and retain care workers including wages, benefits, transportation costs.

In addition to core factors states should include in rate setting methodologies, we recommend CMS require state contracts with managed care organizations implementing HCBS services include provisions to incentivize shifting systems to community integrated outcomes and increasing community integrated provider capacity.

- State contracts should be required to contain provisions that factor in authorized but undelivered services as a trigger to require investment of gains or at least result in a risk corridor calculation that does not hold an MCO harmless for failure to deliver services authorized in a care plan.

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- State capitation rates should incentivize community integrated outcomes into performance-based bonus payments to MCOs. Outcomes should be based on measurable data such as increases in community integrated employment hours and increases in number of participants supported in own homes or apartments.
- State capitation rates should build in rate band progressions and pay scale increases for in-home care workers with specialized skills, or who are serving geographically underserved areas and/or high acuity populations.
- State capitation rates should estimate the number children with significant care needs entering the adult system and transfer the higher service rates with the individual.
- State capitation rates should build in funding for care needs for people transitioning out of state ICF/IDDs or other institutional settings back into the community.

Address the care worker shortage

We recommend CMS take the following actions:

- **Work with the Department of Labor to reclassify direct care, home health care, and personal care workers.** The care workforce should not be classified as domestic workers; they are providing nursing home level of care within home settings.
- **Require states to separate the admin portion of direct care and personal care rates from the worker wage portion of the rate**[1] so state legislatures can directly invest in worker wages and achieve wage parity across HCBS waiver programs, long term care facilities, and hospital settings. The same skilled work should be similarly compensated across settings—HCBS rates have been lower than institutional rates creating greater recruitment and retention challenges for the HCBS system. Designating a set amount for provider agency admin would protect provider agencies, especially smaller providers,

[1] In Wisconsin, the same rate includes funding for provider agencies to run themselves (admin) combined with worker wages. The state legislature has raised the rates but has seen little increase in worker wages, due to a number of administrative factors that prevent money being distributed directly to provider agencies. Increases have been directed to Family Care, but have not applied to the HCBS IRIS or CLTS waivers. For discussion on the mechanism, see the Wisconsin Legislative Fiscal Bureau Budget paper discussion on Direct Care workforce and Personal Care rates (https://docs.legis.wisconsin.gov/misc/lfb/budget/2023_25_biennial_budget/302_budget_papers/420_health_services_medical_assistance_long_term_care_medical_assistance_long_term_care.pdf)

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from MCOs that negotiate lower rates with individual providers than the rate set by the legislature.

- **Require states to use a formula that includes the cost of inflation and the Living Wage (as calculated by the living wage calculator[2]) as the base wage** for Direct Care, Personal Care, and Home Health workers. The methodology would account the actual costs (housing, childcare, transportation etc.) associated with living in the areas that workers serve. Requiring an arbitrary percentage of total funds to pass through to wages as the draft rule proposes (80%) will not address the disconnect between rates and living wages. 80% of a fixed amount of funding that is insufficient to cover true costs of care is still insufficient**.**

- **Direct states to include coverage of transportation costs for paid workers** in the admin portion of provider rates (milage, wear and tear on personal vehicles, coverage of public transit fares, or provision of fleet vehicles to provider agencies for paid staff).

Ensure the provider network can provide the level of authorized services

CMS should direct states to have consistent measures of provider network across states, including:

- Time and distance standards to ensure there are sufficient provider choices to serve participants locally.

- Total number of providers by service category.

- Proportion of provider's budget that is private pay versus HCBS waiver, with ability to assess trends over time. Advocates are hearing providers shifting towards more private pay clients, which reduces the capacity to serve Medicaid participants.

- Number of hours of service provided to participants, by provider with ability to assess trends over time.

- Number of unique participants served by provider, and number of hours of service provided per participant with ability to assess trends over time. Advocates are hearing the capacity to serve people with high care needs is extremely limited; providers are limiting or not taking participants because of workforce shortages.

[2] https://livingwage.mit.edu/

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- Provider capacity to accept new or additional Medicaid beneficiaries.
- Reductions of authorized hours in care plans, and reasons why hours have been reduced. Advocates are hearing hours in care plans are being reduced to reflect what can be provided (e.g. . available workforce) instead of the participant's actual assessed need. Without monitoring and trend analysis, we are concerned authorized care hours could decline even though the disability remains the same.
- Average time between provider reimbursement requests and payment delivery, amount of Medicaid funds frozen by reimbursement denials.
- Claim denials, delineable by service type, and reasons for claim denials. The number of claim denial appeals and results of those appeals.
- Requirement for all collected data to non-proprietary and provided to state departments, CMS, and publicly available to advocates and participants.

CMS should direct states to use above data elements to drive:

- Building provider network capacity, including building capacity for services where there are authorized hours in care plans that are not delivered, geographically under or underserved areas, and increasing provider choice and density to lower time and distance to providers for participants.
- Improving targeted outcomes that lead to greater independence for participants including community integrated employment, community supported living, use of remote support technology, increased access to non-driver transportation options, and social/recreational opportunities.
- Rate formulas to incentivize development of new providers and sustainability of providers, especially in areas with high service needs or where the population needing services is projected to grow.
- Timely payment requirements and audits of paperwork and payment processes for usability and plain language, so providers are reimbursed quickly for services provided.

CMS should require states to establish bonus payment structures that reward a robust provider network, and networks that are resulting in the most inclusive and integrated outcomes in at least the following areas:

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- Bonus payments for MCOs when they demonstrate an adequate number of available providers in each area they serve to cover the amount of services authorized in participant care plans.

- Bonus payments for specialty provider networks that serve complex people including people with I/DD and co-occurring mental health issues, people with I/DD experiencing dementia, people with physical or I/DD disabilities who are aging, etc.

- Bonus payments, weighted or awarded on a sliding scale, to reward a provider network that has a greater proportion of providers achieving strong Community Integrated Employment, Community Integrated Day, and Independent Living outcomes.

- Bonus payments for improving targeted outcomes that lead to greater independence for participants including use of remote support technology and increased access to non-driver transportation options.

Drive states to evolve service systems

We recommend CMS provide strong and clear direction to states to discourage establishment of new segregated residential housing, including a rationale for denial of HCBS service dollars being spent in such settings, and a roadmap of incentives for states moving towards community supportive housing models and away from congregate residential services.

We recommend CMS require states to include pay for performance measures in their contracts specifically to drive state HCBS systems to move away from congregate service delivery and towards integrated employment and independent living outcomes. We recommend the following pay for performance measures be required:

- **Community Supported Living and Independent living** Pay for Performance. We suggest the following metrics be required: number of participants with independent living goals in care plans, number of participants completing housing futures planning, total numbers of participants supported independently in private homes or apartments, number of participants who have transitioned from congregate settings regulated by the HCBS settings rule into HCBS compliant community supported or independent living.

- **Community Integrated Employment Pay for Performance**. We suggest building a sliding scale of increasing incentives based on the number of hours a participant works in Community Integrated Employment. We recommend a scale that rewards MCOs for

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participants working 1-10 hours (less than part time), 11-20 hours (up to part time), and 21-40 hours (part-time up to full-time).

- **Access to internet connectivity and use of technology** pay for performance. We suggest metrics including the number of participants with remote supports or other technologies in their care plan, number of participants who have completed a technology assessment, number of participants using of remote supports, adaptive technology or other technology, number of participants able to work remotely, number of participants able to use Telehealth services.

- **Create new and increase provider network capacity** pay for performance (see Ensure the provider network can provide the level of authorized service section).

- **Create bonus payment structure** to reward systems that have higher community engagement and integration outcomes. Metrics should include: number of members with authorized community-based service hours (Community Based Pre-Vocational, Community Based Day Services, Supported Employment), number of hours per month that members report spending engaged in integrated community activities, number of community membership opportunities a member has (including volunteer opportunities and belonging to groups/clubs/associations), number of friends and unpaid meaningful community connections that members report, number of participants who live near and use affordable public transportation options, number of participants exercising civil rights, including right to vote

We recommend CMS require data collection to assess progress on integrated outcomes and that data and trends be reported—by service category and population group—to CMS, advocates, and the public.

We recommend CMS require states to report on all people who have applied for services and are either on a wait list to be enrolled **and are waiting to receive services**, not just the official number waiting to be enrolled**.**

We recommend CMS require continual engagement and involvement of disability and aging advocates in the development and any revisions of pay for performance measures, metrics, integrated outcome requirements, MCO contract language, and trend analysis.

<u>Transparency and authentic engagement</u>

We recommend CMS requires states to:

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- Include Protection & Advocacy, Developmental Disability Councils, University Centers for Excellence—the three partners authorized under the Federal Developmental Disabilities Act—Independent Living Centers, entities implementing the Long Term Care Ombudsman program under the Older Americans Act, and a representative of Aging and Disability Resource Centers are part of the required membership, with encouragement to include additional state aging and disability advocates

- Include a requirement for a state plan that is revised on a routine basis such as the state's HCBS waiver renewal cycle—with the committee responsible for analysis and assessment of the current HCBS system's strengths and gaps, identification of emerging trends and challenges, analysis of data to assess key metrics that correlate with high levels of integrated outcomes for participants, and recommendations for policy change to be delivered to the state Medicaid agencies and CMS. CMS should actively and continuously engage with these groups on the challenges in their states, and progress towards shifting HCBS systems to more community integrated outcomes.

- CMS should provide questions and topical areas where they want feedback from states so these groups are dynamically responding to content that is useful in federal policy discussions, rather than passively listening to reports from state programs.

Oversight and monitoring

CMS should require states to:

- Require sufficient ratio of participants to staff at the both the state Medicaid Agency and in independent Ombudsmen contracts to investigate complaints and respond to abuse and neglect in a timely manner.

    - Have a statewide central incident management system that collects data in real time and has a public-facing real-time dashboard that includes the ability to collaborate and share information between all State entities that play a role in the investigations of abuse, neglect and financial exploitation to allow for greater information sharing to protect people with disabilities in every state.
    - Ensure that State contracts with managed care organizations or self-directed agencies implementing service coordination for HCBS include detailed requirements on reporting incidents including time frame for reporting, investigation, and providing information to the person or the person's guardians/supporters
    - Create standard definitions of reportable incidents to reduce ambiguity and

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increase consistency in reporting across the HCBS system.

- Require a statewide hotline and online service provider/member portal for reporting abuse and neglect
- Explore using Medicaid administrative claiming to increase funding for Adult Protective Services. Wisconsin's APS system has not received additional funding from the legislature in **more than a decade. Currently, fewer than 4% of reports are investigated, down from 67% a decade ago.**)
- Require states to invest in technology and infrastructure for a statewide Incident Management System to better facilitate communication between all abuse and neglect reporting systems including State agencies and HCBS partners. Statewide should track and trend data of all reportable incident categories. Trending should include a system wide review, by provider type, by provider, by type of event or incident, and by individual for the purposes of evaluation, remediation, and system improvement.
- Ensure that all entities interacting with participants of HCBS have the following:
    - Written abuse, neglect, and financial exploitation reporting policies.
    - Written abuse, neglect, and financial exploitation investigation policies.
    - Training for new and current staff on abuse, neglect, and financial exploitation.
    - Training in mandated reporting.
- Create plain language resources on what is abuse, neglect, and financial exploitation and how to report it. This should be required to be given to the members, legal decision makers, families, and caregivers at enrollment and at each assessment period.
- Requirement to report in writing to the participant and legal decision maker incremental updates to any investigation including a written report at the end of an investigation. The written notification should include the members' rights if they disagree with the results of an investigation by any state entity, case management agency or service provider.

- Have a single statewide phone number/contact for participants and families or professionals to call to report abuse and neglect.

<u>Strengthen person centered service planning</u>

We recommend the Access Rule require States to:

- Develop and implement a standardized person center planning process and forms that

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are used consistently across care management and service providers to eliminate inequitable provision of services in State's. This should also include baseline assessment of the person's overall quality of life and their personal goals which included an in-depth conversation with the person.

- Develop a standard HCBS Rights Modification Plan addendum to the person centered plan to be used across all HCBS long-term care programs to aid in planning and documenting HCBS rights modifications. This form should be written in plain language and include the process that was used to ensure informed consent and the steps that will be taken to reduce and eliminate the modification as soon as it is feasible to do so.
- Include in the Person-Centered Planning process an assessment of the person's understanding of rights, abuse, neglect and financial exploitation and steps to include education in the plan.