NASUAD
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United for Aging and Disabilities

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Comments on CMS-2328-NC

12/21/2015

Jeremy Silanskis
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2328-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Mr. Silanskis,

On behalf of the National Association of States United for Aging and Disabilities (NASUAD), I am writing to provide comments on the request for information (RFI) regarding access to services for Medicaid beneficiaries (CMS-2328-NC). NASUAD is an association of state government agencies that provide services and supports to seniors and people with disabilities, including a large number of our members who serve as operating agencies for Medicaid home and community based services waivers. Given the nature of our membership, our comments will be focused on measures for long-term services and supports (LTSS) and, more specifically, HCBS. We believe that our comments are relevant both in fee-for-service as well as in managed LTSS environments.

NASUAD believes that it is inappropriate to establish any type of numerical provider thresholds; minimum payment standards; or other types of inelastic metrics when evaluating LTSS. There are a number of reasons why it is inappropriate to try and establish rigid measures for LTSS access, including:

- **Lack of payment comparison data:** In the final access regulation, CMS includes a provision at 42 CFR 447.203 requiring states to include information assessing Medicaid reimbursement rates as a percentage of the corresponding payments from public and private insurers, such as Medicare and commercial plans. This type of comparison, as well as any payment standard based upon the percentage of another source of insurance, is wholly inappropriate for LTSS. As you know, Medicare does not include an LTSS benefit and private long-term care insurance is largely nonexistent in the country. Therefore, any attempt to compare payment rates or methodologies would be futile.
- **Broad and flexible benefit package:** LTSS, particularly HCBS, encompasses a wide range of services and supports that includes things such as

medical supports, assistance with activities of daily living, and social supports. State HCBS waivers vary considerably both across the country as well as within each state. The large number of different services that fall within LTSS would make it impossible for CMS to establish any type of national standard regarding reasonable number of providers.

- **Self-direction:** States, with CMS' encouragement, have moved to improve beneficiary control over their services in many LTSS settings. There are a number of models of self-directed care in the Medicaid program, but a central tenet includes the ability of individuals to have control over the provider of care as well as the services rendered. Establishing specific metrics and requiring states to evaluate these types of arrangements against those standards would likely render meaningless information. Similarly, in order to ensure compliance states would need to exert more rigid structures for the provider pool, which would undermine crucial principles of self-direction.

For all of these reasons, NASUAD believes that LTSS access should be assessed using a different strategy. We recommend that LTSS access be evaluated based upon the individualized plan of care for participants. As you may know, Medicaid HCBS programs require an assessment and person-centered plan of care prior to the provision of services. This plan is generally developed through case management functions[1], either within the fee-for-service program or managed care. Case managers are also responsible for providing follow-along supports to ensure that individuals receive the services outlined and authorized within that plan of care.

Because this requirement already exists as a federal standard, NASUAD recommends that LTSS standards be established that build upon these processes. We believe that CMS should develop criteria that allow states to review a statistically significant sample of LTSS participants and evaluate whether the services authorized within that plan were actually provided. This would reduce administrative burden compared to broader metrics that required assessment of all participants while still providing valuable and reliable information on gaps in services. It would also recognize the inherent flexibility in and person-centered nature of LTSS that prevents standardized measures from being used.

We note that several managed long-term service and supports programs, including those in Arizona, Tennessee, Delaware and New Jersey, assess 'gaps in care' – that is services rendered vs. service needs identified in the person-centered plan of care – as an accountability measure for their managed care organizations. Those state agencies could be fruitful sources to better understand this approach.

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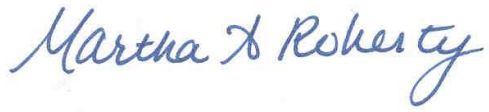
[1] States and managed care plans may have different names for case management; however, assessment, plan of care development, and follow-along supports to ensure that services are provided, are core functions of case-management. Therefore, we generalize the term as case management for this discussion.

We appreciate the thoughtful approach that CMS has taken with the development of the final access rule, and that CMS has issued this RFI. We particularly appreciate the cautious approach that CMS has taken towards long-term services and supports, especially since LTSS access metrics are particularly challenging to identify and articulate. If you have any questions, please feel free to contact Damon Terzaghi at (202) 989-2578 or dterzaghi@nasuad.org.

Regards,



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