

June 28, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–2442–P
P.O. Box 8016
Baltimore, MD 21244-1850

Submitted electronically via <https://www.regulations.gov/commenton/CMS-2023-0070-0001>

Re: Medicaid Program: Ensuring Access to Medicaid Services (CMS–2442–P, published May 3, 2023)

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Social Workers (NASW), I am submitting comments on the notice of proposed rulemaking (NPRM) addressing access to Medicaid services (CMS–2442–P).

Founded in 1955, NASW is the largest membership organization of professional social workers in the United States, representing more than 110,000 social workers. We work to enhance the professional growth and development of our members, to create and maintain professional standards, and to advance sound social policies.

Social workers play an essential role in serving Medicaid beneficiaries across an array of settings. The need for home- and community-based services (HCBS) has increased dramatically as people with disabilities and older adults increasingly seek long-term services and supports outside of nursing homes and other institutional settings.

NASW’s comments address the following sections of the NPRM:

- Medicaid Advisory Committee and Beneficiary Advisory Group (§ 431.12)—Section II.A
- HCBS—Section II.B

Section II.A: Medicaid Advisory Committee and Beneficiary Advisory Group (§ 431.12)

NASW supports CMS's efforts to update requirements for beneficiary engagement in Medicaid programs at the state level. The proposed revisions to Medical Care Advisory Committees would advance meaningful engagement through Medicaid Beneficiary Advisory Groups (BAG) and Medicaid Advisory Committees (MAC) so that Medicaid consumers may provide timely feedback to inform policy and practice change. From their own experiences, Medicaid beneficiaries understand effective practices, barriers to services, and implications of proposed policy changes for individuals and families.

NASW endorses strategies to encourage the participation of beneficiaries who are representative of the Medicaid populations served within BAG and eliminate barriers to participation, such as providing opportunities for virtual participation and rotating the location of meetings. Consideration of diversity in many regards including demographic, geographic, health and disability status, etc. is recommended. A diversity of experiences of BAG members can support Medicaid programs to advance health equity and proactively identify barriers to enrollment, retention, and service access.

NASW also supports the integration of BAG members into the MAC to ensure that consumer voices are heard at decision-making tables. States can encourage participation by increasing transparency about the composition and activities of the MAC and making information available publicly. Moreover, NASW encourages CMS to include in state MACs social workers who are Medicaid providers. As providers in health care and community settings, social workers have expertise in addressing the social determinants of health and supporting individuals with complex and chronic physical, mental, and behavioral health conditions.

NASW hopes to see implementation of the new MAC and BAG structure within a year, particularly during this important period when Medicaid redeterminations in states will have a significant impact on beneficiaries. States will benefit from valuing consumer experiences and insights to improve state Medicaid programs and promote health nationally.

Section II.B: HCBS

NASW wholeheartedly commends CMS for its efforts to improve Medicaid beneficiary access to HCBS. Our comments regarding specific HCBS proposals follow. Within the context of these comments, the term "state" includes the District of Columbia, in keeping with the language of the NPRM.

SUBSECTION II. B.1—PERSON-CENTERED SERVICE PLANS (42 CFR 441.301(c), 441.450(c), 441.540(c), and 441.725(c))

NASW strongly supports CMS's proposal to require states to demonstrate that a reassessment of need is completed at least once a year for every person continuously enrolled in an HCBS program. We also support the proposed requirement that each beneficiary's HCBS service plan be reviewed annually—and, if that reassessment warrants, that the service plan be revised. We

concur with CMS that implementation of these requirements would strengthen accountability for person-centered planning.

Furthermore, NASW supports the associated reporting requirements delineated in subsection II.B.7.a.3 of the NPRM.

SUBSECTION II. B.2—GRIEVANCE SYSTEM (§§ 441.301(c)(7), 441.464(d)(2)(v), 441.555(b)(2)(iv), and 441.745(a)(1)(iii))

NASW supports CMS’s proposal to require that each state institutes and manages a grievance process for beneficiaries who access services through Medicaid fee-for-service (FFS) plans, including the following components:

- enable any beneficiary to notify their state Medicaid agency if they are displeased with a provider or have a complaint about how a provider or the state is complying with Medicaid requirements (such as the person-centered planning requirements or the HCBS settings final rule)
- establish a process for the state to investigate and respond to the beneficiary’s concern
- institute record-keeping requirements
- review grievance data as part of each state’s ongoing monitoring procedures
- provide grievances to CMS upon request

SUBSECTION II.B.3—INCIDENT MANAGEMENT SYSTEM (§§ 441.302(a)(6), 441.464(e), 441.570(e), and 441.745(a)(1)(v))

NASW agrees with CMS that incident management systems should not only respond when a Medicaid beneficiary is harmed or at risk of harm, but also should identify trends and patterns and enact policies to prevent such incidents. Accordingly, we support the proposal to establish a minimum definition of critical incidents, including verbal, physical, sexual, psychological, or emotional abuse; neglect; exploitation including financial exploitation; misuse or unauthorized use of restrictive interventions or seclusion; a medication error resulting in hospitalization, death, or a telephone, two-way audio–video, or in-person consultation with a poison control center, urgent care, or emergency department; or an unexplained or unanticipated death, including (but not limited to) a death caused by abuse or neglect. We agree with CMS that establishment of such a definition would increase consistency across states. Likewise, NASW supports the following CMS proposed requirements for states:

- operate and maintain an electronic incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents
- use information from sources other than provider reports to identify critical incidents; such sources may include claims, Medicaid Fraud Control Units, adult and child protective services systems, and law enforcement, to the extent allowed under state law
- share information about the status and resolution of investigations with other agencies, to the extent allowed under state law
- establish time frames for investigation, resolution, and corrective actions related to critical incidents

NASW also supports CMS's proposal for states to report the results of an incident management system assessment to demonstrate adherence to the new requirements. However, we encourage CMS to change the time frame for such reporting from two years to one year.

Moreover, NASW supports the associated reporting requirements delineated in subsections II.B.7.a.1 and II.B.7.a.2 of the NPRM.

SUBSECTION II.B.5—HCBS PAYMENT ADEQUACY (§§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi))

NASW concurs with CMS that in-person access to services provided by direct care workers (DCWs) is integral to most Medicaid beneficiaries who use HCBS. Thus, we support the following CMS proposals to bolster hiring and retention of DCWs:

- require that at least 80 percent of all Medicaid HCBS payments for homemaker services, home health aide services, and personal care services be spent on compensation for DCWs
- require states to make all Medicaid FFS payment rates publicly available through a published rate schedule
- require states also to report annually on the percentage of payments spent on DCW compensation in HCBS programs
- require states to conduct a payment rate analysis every two years
- require a stakeholder advisory committee to make recommendations regarding rates paid for DCW services

Likewise, NASW supports the associated reporting requirements delineated in subsection II.B.7.d of the NPRM.

SUBSECTION II.B.6— SUPPORTING DOCUMENTATION REQUIRED (§ 441.303(f)(6))

NASW shares CMS's concern that the federal government's lack of data collection about states' HCBS waiting lists makes it difficult to determine accessibility to HCBS in different states. Therefore, we support the proposal to require each state that has a waiting list for its waiver program to report to CMS, on an annual basis, the following data:

- the number of people on the HCBS waiting list
- the average length of time people remain on the waiting list
- how the state maintains the waiting list, including whether people on the waiting list are screened for eligibility and whether (and how often) they are periodically rescreened for eligibility

NASW also supports associated requirements in subsection II.B.7 of the NPRM. We encourage CMS to require states not only to report overall data on each element in total, but also to stratify data for each element by age, disability, ethnicity, language, race, sex, Tribal status, and rural/urban status, as proposed within the HCBS quality measure reporting subsection. Furthermore, we urge CMS to incorporate the following elements within such data stratification:

- intersex status

- gender identity (including nonbinary and transgender identities)
- sexual orientation (including, for Indigenous respondents only, Two-Spirit)

Such reporting would facilitate state identification of disparities and advancement of health equity. Given the sensitivity of the preceding data elements and Medicaid beneficiaries' potential reluctance to disclose such information for fear of discrimination, volunteering of such demographic data must be optional. Moreover, NASW urges CMS to incorporate in the final rule guidance to states to use culturally competent, evidence-based approaches to obtaining such information, as outlined in the report *Measuring Sex, Gender Identity, and Sexual Orientation*, published by the National Academies of Sciences, Engineering, and Medicine (NASEM) in 2022.¹

SUBSECTION II.B.7—REPORTING REQUIREMENTS (§§ 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

NASW supports CMS's proposal to retain the current requirement that states report on the type, amount, and cost of services provided through HCBS programs. We also support CMS's proposal to require states to report the following data annually:

- the average length of time people must wait for homemaker, home health aide, or personal care services to begin after they are initially approved to receive such services
- the percentage of authorized hours that are provided to individuals for those DCW services

We encourage CMS to require states not only to report overall data on each element, but also to stratify data for each element by age, disability, ethnicity, language, race, sex, Tribal status, and rural/urban status, as proposed within the HCBS quality measure reporting subsection. Furthermore, we urge CMS to incorporate the following elements within such data stratification:

- intersex status
- gender identity (including nonbinary and transgender identities)
- sexual orientation (including, for Indigenous respondents only, Two-Spirit)

Such reporting would facilitate state identification of disparities and advancement of health equity. Given the sensitivity of the preceding data elements and Medicaid beneficiaries' potential reluctance to disclose such information for fear of discrimination, volunteering of such demographic data must be optional. Moreover, NASW urges CMS to incorporate in the final rule guidance to states to use culturally competent, evidence-based approaches to obtaining such information, as outlined in the 2022 NASEM report *Measuring Sex, Gender Identity, and Sexual Orientation*.

¹ National Academies of Sciences, Engineering, and Medicine. (2022). *Measuring sex, gender identity, and sexual orientation*. <https://nap.nationalacademies.org/catalog/26424/measuring-sex-gender-identity-and-sexual-orientation>

SUBSECTION II.B.8—HCBS QUALITY MEASURE SET (§§ 441.312, 441.474(c), 441.585(d), and 441.745(b)(1)(v))

NASW supports CMS's proposal to require states to report every two years on a set of nationally standardized quality measures specifically for HCBS, as is required for other Medicaid services. We concur with the importance of requiring quality measures that assess quality of the services delivered and how those services impact beneficiary quality of life. Similarly, we support the proposal to require that each state establishes performance targets for each of the mandatory measures and reports on the strategies it uses to reach those goals.

Similarly, NASW supports the associated reporting requirements in subsection II.B.7.b of the NPRM. We applaud CMS's efforts to reduce health disparities and advance health equity by requiring states to report quality measure data stratified by age, disability, ethnicity, language, race, sex, Tribal status, and rural/urban status. We urge CMS to incorporate the following elements within such data stratification:

- intersex status
- gender identity (including nonbinary and transgender identities)
- sexual orientation (including, for Indigenous respondents only, Two-Spirit)

Such reporting would facilitate state identification of disparities and advancement of health equity. Given the sensitivity of the preceding data elements and Medicaid beneficiaries' potential reluctance to disclose such information for fear of discrimination, volunteering of such demographic data must be optional. Moreover, NASW urges CMS to incorporate in the final rule guidance to states to use culturally competent, evidence-based approaches to obtaining such information, as outlined in the 2022 NASEM report *Measuring Sex, Gender Identity, and Sexual Orientation*

In conclusion, NASW believes that implementation of these two sections of the NPRM would meet CMS's goals of both enhancing access to and the quality of Medicaid-funded services. We thank CMS for issuing this proposed rule and appreciate your consideration of NASW's comments. Please contact me at BBedney.nasw@socialworkers.org if you need additional information.

Sincerely,



Barbara Bedney, PhD, MSW
Chief of Programs