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July 3, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Agency/Docket Number CMS-2442-P

Dear Administrator Brooks-LaSure:

Modivcare Inc. ("Modivcare") is pleased to provide comments on CMS proposed rule **2442-P, Medicaid Program: Ensuring Access to Medicaid Services**. Modivcare offers critical and essential personal care services to over 20,000 patients through a network of over 18,000 caregivers. We serve a diverse population, from children to older adults, with a wide range of home care needs. Modivcare is uniquely positioned in the industry to serve communities through a suite of supportive care services that include personal care, remote patient monitoring, non-emergency medical transportation, and home-delivered meals.

Home and Community Based Services ("HCBS") are crucial to the health and wellbeing of the most vulnerable in our society and healthcare system. In particular, personal care services deliver needed preventative care at the lowest cost and in patients' preferred settings. Modivcare has demonstrated the ability to dramatically improve outcomes for these patients. Home-based care has played an integral role in reducing emergency department utilization, hospitalizations, hospital length-of-stay, unnecessary institutionalization, medication adherence, and other improved health outcomes. Modivcare takes pride in elevating the quality of services provided and strives to engage, educate, and empower direct care workers and patients to take a proactive approach to managing health at home. With our unique suite of services powered by technology and predictive analytics, home care patients stay healthier at home longer.

Proposed Rule Provisions Perspective

Modivcare is generally in alignment with numerous other agencies, providers, and associations regarding this proposed rule, including the Partnership for Medicaid Home Based Care ("PMHC") and the National Association of Homecare and Hospice. Modivcare is in favor of efforts that thoughtfully advance transparency in reporting, data analytics, and quality of care across our industry. However, we also fear unintended consequences to the rule as proposed could result in:

- Devalued training and career development for caregivers resulting in increased workforce challenges and diminished quality of care for patients;
- Lack of investment in quality initiatives and oversight, deprioritizing patient outcomes and overall cost of care management; and
- Diminished access to care with the potential for care deserts in certain geographies and demographics.

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Specifically, Modivcare will be addressing the following proposed rule provisions:

1. **New HCBS Transparency and Reporting Requirements**
   Modivcare position: Generally in favor, with recommended considerations

2. **HCBS Quality Measures**
   Modivcare position: Generally in favor, with recommended considerations

3. **Standard Reporting Requirements for Waiting Lists**
   Modivcare position: Generally in favor, with recommended considerations

4. **Incident Management System**
   Modivcare position: Generally in favor, with recommended considerations

5. **Grievance System**
   Modivcare position: Generally in favor, with recommended considerations

6. **80 Percent Wage Threshold**
   Modivcare position: Substantial concerns. Request to withdraw provision from the proposed rule

Please find below Modivcare's detailed comments regarding the following proposed rule provisions. We respectfully await CMS's responses to our comments and recommendations.

Comments on Proposed Rule Provisions

Proposed Rule Provision #1: New HCBS Transparency and Reporting Requirements

Modivcare supports new state reporting requirements that address transparency, reporting standards, and inclusive stakeholder engagement in the reimbursement rate setting for Medicaid HCBS programs.

Modivcare aligns with the PMHC in support of CMS's proposal to rescind the reporting requirements under the 2014 Home and Community Based Services Final Regulation[1] and implement new state reporting requirements that would – for the first time – address transparency, reporting standards, and inclusive stakeholder engagement in the reimbursement rate setting for Medicaid HCBS programs.

- ***Public Reporting.*** Modivcare asserts that adequacy, transparency, and parity of public reporting may be just as important as reporting itself. Without clearly defined reporting standards that allow for accurate comparisons, CMS and other home care industry stakeholders will not be able to discern an agency's poor quality due to a relatively high volume of critical incidents versus an agency's poor quality due to lack of oversight and under-reporting. Modivcare encourages CMS to organize data at a minimum by care delivery model (e.g., agency, registry, consumer-directed), geography, and patient population. In doing so, stakeholders can easily identify systematic disparities and focus on resolutions that drive equity across all home care delivery models.

[1] 79 FR 2947

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- ***Payment Transparency.*** First, Modivcare encourages CMS to extend transparency requirements across all Medicaid HCBS programs, driving the industry toward standardization and administrative simplification. While we are proponents of transparency, we urge CMS to consider the inherent differences between agency-based home care, registry-based home care, and consumer-directed home care models. We are concerned about side-by-side comparisons across these models as the nature and financial structure of agency-based home care and consumer-directed home care are inherently different. Modivcare maintains that transparency requirements should consider these differences to avoid disruption to current and future direct care workforce recruitment and retention efforts. Nationwide, the direct care workforce climate in home care is already tenuous, and transparency should be designed to advance the goals of CMS to improve visibility while being careful not to unintentionally stress parts of the industry that are in high demand, negatively impacting both quality of care and the ability of providers and stakeholders to strengthen and expand the direct care workforce that is desperately needed to serve our nation's aging and disabled populations. In addition, Modivcare recommends that CMS include the following metrics under the new transparency reporting requirements:
  - Training Costs and Expenditures
  - Health Benefits
  - 401(k) Plan Contributions
  - Paid Time Off
  - Holiday Premiums
  - Overtime Hours and Pay
  - Bonuses
  - Employee Perks

  We maintain that payment transparency reporting requirements that do not take into account the full range of benefits/compensation available to direct care workers will likely result in unintended consequences to the industry in the form of regular disruption to patient care and oversight due to high volume movement between models of care that is driven by caregiver reimbursement rather than by patient need or choice.

  Additionally, Modivcare recommends that CMS include public reporting requirements that emphasize the linkage between payment and quality and those metrics that drive performance from providers. We assert that the inclusion of the following indicators will more effectively identify the linkage between payment rates and quality:
  - Timely Initiation of Patient Care
  - Incident Reporting (including Hospitalizations and Re-Hospitalizations)
  - Complaint Reporting
  - Escalations to Service Coordinator, Physician, or Emergency Contact
  - Escalations to Home Care Agency for Intervention
  - Utilization (Authorized versus Utilized)
  - Missed Visit Reasons
  - Patient Satisfaction

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- ***Advisory Group.*** Modivcare supports the creation of state-level advisory groups to provide input on reimbursement rates and suggests that these advisory bodies include, at minimum, Medicaid HCBS beneficiaries, direct care workers, provider agencies, and provider state associations. We recommend that CMS define minimum participation standards for interested parties, which should minimally include unduplicated equal representation by stakeholders, including agency-based model providers, consumer-directed model providers, union representatives, patient advocates, program administrators, politicians, and the general public. To continue, Modivcare recommends that Advisory Group membership should change every two years, at minimum, to ensure diversity of opinion and an inclusive approach to active participation for all interested parties.

Proposed Rule Provision #2: HCBS Quality Measures
Modivcare supports a uniform definition of HCBS quality measures and standardized reporting and monitoring timelines to ensure provider readiness and equitable access to high-quality, person-centered services and supports across Medicaid HCBS programs.

In alignment with PMHC, Modivcare is a staunch supporter of accurately and appropriately measuring care quality to improve individual and population-level outcomes and inform responsiveness and innovation at the provider and system levels. We recommend a unified, national measurement methodology and measure set inclusive of defined measurement criteria and sufficient time for public comment in alignment with States' processes. A clear, uniform definition of HCBS quality measures and related reporting and monitoring timelines are critical to ensuring provider readiness and equitable access to high-quality, person-centered services and supports across Medicaid HCBS programs.

Modivcare asserts that comprehensive, valid, and reliable quality measures that accurately represent the full scope of home-based services and supports are an essential component of a continuous improvement approach and continue to express our strong belief that measures should focus on adequacy, transparency, and health and wellness outcomes for patients receiving HCBS. Modivcare advocates that updates to the HCBS Quality Measure Set should be completed in a methodical, timely manner. In alignment with our commitment to reducing health disparities and advancing health equity, Modivcare supports CMS's approach to require that certain measures be stratified by race, ethnicity, Tribal status, sex, age, rural/urban status, disability, language, or other dimensions of personal identity.

Proposed Rule Provision #3: Standard Reporting Requirements for Waiting Lists
Modivcare supports a standardized, national Medicaid HCBS waiting list/registry and waiting list reporting requirements that account for all phases of the enrollment process and service delivery initiation.

Modivcare is pleased to see that the proposed rule includes updated requirements to address the widespread, long-standing issue of relatively long periods of time from when an eligible Medicaid patient joins a waiting list for Medicaid HCBS to when the patient actually receives services and

supports. The Medicaid and CHIP Payment and Access Commission ("MACPAC")[2] and the Kaiser Family Foundation[3] documented that Medicaid HCBS waiver waiting lists/registries do not provide a complete picture regarding the unmet HCBS need and lived experiences among Medicaid patients who require a nursing facility level of care. Furthermore, waiting list/registry enrollment data and administrative processes (e.g., waiting list management, reporting) vary by state and cannot be compared across states.[4]

To standardize Medicaid HCBS waiting list reporting requirements, Modivcare recommends that CMS execute the following:

- Development and implementation, with adequate time for public comment, of a clear methodology that can and will be followed across all states
- Development and implementation of "waitlist" according to valid and reliable metrics including, but not limited to, the number of enrolled Medicaid patients who are awaiting HCBS; the number of Medicaid beneficiaries assigned to a provider with no utilization of services; the number of Medicaid patients who passed away or transfer to an institution while awaiting care
- Collection of service utilization data for beneficiaries on a waitlist as waitlist enrollment is just one component of understanding how individuals are delayed from receiving necessary care, and beneficiaries can be connected only to partial services due to insufficient supply to meet demand
- Conduct utilization review in addition to waitlist review

To realize a national Medicaid HCBS waiting list/registry and related measures that can inform policy change and effective program management, waiting list reporting must be standardized across all states. We would encourage reporting methodology that takes into consideration all phases of the enrollment process, as well as any time spent waiting for full-service delivery, recognizing that access to services and supports is currently severely limited by supply and that patients do not always receive the full scope of HCBS for which they are eligible. Furthermore, we urge the same consideration afforded to nursing facility care and encourage CMS to explore deemed/presumed eligibility for individuals who are seeking in home care but are waiting on burdensome administrative processes to be able to access needed services and supports. Many such patients find themselves forced into institutional care due to unnecessary administrative barriers required to access Medicaid HCBS.

[2] Medicaid and CHIP Payment and Access Commission, State Management of Home- and Community-Based Services Waiver Waiting Lists (Washington, DC: MACPAC, 2020), https://www.macpac.gov/publication/state-management-of-home-and-community-based-services-waiver-waiting-lists/.

[3] Alice Burns, Molly O'Malley Watts , and Meghana Ammula, A Look at Waiting lists for Home and Community-Based Services from 2016 to 2021 (San Francisco, CA: Kaiser Family Foundation, 2021), https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-home-and-community-based-services-from-2016-to-2021/

[4] *Ibid.*

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Proposed Rule Provision #4: Incident Management System
Modivcare supports new requirements for states to operate and maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.

Modivcare supports improved reporting systems and endorses this new requirement for states to provide an assurance that they operate and maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. It is important to track incidents through an updated incident management system that is created based on input from a variety of stakeholders, including providers, managed care organizations, and innovators of technology along with states, to ensure feasibility and accountability. There are similarities to be drawn from the implementation of electronic visitation verification ("EVV"), where the collaboration of states along with these stakeholders is crucial and has become an important part of the official CMS stakeholder calls around implementation. We recommend that CMS collect feedback and set consistent standards for the incident management system to be adopted in each state simultaneously to ensure consistent reporting and tracking in each jurisdiction. At a minimum, we urge CMS to leverage the best practices identified for incident management systems as it sets minimum requirements for State systems, including requirements that the incident management system is web-based, HIPAA compliant, and allows for reporting back to providers to eliminate the need for duplicative tracking to monitor and address trends.

Further, we encourage CMS to require that States use one system across all programs and payors, inclusive of Managed Care Organizations, for both incident reporting and tracking to eliminate any duplication of data and administration across different state departments. Minimally, we encourage CMS to set consistent definitions for incidents, including critical and non-critical, to ensure consistent reporting and comparisons across States. Having consistency in reporting will allow CMS and States to readily identify and quantify the important role that paid caregivers play in escalating, triaging, and protecting the health and safety of individuals during critical events.

Proposed Rule Provision #5: Grievance System
Modivcare supports the development of a new grievance system that aligns with States' administrative processes to enhance the patient experience.

As CMS focuses on improving the Medicaid Program, Modivcare is supportive of the new development of a grievance system and is hopeful that it will enhance the patient experience. Modivcare and PMHC provider members want to ensure that systems are built that reveal clear facts about the system so that policymaking that results from this information can be accurate and impactful. We ask that CMS work with a diverse array of stakeholders, especially beneficiaries, to create a grievance system that is practical and sets realistic expectations for its users. Millions of home care patients we serve depend on these daily services, and it is critical that this grievance system results in meaningful resolution of their grievances in a timely manner. Modivcare provides services predominantly to patients who are older adults as well as people with disabilities; therefore, we encourage CMS to create a grievance system platform that is accessible for these patients and their families and support systems. Grievance system policies and procedures should state what users can expect once a grievance is submitted. Consistent with our recommendation above, we again urge CMS to set minimum requirements for State grievance systems, including

requirements that the system is web-based, HIPAA compliant, and allows reporting back to providers to eliminate the need for duplicative tracking to monitor and address trends.

In order to provide States with flexibility, Modivcare also recommends that the grievance system be aligned with each State's Medicaid appeals process and that the designated state agency staff be engaged to simplify the experience for recipients. It is important that these systems align to avoid unnecessary burdens and effort associated with the grievance system. CMS should also require that Managed Care Organizations and States use a single grievance system to ensure the process is as streamlined and manageable as possible for all parties.

Proposed Rule Provision #6: 80 Percent Wage Threshold
Modivcare respectfully requests that CMS withdraw the wage threshold provision from the proposed rule.

Modivcare has significant and substantial concerns regarding the threshold provision requiring 80% of all Medicaid payments to be spent on compensation to direct care workers for homemaker, home health, and personal care services. We respectfully request that CMS withdraw this provision from the proposed rule.

Modivcare believes that CMS is acting with good intentions in proposing this rule change and that addressing direct care workers' and caregivers' compensation is an excellent pursuit. However, we do not believe this proposed rule will result in increased payments to direct care workers but rather reduced access to HCBS and increased strain on an already underfunded system. We would like to illuminate the fact that direct care worker wages are not limited by company overhead but instead by the rate of reimbursement provided by the various Medicaid and Managed Care programs.

The current workforce crisis is directly related to chronic underfunding of Medicaid payment rates throughout State HCBS programs for direct care workers. A number of state and federal administrative and regulatory requirements are necessary to provide HCBS to a diverse Medicaid population, and imposing an aggressive wage threshold is not respecting the cost of compliance associated with these requirements nor allow for the necessary investments to protect the quality and continuity of these services.

Impact on Quality and Value-Based Care Investments
Modivcare strongly supports higher wages for direct care workers; however, the 80/20 proposal diverts funding from core activities focused on quality improvement and value-based care initiatives. The proposal threatens providers' ability to innovate and develop models of care delivery that enhance both the patient's and direct care worker's experiences.

We share CMS's vision for enhanced quality, reporting, and processes to provide for the safety and care delivery of Medicaid-funded HCBS. We have made considerable investments in quality improvement technologies, processes, and personnel designed to improve patient experience and care outcomes, including:

- Standardized incident and grievance management technologies and personnel to ensure compliance and address trends;

- Value-based care initiatives to reduce falls, identify potential exacerbations of illnesses, and prevent hospital admissions and emergency department utilization, e.g., STOP AND WATCH and closing health gaps;
- Continuous patient experience surveys;
- Investments in EVV improvements via technology and process improvements, e.g., company-paid smartphones for caregivers and resources for caregiver support and training; and
- Dedicated personnel focused on:
    - Workforce development and training enhancements, e.g., dementia care and specialized patient-safety and care training to mitigate trends in incidents, grievances, and quality audits; and
    - Proactive internal audits to identify, address, and trend areas of opportunity.

The 80/20 proposal threatens advancements in quality improvement. None of the investments identified above are included in the 80/20 calculations.

Under the proposal, these investments directly compete for already limited funding to support functions that are:

- Directly supporting the direct care worker, including HR;
- Needed for business operations, including Accounting;
- Required by federal regulations, including Compliance; and
- Investments in technology platforms to support continuity of care, elimination of care gaps, and innovation in care delivery.

Modivcare has repeatedly invested in quality improvement while also investing in direct care worker wages. We urge CMS to re-evaluate the wage proposal to ensure that the shared goal of increased wages for direct care workers does not threaten or eliminate our and others' ability to continue to invest in other shared goals related to quality improvement and patient care outcomes. Continuous improvement empowers direct care workers through knowledge and technology to provide the right care, at the right time, to vulnerable members of our society. As stated, 80% of a low reimbursement rate will not drive meaningful wage improvements for direct care workers. Similarly, 20% of a low reimbursement rate leaves providers bereft of funding to support the needed investments in quality, innovative value-based care models and other components of this proposal.

HCBS Selected for Threshold Calculation

Modivcare understands the motivations behind CMS's workforce-related proposal as we appreciate the linkage between direct care worker wages and benefits and issues related to equity. Improved wages and benefits can only strengthen the direct care worker workforce, which would improve access to and consistency of HCBS delivered to patients.

A massive challenge Modivcare and PMHC members faced in responding to this proposal was the lack of data presented or made available to adequately assess current ranges of workforce wages and HCBS reimbursement rates across States or even within one state. As an organization that serves multiple states and diverse populations via various programs, Modivcare maintains that the unique nature of each Medicaid waiver program, the non-uniformity of State program

requirements, and the disparity of reimbursement rates across and within States does not support the implementation of a federal standard for a minimum percentage threshold for direct care worker wages and benefits of the overall payment.

The proposed wage threshold rule lacks sufficient data to support establishing a specific threshold and only cites two states that have implemented somewhat similar but lesser threshold requirements in a relatively small number of their State Medicaid HCBS waiver programs. Additionally, the proposed rule includes citations that reference some state pass-through requirements for American Rescue Plan Act ("ARPA") funds; this is an apples-to-oranges comparison, given that ARPA payments are temporary supplemental payments made beyond the structure of base reimbursement rates. Furthermore, without a federal requirement, pass-through requirements for ARPA funds were implemented at the state option, which is evidence that States have the best insights regarding the optimal course of action to address the direct care worker shortage.

Regional Rate Variance

Reimbursement rates range from as low as $15 to over $30 and can vary significantly even within State Medicaid HCBS waiver programs as well as between states. Twenty percent of a low rate simply does not support the same level of fixed costs as a state with a higher reimbursement rate. Further, guaranteeing 80% of a very low state Medicaid reimbursement rate to direct care workers will not always materially increase pay rates or address the current direct care workforce crisis. The current Medicaid HCBS rate structure in nearly all applicable regions simply does not support a high threshold as proposed by CMS.

Modivcare offers wages designed for direct care worker recruitment and retention. Modivcare additionally recognizes the significant investment in the direct care worker employment experience and career development that is needed to truly sustain this industry's growing demand. This includes investments in training and education that directly impact the quality of care and workforce development. These conditions must be considered, or the existing direct care workforce could be severely and adversely impacted, resulting in an environment that would diminish training and development initiatives.

The wage threshold proposal also does not acknowledge the uniqueness of States' Medicaid HCBS waivers. Of the over 300 Medicaid HCBS waivers in the country, no two are identical with regard to the target population, the scope of services and supports, staff required for the provision of services and supports, compliance and regulatory requirements, or provider reimbursement rates. Additionally, Modivcare finds that the proposed wage rule is vague as to what costs are included in the calculation of the share of direct worker costs relative to reimbursement rates to propose a specific wage threshold across all States. While Modivcare does not support federal regulation requiring 80% of payment for direct care worker wages and benefits for all the reasons specified above, at a minimum, the following costs should be captured in any definition of direct care worker costs with current inflationary impacts being taken into consideration:

- All wages for direct care workers, including overtime, travel time, and training wages;
- Wages for staff who develop, conduct, and ensure compliance with training and in-services for family caregivers;

- Health insurance, dental insurance, life insurance, disability insurance, and other employee benefits;
- Any paid time off ("PTO") benefits (e.g., sick time, vacation, general use PTO);
- Technology and wages for staff focused on health outcome improvement for patients;
- Tuition reimbursement;
- Payroll taxes, including federal and state unemployment insurance;
- Workers' compensation insurance;
- Mileage reimbursement (separate from travel time payment);
- Public transportation reimbursement;
- Stipend or expense reimbursement for mobile devices used for EVV;
- Uniforms;
- General liability insurance;
- Background check costs, including all federal/state exclusion screenings;
- CPR Training;
- TB Testing and pre-service physical exams;
- Any delineated direct care worker pay or benefits included in a Collective Bargaining Agreement;
- Rent or mortgage brick and mortar costs;
- Technology in addition to telephone and internet service;
- Personal protective equipment costs;
- Meal breaks or time; and
- Retirement benefits (e.g.,401(k) plan).

Similarly, CMS has defined the denominator in the calculation of direct care worker costs of payment as *"…Medicaid payments, including but not limited to base payments and supplemental payments… ."*[5] We assert that description also could benefit from additional clarification as the definition may not capture all elements impacting Medicaid payments. Some additional items that were not addressed in the proposal include:

- Only collected revenue and not billed charges would be considered base or supplemental payments;
- Refunded or recouped payments from current or prior years based on program financial audits would be deducted from total Medicaid payments; and
- Revenue from value-based care ("VBC") arrangements in managed long-term services and supports or any other program should be exempt so as not to disrupt State or managed care efforts associated with moving toward VBC or to disincentivize providers from pursuing innovative strategies to improve health and financial outcomes such as lowering emergency department visits, inpatient utilization, and lowering attrition from HCBS to skilled nursing facilities.

In a preliminary national survey of HCBS providers (the majority of which are small providers) following the release of the proposed rule, PMHC found the following:

- 55% of agencies surveyed would not survive, while 35% of these agencies would narrow service offerings or geographies served;

- Over 93% of providers surveyed would be limited in their ability to take on new referrals;
- In order to meet the threshold, providers would be forced to make cuts to non-direct care workers (coordinators and other essential staff), clinical oversight, and training, amongst other cuts; and
- Over 90% of providers would face challenges serving more costly rural populations, and 85% would be impacted negatively in serving underserved populations.

Ultimately, this survey revealed that access for HCBS patients is at stake if this proposal is finalized as drafted. As such, Modivcare implores CMS to take PMHC's initial data and the survey data collected by other associations seriously in contemplating this proposal and the unintended consequences regarding equitable access to high-quality, person-centered HCBS.

Unintended Consequences

Modivcare does not believe that the best interest of the patient and corresponding access to HCBS is under adequate consideration with regard to this proposal. Furthermore, we believe that implementation of such a proposal will have the following unintended consequences resulting in reduced, rather than improved, access:

- Decrease in quality of care as an unintended consequence of a misallocation of costs as captured in the numerator/denominator calculation, essentially devaluing training and other value-based care initiatives;
- Unintended transfers of populations between models of care driven by reimbursement rather than patient need or choice;
- Loss of numerous agencies and providers, leaving patients bereft of care options in certain geographic regions;
- Provider agencies reducing service areas, particularly high-cost and low-volume rural areas or high-cost, high-crime areas;
- Access issues within Medicaid and other payer-funded HCBS from disparities in wages between Medicaid HCBS waiver programs requiring 80% and programs that do not require an 80% threshold, including Medicaid State Plan services, services and supports under the Older Americans Act or the Department of Veterans Affairs; and
- Fluctuation in hourly wages paid due to changes within a state. For example, if the proposed rule is implemented and a state meets the 80% wage and benefit threshold but then passes a mandatory paid time off law without a corresponding rate increase, wages would be reduced to pay for the PTO benefit within the 80% requirement, creating considerable turnover in the direct care workforce.

General Commentary

Alignment with CMS Framework for Health Equity (2022-2032)

Modivcare is aware that racial/ethnic, geographic, and cultural disparities in HCBS access, utilization, and outcomes are well documented by anecdotal evidence and in peer-reviewed

literature.[6,7,8,9,10] As our nation becomes increasingly more diverse across various dimensions of personal identity, including racial and ethnic background, preferred language, and cultural beliefs and practices, more robust reporting and monitoring will be required to deliver high-quality, person-centered HCBS in an equitable manner. In alignment with the current CMS Framework for Health Equity,[11] Modivcare utilizes a data-driven, integrated approach to embed health equity principles and practices into all aspects of our operations across seven markets to reduce health disparities and improve the experiences and outcomes among those we serve and employ as direct care workers. As of 2022, more than 30% have a preferred language other than English. The size and composition of the Medicaid HCBS population have implications for the delivery of culturally and linguistically appropriate care. As of 2022, two-thirds (67%) of our direct care workforce comprised persons who self-identified as American Indian/Alaska Native; Asian; Black or African American; Hispanic or Latino; Native Hawaiian or Other Pacific Islander; or multi-racial; 88% self-identified as female, reflecting national workforce trends.

Modivcare acknowledges that the key provisions of the proposed rule – person-centered planning, grievance procedures, incident management, payment adequacy and transparency, quality measurement, and reporting requirements – reinforce the five priorities for the CMS Framework for Healthy Equity:

- Priority #1: Expand the Collection, Reporting, and Analysis of Standardized Data;
- Priority #2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps;
- Priority #3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities;
- Priority #4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services; and

[6] Gorges RJ, Sanghavi P, Konetzka RT. A National Examination Of Long-Term Care Setting, Outcomes, And Disparities Among Elderly Dual Eligibles. Health Aff (Millwood). 2019 Jul;38(7):1110-1118. doi: 10.1377/hlthaff.2018.05409. PMID: 31260370; PMCID: PMC7147241.

[7] Fabius CD, Thomas KS, Zhang T, Ogarek J, Shireman TI. Racial disparities in Medicaid home and community-based service utilization and expenditures among persons with multiple sclerosis. BMC Health Serv Res. 2018 Oct 12;18(1):773. doi: 10.1186/s12913-018-3584-x. PMID: 30314479; PMCID: PMC6186063.

[8] Bercaw LE, Levinson A, Fletcher D, Shuman SB, Hughes S, Peddada S, Walsh EG. Assessing Disparities in Medicaid Home- and Community-Based Services: A Systematic Review. J Aging Soc Policy. 2023 May 4;35(3):302-321. doi: 10.1080/08959420.2022.2081424. Epub 2022 Jun 1. PMID: 35648802.

[9] Siconolfi D, Shih RA, Friedman EM, Kotzias VI, Ahluwalia SC, Phillips JL, Saliba D. Rural-Urban Disparities in Access to Home- and Community-Based Services and Supports: Stakeholder Perspectives From 14 States. J Am Med Dir Assoc. 2019 Apr;20(4):503-508.e1. doi: 10.1016/j.jamda.2019.01.120. Epub 2019 Mar 1. PMID: 30827892; PMCID: PMC6451868.

[10] Shippee TP, Duan Y, Olsen Baker M, Angert J. Racial/Ethnic Disparities in Self-Rated Health and Sense of Control for Older Adults Receiving Publicly Funded Home- and Community-Based Services. J Aging Health. 2020 Dec;32(10):1376-1386. doi: 10.1177/0898264320929560. Epub 2020 Jun 14. PMID: 32538249.

[11] Centers for Medicare and Medicaid Services (CMS), Office of Minority Health, CMS Framework for Health Equity 2022–2032 (Baltimore, MD: CMS, April 2022), https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf.

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- Priority #5: Increase All Forms of Accessibility to Health Care Services and Coverage.

To this end, we wish to reiterate our commitment to partnering with CMS to expand access to Medicaid HCBS for all populations via data-driven, community-informed strategies that center around equity, transparency, and continuous quality improvement.

Limited Provider Bandwidth and Timing Considerations for Proposed Provisions
Modivcare urges CMS to remain attuned to the challenges it and other personal care service providers may face in their efforts to implement all applicable proposals contained in the Proposed Rules. States grappled with the three-year reporting requirement of select Medicaid measures as required by the 2015 Medicaid Access Rule. Similarly, EVV timelines were extended, the HCBS Settings Rule had a significant extension, and several other Medicaid policies endured similar fates. The requirements of states greatly impact home care providers and, above all, the beneficiaries that we support, and it is critical that all stakeholders adopt new processes in a systematic way that is thorough and allows time for technical assistance and clarity during this complex process. States have had to endure tight timeframes in the past, and based on those experiences, some new proposals take at least ten years to begin compliance. Medicaid policy is a complicated program, and it is challenging to orchestrate and implement compliance programs that are different in each state. Many have existing onboarding requirements, state legislative processes, and new technological developments that need to be taken into consideration. Relatedly, with the expiration of the Public Health Emergency, ongoing redetermination process, and severe deficits in state staffing, Modivcare asks that CMS reconsider the proposed timing of each provision and acknowledge that proper implementation of most of the proposals in this proposed rule will take much longer than five years to be executed correctly. We will defer to and rely on State Medicaid Agency comments with regard to timeframes, however, and will be supportive of those comments.

Conclusion

Modivcare is in favor of efforts that thoughtfully advance transparency in reporting, data analytics, and quality of care. Additionally, Modivcare strongly supports workforce development and continues to support solutions to our workforce crisis. We have supported legislation that would address workforce wages and further professionalize the career path associated with direct care workers. Additionally, we recently developed an extensive home care bill in collaboration with PMHC which would, similar to the ARPA, seek to extend permanent funding that would be directed to support the HCBS workforce.

Modivcare is concerned that unintended consequences of the proposed provisions could negatively impact quality of care, access to care, workforce sufficiency, investment in value-based care initiatives, and access to appropriate training resources that empower and engage caregivers to drive positive care outcomes.

We strongly urge CMS to withdraw the provision for a wage threshold that devalues training, investment in quality initiatives, and innovative care models. This threshold fails to consider regional and programmatic disparities that exist today and does not contemplate a path to thoughtfully and equitably support patients in all regions and demographics. Compliance with such an aggressive threshold will only exacerbate the existing workforce challenges and will likely

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create large care deserts in which certain services are simply not available for otherwise qualified populations.

Modivcare would like to thank you again for this opportunity to share our insights and offer recommendations on the Medicaid Access Proposed Rule. We look forward to continuing to engage with the agency and drive policies that expand access and improve outcomes for Medicaid patients across the country.

Sincerely,

L. Heath Sampson
CEO, Modivcare Inc.