NACDD
National Association of Councils on Developmental Disabilities

October 2, 2020

Seema Verma, Administrator
Centers for Medicaid and Medicare
The Hubert H. Humphery Building
200 Independence Ave., S.W.
Washington, DC 20001

RE: NACDD Recommendations on HCBS Long Term Care Waiver Flexibilities

Dear Administrator Verma:

Thank you for meeting with the members of the National Association of Councils on Developmental Disabilities Taskforce on Emergency Medicaid Waivers. It was a pleasure speaking with your team about state developmental disabilities councils' advocacy during the COVID-19 emergency, including our work with state agencies on using Medicaid waivers to better support for people with IDD during the pandemic and more permanently to address rebalancing.

As your team considers how to best unwind emergency Medicaid waivers granted in response to the COVID-19 public health emergency, we wish to provide some additional perspective from states on the perceived benefits and risks of select flexibilities authorized under 1915 (c) Appendix K emergency waivers.

The COVID experience has demanded changes to service delivery and inadvertently provided an opportunity to test these new approaches. Many of these changes benefit Medicaid beneficiaries, result in less reliance on congregant settings, and offer insight into new capabilities our service systems should plan and adjust for in a post pandemic world (including virtual workspaces, remote learning, internet connection and technology as critical service system infrastructure). However, DD Councils share CMS's concern that caution is warranted to ensure continuation of approaches put into practice during the pandemic are the choice of the participant and do not result in greater social isolation, less community integration, or negatively impact participant rights.

Analysis of select flexibilities that may have long term value for HCBS LTC participants

General recommendations include:

- Ensure that states are using meaningful stakeholder input as Medicaid agencies decide which aspects of the Emergency K Waivers to maintain, if any. Councils often play

leadership roles in stakeholder input. **CMS should look for and review Councils' input in each state's Medicaid waiver renewal process, as Councils represent the perspective of citizens of their states who use (or need) HCBS.**

- Increase emphasis and focus on accountability for person-centered planning in HCBS waiver services. The difference between advantages and considerations below hinges on effective person-centered planning. **As states move out of emergency waivers into a "new normal", CMS should expect that states have enhanced and modernized the mechanisms in place to identify and enforce effective person-centered planning.**

Flexibility	Advantages	Considerations
Telehealth	• Allows access to health care professionals for routine needs. • Allows access to services where the number of health care providers is limited (ex. Psychologists) or the participant is geographically distanced from specialists. • Eliminates need for participant to coordinate transportation to facilities and participant time invested in travelling. • Eliminates missed appointments due to late or no-show rides.	• Requires robust, effective person-centered planning assessment that includes ensuring the person receiving services is a meaningful part of the decision to use these supports, understands how to use them, and understands how to request changes if their needs/preferences change. • Requires internet connectivity, technology, and technology skills to access • Not applicable in circumstances where a physical examination or medical testing is needed. • If other household members are present, patient communication with professional could

		be influenced or compromised.
Virtual Services ***(Allowing any service that can be provided with the same functional equivalency of face-to-face services to occur remotely)***	• Workers providing in-home services who travel from client home to client home may be able to reduce their travel distance, time in transit, and costs when some clients elect remote services. Medicaid reimbursement rates often do not cover transit to and between HCBS client homes; workers are not reimbursed for these costs. Low wage HCBS workers identify transportation access and cost as one reason for leaving the workforce. • Provider agencies may be able to more efficiently schedule services and staff. Providers may be able to expand service capacity if staff using virtual methods can provide services to more clients. • Participants may find virtual services more convenient and flexible for their schedule. Virtual service delivery eliminates need for participant to coordinate transportation. • Virtual services are an alternative to congregate facility-based day and pre-vocational centers.	• Requires robust, effective person-centered planning assessment that includes ensuring the person receiving services is a meaningful part of the decision to use these supports, understands how to use them, and understands how to request changes if their needs/preferences change. • Requires internet connectivity, technology, and technology skills to access. • Oversight needed to ensure remote services are functionally equivalent to in-person services and that there is no disparity in outcomes correlated to method of service delivery. • Protections needed to ensure participants choosing remote service delivery are not steered towards remote service delivery and have the option to change to in-person service delivery at any time.

	Reducing reliance on congregate settings has public health benefits and virtual services may be an important bridge to help transition away from facility-based models. • Virtual services can be an innovative and mobile way to maintain connection with clients as needed (ex. community employment providers offering real-time on-the-job support).	
Remote Support Technology	• Remote services can reduce need for multiple or constant staffing of participant residences (ex. sensing devices that allow people to live independently without cameras). • Appropriate use of remote services can lead to greater participant independence, daily living skills, and privacy. • Remote support technology could include the equipment and connectivity required to access remote services and resources. • Many non HCBS LTC services and systems have moved processes online (employment applications, government services); those experiencing a digital	• Requires robust, effective person-centered planning assessment that includes ensuring the person receiving services is a meaningful part of the decision to use these supports, understands how to use them, and understands how to request changes if their needs/preferences change. • Requires internet connectivity, technology, and technology skills to access. • Must be complemented by access to direct support professionals as needed, including as the person's needs change. Some families are concerned that selecting to use technology

	divide stand to become more disconnected from their communities without access to technology. • Assistive technology is important to help participants engage with and successfully use remote support technology • Technical expertise to assist with setting up and successfully use technology is needed to ensure participants can be as fully engaged as they wish in virtual services, remote supports, remote administrative functions, and other daily living tasks that can be accomplished online.	necessarily means giving up access to in-person support. Providing a slower transition and/or guarantee that a person can always become available will help incentivize people to try technology.
Overtime/Hazard Pay for Direct Care workers	• Most states are facing a direct care worker shortage resulting in too few workers providing care for participants. Direct Care workers should receive added compensation (an enhanced rate) when working with participants who need a high level of complex care, are exposing themselves to an imminent risk of infection, or are working more than typical hours to meet care needs because of staffing shortages.	• CMS should offer technical assistance for states to figure out how to offer these rate increases temporarily so that workers are recognized for their contributions, and have sufficient compensation to ensure they do not continue working when they are sick. • CMS could consider incentivizing or promotion of ways states can use rate bands to incorporate certificate/tier training

		completion of direct support professionals (DSPs), resulting in higher wages for DSPs with advanced training.
Reform of Current Onboarding/Training Process for direct support professionals	• Because many emergency waiver authorities included waiving up-front onboarding requirements, including training, many providers found it easier to get direct support professionals to work right away. This has meant incorporating more training after the person begins working. Moving away from training models that rely on hours of up-front, online or classroom training and toward a model that has more ongoing, coaching oriented training is consistent with research about best practices in adult learning.	• It will not be effective, and in fact will be dangerous, to grant states more flexibility in onboarding without accountability to effective ongoing training and coaching that ensures the direct support professionals are equipped to work with people receiving HCBS and familiar with that person's unique needs.
Family members as paid support	• The shortage of direct care workers has resulted in many family members functioning as unpaid support. • Family members make difficult choices, including leaving the workforce, to provide care for loved ones that may put them and their families at financial risk. • When the HCBS LTC system cannot provide	• Requires robust, effective person-centered planning assessment that includes ensuring the person receiving services is a meaningful part of the decision to use these supports, understands how to use them, and understands how to request changes if their needs/preferences change.

	quality, reliable, consistent help those who are providing care should be compensated. • Some participants may prefer to be cared for by people they live with or know. • When family members are capable and willing and the participant desires it, family caregivers boost the capacity of the paid workforce to provide care for others.	• Mechanism needed to assess caregiver's physical and mental ability to continue providing the same level of care as well as their willingness to do so. • Oversight needed to ensure easy and rapid transition to paid caregivers should the ability or willingness of family caregivers change • Processes and policies needed to ensure participants can decide or change who provides their care. • Protections needed to ensure participant is not manipulated or abused by family caregivers.
Electronic signatures	• Many non-HCBS LTC processes have incorporated the use of electronic signatures as a valid way of affirming participant authorization, permission, or understanding. • Many processes that require signatures are administrative and routine. These should be accomplishable by participants on their schedule in their own homes. • Efforts to streamline and reduce the amount of	• Requires internet connectivity, technology, and technology skills to complete. • Thought must be given to whether and what kind of signatures should be required to be witnessed and in-person. E.g. if the reason a signature is needed is to affirm the person is making a self-determined decision and is not under duress, an in-person signature makes sense.

	time and funding spent on administration necessarily requires a review of administrative processes that require direct in-person engagement of participants. Use of electronic signatures can expedite processes and can save participants from transportation coordination and time lost in transit.	
Administrative functions ***(Allows assessments, evaluations, administrative requirements, and person-centered service planning meetings to occur remotely)***	• Remote assessments and evaluation may help expediate eligibility determinations or need for services for participants. Appointment availability, transportation, location of evaluators can administratively delay important services for participants. • The ability to see and evaluate the participant in their own home and context may add value for evaluators, especially regarding demonstrating daily living skills and functionality. • Some administrative requirements require participant signatures, but are primarily procedures that document or are needed by providers or state Medicaid agencies for compliance or	• Participants should be able to choose in-person assessment, evaluation, or planning meeting if they desire. • If the person has had a remote evaluation and is found ineligible for a program or service thought is needed to determine whether and under what conditions the result of a remote evaluation can be appealed to trigger a required in-person evaluation. • States can be encouraged to conduct process and documentation reviews to determine whether electronic signatures could be used in place of in-person signatures. • Technical guidance needed to give planning teams guidance on using

	recordkeeping. While participants should know what they are signing, this understanding can be accomplished without the participant's physical presence. • Person centered planning meetings can be conducted in virtual meeting space. If virtual meetings are more convenient for the participant, allow more timely or routine gathering, and involve the same content and members, it is unclear why remote meetings should not be an option.	remote technology and virtual environments in ways that ensure the participant is driving the person-centered planning process.

CMS can use the COVID experience to incentivize rebalancing initiatives.

DD Councils appreciate CMS's expertise on the many waiver authorities available to states, as well as the comment that states may incorporate these flexibilities as permanent parts of their existing waiver through amendment.

Our experience as DD Councils working with state Medicaid agencies is that most states are operating within their state's existing waiver authority ecosystem and may be unfamiliar or reticent to use additional waiver authorities. In some states, amending an existing waiver may be difficult as increased staff workload may not be prioritized, the impact waiver changes may have on state budgets are unclear, or specific legislative or other review/approval may be required. Many states have experienced turnover within their Medicaid agencies, and new staff may be unfamiliar with the opportunities different waiver authorities may offer their states. **For all of these reasons, DD Councils encourage CMS to develop memorandums or guidance that incentivizes and shows states how they may use flexibilities within their existing waiver or through continuation of flexibilities granted as part of COVID-19 response to further the goals of community integration.**

DD Councils have long been proponents of home and community-based services and rebalancing state Medicaid investments towards the community and away from institutional

settings. Many states use the 1915 (c) waiver authority for HCBS LTC services, which requires states demonstrate that providing waiver services will not cost more than providing these services in an institution. We believe the COVID-19 crisis illustrates the need to include public health benefits that accompany less congregant settings and the quality of life metrics[1] associated with more integrated community lives as factors states should consider in addition to cost. **Considering cost, public health, and quality of life significantly weights the benefit of investment towards the community—even if it costs more for some individuals—and is keeping with the spirit of the Olmsted decision**

In closing, we reiterate the general recommendations listed at the beginning of the letter, asking that CMS look for and review Councils' input in each state's Medicaid waiver renewal process as states unwind their emergency provisions. NACDD would be happy to facilitate this process and, as appropriate, could facilitate a dialog among CMS, the State Medicaid Agency and the State Council regarding the input.

Thank you for considering this feedback. We welcome a follow-up call with your team.

Sincerely,

Donna Meltzer
Chief Executive Officer
National Association of Councils on Developmental Disabilities

[1] As quantified by National Core Indicators. *See* "National Core Indicators." Human Services Research Institute (HSRI) and National Association of State Directors of Developmental Disabilities Services (NASDDDS), www.nationalcoreindicators.org/.