

**To:** Senate Finance Committee Leadership (att: Kim Brandt, Becky Shipp, and Shannon Legeer)  
**From:** Barbara Merrill, CEO, ANCOR  
Esme Grant Grewal, Senior Director of Government Relations, ANCOR  
**Re:** ANCOR Suggestions Related to Medicaid Reform  
**Date:** February 21, 2017

Thank you very much for your interest in advancing the Medicaid program’s services and supports for Americans with intellectual and developmental disabilities (I/DD). ANCOR is the national trade association for providers supporting people with intellectual and developmental disabilities to fully participate in their communities. We directly represent 51 state associations of private providers and approximately 1,200 community agencies of community living that provide residential and employment supports and services to more than 800,000 individuals with disabilities. ANCOR members offer a full array of long term supports and services, including but not limited to early intervention, school age wrap around services, schools, residential, day, employment, respite, brokerage, self-direction, and fiscal intermediary supports. Our members are both nonprofit and proprietary organizations including highly sophisticated multi-state entities operating diverse business lines as well as small, independently operated organizations. We count among our membership agencies established in the 1800s to recent startups, faith-based organizations and many holding national affiliations, such as Arc chapters, UCP affiliates, Easter Seals, Goodwill, and more. Collectively our membership brings together a strong network in every state.

We look forward to sharing some of the topline issues we believe should be addressed in policymaking in the immediate future to strengthen all these services.

*Workforce:* ANCOR has an obligation to our members to begin by bringing attention to the acute direct support professional workforce crisis that is severely challenging disability service providers across the country, and urge you to consider the impact of any Medicaid reform proposal on this issue. Will the proposed reform improve the ability of states to adjust payment methodologies to attract and retain qualified workers, or further exacerbate the crisis? These are the workers that provide hands on supports ranging from assistance with basic ADLs to providing employment supports – services that are provided across the lifespan. Providers are struggling to attract and retain qualified staff – the crisis has grown to the extent that providers in many parts of the country report experiencing such high turnover and position vacancy rates that they aren’t accepting new referrals from people on waiting lists for services – because they can’t staff the services required. The National Core Indicators (conducted by HSRI in collaboration with NASDDDS) surveyed 17 states in 2015 and found the average turnover rate was 45%. The range went from a high in Utah of 75% to DC at 15%. Whether a state was on the high or low end of the survey, the results are still unacceptably high and disrupt services significantly. Providers compete with fast food and other low wage industries for workers, yet the skills required to support community integration for people with disabilities are much more significant. The Department of Labor has identified this workforce as one of the fastest growing professions over the course of the next decade without enough labor entering the workforce to meet the need.

We have also worked with the Department of Labor and Department of Health and Human Services to issue salary data showing the significant wage deficits and turnover for DSPs. The key change that Congress can impact in this area is ensuring that any amendment to Medicaid law or funding includes significant attention to and resource development for workforce. We also stress the need for interagency collaboration. ▸

*Technology:* One of the areas that we believe could support workforce, and other areas of disability service provider efficiency and successful service delivery is technology advancement. Medicaid regulations and CMS guidance should encourage and reimburse for the use of technology for HCBS and disability service providers – note that many of the federal grants created for electronic health record development were not available to our field. Congress should strongly encourage the Centers for Medicare and Medicaid Services (CMS) to improve the incorporation of technology in HCBS service delivery and assure that regulatory and payment methodologies enable providers and families access to the most innovative and emerging technologies. CMS and states must seek to remove obstacles to technology and raise the priority level of the use of technology in all aspects of HCBS. One example is the use of “remote monitoring” and telehealth delivery capabilities, including manager, caregiver, and family communications with staff and clients. Technology has positive implications for the care management, workforce scheduling, and documentation functions and Congress can play a key role in ensuring these goals are met by CMS.

*Innovation:* ANCOR is determined to see innovation in the Medicaid program over the next decade take shape as we believe it is necessary to ensure the best delivery to the individuals we serve.

Specifically, ANCOR recommends CMS work with states to define quality indicators and to develop reimbursement systems that include financial incentives when quality indicator(s) are attained. These quality reimbursement systems must be adequately funded, to pay providers for the reasonable cost of providing the services with the funding for the incentives coming from shared savings. By incentivizing the achievement of quality outcomes that are cost-effective, everybody wins. The individuals served have better lives, providers are able to pay their DSPs a higher wage and states/CMS realize cost savings. Shared savings approaches based on quality indicators will drive our system toward better outcomes for individuals with IDD, a more stable DSP workforce and lower cost per person for our system. It’s simply not enough for quality indicators to be compliance-based, the attainment of quality indicators needs to result in financial incentives to drive behavior of providers toward those quality indicators. Furthermore, quality indicators need to be meaningful to the people served, clearly defined, simple to understand, measurable, applicable to the individual served, and agreed upon by individuals with IDD, family members, CMS, states, providers and other key stakeholders.

Another innovation that should be encouraged by Medicaid law is a provider-led model that has been successfully piloted in Pennsylvania, the Adult Community Autism Program (ACAP). ACAP is a collaboration of disability service providers fully managing comprehensive Medicaid services for their recipients and under the orchestration of an actuarial firm. This design has allowed providers typically in a fee for service structure to reduce administrative costs from 30% to around 15% not by requirement but by natural result of the collaboration and program design.

The providers in turn provide the best managed care for the individuals they serve because they know the services well (it turns out less than 7% of these services are medical so I/DD expertise is key), but are able to do it in a better functioning payment system. This program has competitively employed 52% of the participants and graduated several of them out of the program for earning extremely competitive salaries – no small feat for people with disabilities. There are some improvements needed for the program – for instance, in order to move to residential they need approval from the federal government and this is a thorough administrative process. Also, as we mentioned earlier, electronic health records are key to recording successes, but as mentioned above, Medicaid has not geared funding or incentives to disability service providers for use or development of these systems as it has for other providers.

*Housing:* The provision of housing (room and board) is not currently authorized under Medicaid waivers, resulting in significant strain for providers and families as they seek to provide community housing for HCBS recipients. Currently over 75% of adults with intellectual and developmental disabilities are living in family homes, oftentimes with aging parents. While the Department of Housing and Urban Development provides some support through vouchers, it is very limited in scope. As a result, we feel it is appropriate and imperative for Medicaid to address the housing crisis immediately. We suggest pilots and 1115 waivers that are permitted to explore creative housing options allowing providers to reapply savings to housing costs for individuals served. We highly advocate the exploration of a small, limited program where housing is included in the array of services for individuals and then outcomes are measured and compared to traditional instances where housing is not supported. The provision of housing is supported in the current literature, demonstrating the correlation to lowered health care costs and better overall outcomes related to the social determinants of health and well-being. In a nutshell, Medicaid works if all the parts are in place and we believe that housing is a key missing part.

*State/Federal Partnership:* There are a number of issues we would like to raise that relate back to how the federal Medicaid program partners with states. We feel it is imperative to comment on these issues now given the likelihood that they come up in future policymaking. First and foremost, we are greatly concerned about the inadequacy of payments to disability service providers across the country. While we can envision improved programmatic changes with some greater state flexibility, federal oversight is necessary in key areas, particularly when the Supreme Court held in *Armstrong v. Exceptional Child, Inc.* that providers do not have legal standing to challenge inadequate provider payments. It is also important to note that our members rarely receive cost-of-living adjustment (COLA) increases for the work they do and when they do, it is usually the result of lobbying their state legislatures. ANCOR was sorely disappointed that HCBS programs were excluded from the 2015 Medicaid Access rule regulations and have advocated to have them recognized for stronger federal review.

There are certainly areas where states could use flexibilities and it could improve the quality of the Medicaid program. Our top request would be that HCBS services not be subject to a waiver from institutional services in order to provide community services. In 2017, this antiquated part of Medicaid law is no longer acceptable. While the HCBS program has been one of Medicaid's most successful programs, we believe it has been left out of key incentivizing policy. For example, if healthcare related assessments, also known as provider taxes, should continue to exist, states should be able to apply them to the HCBS class. We feel strongly that this is

outdated policy that is a disservice to the program and to states trying to address waiting lists and rebalance their system.

*Waiting Lists:* We have taken note that there has been increased discussion around waiting lists by Congressional leaders. While we are pleased to see attention to the issue of waiting lists, we want to make three points here. First, programs like Money Follows the Person, the Balancing Incentive Program, and Community First Choice Option are successful tools for states to truly rebalance their programs and reduce waiting lists. Secondly, it is important that policymakers understand that waiting lists are uniquely defined by each state, they do not necessarily capture all individuals in need of services, and also that states without waiting lists still have significant I/DD populations that wait for services. Finally, progress on reducing waiting lists cannot be made without a commensurate increase in the availability of direct support professionals. Without available staff, there will be no one to serve people coming off of a waiting list.

*Funding Structure:* I would like to end our statement by being very clear about where ANCOR stands on changes to the funding structure of the Medicaid program. ANCOR does not support block grants which would end guaranteed access for millions of Americans with I/DD who are eligible for Medicaid services as a way to reduce federal funding resulting in shifted costs to states and state taxpayers. We also do not support per capita cap proposals which would result in cost shifts to state governments, providers, individuals and families and without knowing details of how each state would reflect the cost of care or determine growth rates for the variation of people with disabilities served. As I mentioned earlier, we do support greater flexibility for states to innovate and provide higher quality care, but we are adamant that any productive discussion of per capita cap proposals or block grants must not be geared towards reducing federal funding and instead focus on ways to improve the lives of people with I/DD and ensure both a stable workforce and a sustainable Medicaid program.

Thank you again for the opportunity to present to you today. For further information or questions, please contact our Senior Director of Government Relations, Esme Grant Grewal, at [egrant@ancor.org](mailto:egrant@ancor.org) or 202-579-7789.

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