

December 18, 2024

Verlon Johnson  
Chair  
Medicaid and CHIP Payment and Access Commission  
1800 M St NW, Suite 650 South  
Washington, DC 20036

Kate Massey  
Executive Director  
Medicaid and CHIP Payment and Access Commission  
1800 M St NW, Suite 650 South  
Washington, DC 20036

Dear Chair Johnson and Executive Director Massey:

The National Academy of Elder Law Attorneys (NAELA) is pleased to offer comments in support of the Medicaid and CHIP Payment and Access Commission (MACPAC)'s work on improving access to Medicaid home- and community-based services (HCBS).

NAELA represents over 4,000 elder and special needs law attorneys and 31 chapters, with members in every state and even some abroad. We are the only professional, non-profit association of attorneys that conditions membership on a commitment to the Aspirational Standards for the Practice of Elder and Special Needs Law Attorneys. Extending beyond the benchmark set by the American Bar Association's Model Rules of Professional Conduct, these standards recognize the need for holistic, person-centered legal services to meet the needs of older adults, people with disabilities, and their caregivers. Supporting the dignity and independence of these vulnerable populations is at the center of what we do.

As advocates for older adults, people with disabilities, and their families, we strongly support MACPAC's efforts to enhance and expedite access to HCBS. Improving access to HCBS is one of NAELA's core policy priorities. From this perspective, we offer comments on two important subjects discussed at MACPAC's December 2024 meeting, and on MACPAC's workstream on access to HCBS more generally:

**Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce:** As MACPAC has noted, workforce shortages directly affect the ability of state Medicaid programs to deliver HCBS programs as promised, and of Medicaid beneficiaries to receive the HCBS services they need. We appreciate MACPAC's convening of a technical expert panel (TEP) on how Medicaid payment policies can be used to bolster the HCBS workforce. We agree with the TEP's findings, and add three additional considerations:

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NAELA will shape, support, and inspire the national legal community.*

- As at least one commissioner acknowledged during the December 13 meeting, direct care workers may not want to report all income on their balance sheets, due to their own need to maintain state or federal benefits. This is a real issue that puts home-based employers in a difficult position.
- In addition to payment rates, it is important to study shift length, and the relationship between part time shifts and worker dissatisfaction. In our experience, assessment tools used by states often recommend hours in quantities that amount to very short shifts each day.
- Misalignment and delays between eligibility determinations, onboarding, and receipt of services (discussed further below) create payment crises for caregivers. These may cause caregivers to seek other work during the delay, increasing the chance of institutionalization for the beneficiary.

**Timely Access to Home- and Community-Based Services:** Improving the timeliness of HCBS eligibility determinations and receipt of services is a particularly important issue. Connecting people with needed HCBS when they need them is not only important for individuals’ physical and mental health, but has also been shown to reduce unnecessary institutionalizations, hospital readmissions, and undesirable outcomes, as well as hospital and nursing home expenditures for states and the federal government.<sup>1</sup>

There is widespread recognition of these facts and widespread agreement that expanding HCBS is a worthy policy goal. But too often, the process of actually providing HCBS is plagued by delays and misalignment in the various steps between HCBS application and receipt of services. These delays lead to a far-too-common scenario where elderly individuals who are admitted to the hospital and are either discharged directly to a nursing facility when they could be at home or with appropriate supports, or are discharged to home without appropriate supports, and subsequently experience a fall or other event that results in a hospital readmission – undermining the very policy goals we seek to achieve via HCBS programs.

We offer several considerations for MACPAC, which are detailed further below.

- State HCBS and policies written on paper do not always translate to their practices. This includes policies related to expedited eligibility, presumptive eligibility, and provisional plans of care. Many states that MACPAC has identified as using these authorities based on their waiver documents are not actively doing so in practice on any meaningful scale.

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<sup>1</sup> For example, see:

- Agency for Healthcare Research and Quality (AHRQ): Assessing the Health and Welfare of the HCBS Population at <https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/findings/index.html>.
- Van Cleve et al. 2023: Risk of hospitalization associated with different constellations of home & community based services at <https://bmgeriatr.biomedcentral.com/articles/10.1186/s12877-022-03676-2>.
- Segal et al. 2014: Medicare-Medicaid eligible beneficiaries and potentially avoidable hospitalizations at [https://www.cms.gov/mmrr/downloads/mmrr2014\\_004\\_01\\_b01.pdf](https://www.cms.gov/mmrr/downloads/mmrr2014_004_01_b01.pdf).
- Konezka et al. 2020: Outcomes of Medicaid home- and community-based long-term services relative to nursing home care among dual eligibles at <https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13573>.
- Wang et al. 2024: The role of Medicaid home- and community-based services in use of Medicare post-acute care at <https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.14325>.

- While we agree with many of the barriers MACPAC has identified regarding take-up of options to improve timely access to services, we also note that many states are unwilling or unable to take steps to expedite access due to resource constraints and an already overburdened HCBS system. These states are unlikely to take meaningful steps to expedite access until underlining challenges in their HCBS systems are addressed.
- Conversations around improving timely access to HCBS should focus not on take-up of any specific authority, but rather, actually delivering on a state's program as designed by addressing the operational and procedural difficulties associated with aligning the financial assessment, functional assessment, and person-centered services plan development.
- Any CMS guidance recommended by MACPAC (or subsequently issued by CMS) should focus on practical steps that states can take to expedite timely receipt of services, as opposed to simply detailing available authorities.

### **Detailed Comments – Improving Timely Access to HCBS**

MACPAC has done substantial work to understand state policies related to improving timeliness of HCBS access, including through a recent environmental scan of state policies regarding HCBS eligibility and interviews with state officials and other stakeholders. This work revealed that although multiple different authorities are available to allow states to provide presumptive eligibility (PE) for non-modified adjusted gross income (MAGI) beneficiaries, expedited eligibility for HCBS, and provisional plans of care, there is relatively limited take-up of these options by states. Even in the relatively small number of states that have technically opted to use one or more of these strategies, in general, they are used in a relatively small number of cases or circumstances.

MACPAC's findings from its conversations with stakeholders are generally consistent with what NAELA members have observed as they assist HCBS applicants on a daily basis and engage with their states around eligibility policies and procedures. We offer several additional observations below:

#### **Authorities to Expedite Access to HCBS**

First, it is important to acknowledge that even if a state, through their waiver documentation, has technically elected to use PE, expedited eligibility, or allow provisional plans of care, that does not mean that they are actually using those authorities on a broad scale that meaningfully expedites access to HCBS for a substantial number of applicants. For example:

- Maryland has been identified by MACPAC as a state that allows the use provisional plans of care. However, in NAELA members' experience, provisional plans of care are rarely used, if at all. More generally, the state has made limited progress in expanding or expediting waiver services in the last several years and repeatedly makes clear to stakeholders (e.g., NAELA members) that they do not wish to do so.

- New Jersey has been identified by MACPAC as a state with PE for non-MAGI groups. New Jersey approved PE via legislation in January 2024.<sup>2</sup> However, this program is not yet operational: per state law, it must be enacted within 30 months (July 2026). Although state officials recently shared that they have hired a consultant to assist with implementation, NAELA members in New Jersey have seen no other evidence of progress to date.

MACPAC staff and commissioners have acknowledged this issue in recent public meeting presentations and conversations, as have other public commenters. We ask that MACPAC directly and clearly acknowledge this issue in its report to Congress. We also note that as MACPAC continues its efforts to identify challenges and barriers to why states have not taken up the options available to them to increase timeliness of HCBS access, it should also focus on the states that have done so on paper, but not in operation in any meaningful way.

### **Challenges to Improving Timely Access to HCBS**

Regarding barriers to state take-up of policies that expedite access to HCBS, we agree with MACPAC that among them are a lack of understanding around the state’s financial risk for services provided to individuals found presumptively eligible for HCBS and then later found ineligible, and concerns about a “benefit cliff.” We also note that given the multi-faceted approach to HCBS eligibility and benefit determinations, *take-up of one or more specific authorities is not in and of itself sufficient* to expedite access to needed services. For example, states that are not able or willing to offer an expedited development of a person-centered service plan may take the position that implementing PE will not yield expeditious receipt of services and is therefore not worth pursuing.

Another important barrier to consider is state willingness – or lack thereof – to expand or expedite HCBS in light of budget and capacity constraints. While a state may report to CMS or MACPAC that it wishes to improve the timeliness with which HCBS applicants can receive needed services, if that state already has one or more waiting list or otherwise has to limit HCBS services, they may not be inclined to expedite receipt of services. For example, a state in this situation would forgo provisional plans of care or expedited eligibility policies out of concern that doing so would only further stretch the system. In our experience, states in this position do not have the ability or willingness to implement *any* of the options MACPAC has examined on a broad scale, even though doing so would likely reduce expenditures for other service categories (i.e., nursing facility and hospital services) in the long run.

### **Alignment of Steps in the Eligibility Determination Process**

NAELA’s view is that conversations around improving timely access to HCBS should focus not on take-up of any specific authority, but rather, actually delivering on a state’s program as designed by addressing the operational and procedural difficulties associated with aligning the financial assessment, functional assessment, and person-centered services plan development.

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<sup>2</sup> ([A4049/S3495](#), now codified at NJSA 30:4D-3d1.

Ohio is a state that illustrates this challenge. Ohio has adopted presumptive eligibility for non-MAGI populations, but in order for presumptive eligibility to be used, an applicant must still go through the functional assessment process and development for a person-centered services plan. This process takes weeks, and there can be an additional delay for caregivers to arrive to start providing services. By that time, the financial determination has typically been completed, meaning the use of PE does not serve to meaningfully expedite receipt of services.

NAELA members in Ohio estimate that pairing the uses of PE with provisional plans of care could reduce wait times by two to four weeks. This short but critical amount of time would likely be sufficient to avert unnecessary institutionalizations and other adverse outcomes while full eligibility determinations are carried out and person-centered services plans are being developed. Like other stakeholders that have provided public comments to MACPAC on this issue, we are unaware of any state using this process successfully for a substantial number of applicants.

We acknowledge that some Commissioners and stakeholders have stated that in their states, the financial eligibility determination is the primary source of delay, as opposed to the functional assessment and/or development of a person-centered care plan. This suggests that in some states, PE coupled with investments in electronic verification systems and other financial eligibility processes may be the more effective lever than allowing a provisional plan of care. These differences reinforce the need to address all aspects of the eligibility determination process with the goal of better aligning and expediting the various steps and highlight the need for greater attention to different elements in different states.

### **Ongoing Policy Discussions**

Consistent with the considerations discussed above, we offer suggestions for MACPAC as it carries out its future work on this specific topic, as well as its broader scope of work on HCBS.

#### *Potential Recommendation on CMS Guidance*

First, we generally support MACPAC's potential recommendation that "CMS should issue guidance to outline the Medicaid authority, either state plan or waiver, that states can use to adopt provisional plans of care, and to identify policy and operational issues that states should consider in the course of implementation." At the same time, we share some commissioners' and stakeholders' concerns that such guidance could become overly technical or prescriptive, and creating new barriers.

Therefore, we request that MACPAC add additional language or context to the rationale of the recommendation that CMS's guidance (and any accompanying or complementary technical assistance) should focus specifically on expediting approval for payment of services, as opposed to the authorities themselves. From a CMS perspective, such guidance might include:

- Recommendations as to how states can facilitate timely provisional plans of care (for example, by providing partially pre-populated forms to health care providers and beneficiaries as appropriate).
- Examples of how provisional plans of care can be combined with other options to expedite access to care (e.g., presumptive eligibility).

- Answers to common state questions or concerns about the process and effective operation of provisional plans of care and other relevant processes that expedite eligibility.
- Waiver or state plan preprints or other instructions for receiving timely approval for a waiver or state plan amendment.

We note that NAELA has previously urged CMS to take actions along these lines, perhaps most notably through comments on the Access Rule.<sup>3</sup> In these comments, we recommended a set of administrative actions and stated that each of these should be accompanied by detailed technical assistance to encourage and incentivize states to reform their HCBS programs:

- Encouraging states to take advantage of Section 1115 demonstration authority to provide presumptive eligibility for certain populations.
- Interpreting Section 1915(c) of the Social Security Act more broadly to allow states to receive federal financial participation (FFP) for services provided prior to the development of the service plan in certain circumstances — perhaps through development of a regulatory pathway for certain groups who are very likely to be ultimately determined eligible.
- Outlining through subregulatory guidance the manner in which states may recognize presumptive eligibility using state-only funds while waiting for full approval and development of a service plan, after which the state can receive FFP retrospectively for the interim HCBS coverage period.

#### *Current and Future Efforts to Facilitate Timely HCBS*

Second, we reiterate that current and future MACPAC and CMS efforts to improve timely access to states should focus not just on specific authorities or processes, but rather, the full picture of operational procedures, beneficiary/representative, caregiver, and provider experience, and challenges that occur on the ground which result in delays in HCBS eligibility determinations and access to services. This work should be done with the goal of better understanding what resources, guidance, or further authorities states need.

#### **Conclusion**

Given the wide variation in state HCBS programs, eligibility determination systems and processes, and other operational considerations and challenges, we are pleased to offer to connect MACPAC with NAELA Federal Advocacy Committee (FAC) members who work directly with HCBS applicants in several different states and can shed light on the specific issues and opportunities associated with timely receipt of HCBS services in those states.

1. Lindsay Jones, Schraff Thomas Law LLC (OH)
2. Lauren Marinaro, Fink Rosner Ershow-Levenberg Marinaro, LLC (NJ)
3. Paige Fox (Fox Law, LLC) (IL)
4. Julie Rowett (Oregon Elder Law) (OR)

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<sup>3</sup> Appendix A and see “NAELA Comments on Access NPRM” at [https://downloads.regulations.gov/CMS-2023-0070-0919/attachment\\_1.pdf](https://downloads.regulations.gov/CMS-2023-0070-0919/attachment_1.pdf).

5. Elena Sallitto (Stavely & Sallitto Elder Law, LLC) (MD)

We thank MACPAC for its commitment to improving the timeliness of access to HCBS. We appreciate this and future opportunities to work with MACPAC and welcome the opportunity to engage with you on policy and operational discussions moving forward. If you have any questions or would like to set up a discussion with NAELA or individual NAELA members, please reach out to Kacey Dugan, Policy Advisor to NAELA, at (202) 589-2828 or [kaceyfaegredrinker@naela.org](mailto:kaceyfaegredrinker@naela.org).

Sincerely

Lindsay Jones  
Co-Chair, Federal Advocacy Committee  
NAELA

Lauren Marinaro  
Co-Chair, Federal Advocacy Committee  
NAELA

CC: Judith M. Flynn, CELA  
President, Board of Directors  
NAELA



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## **Appendix A**

NAELA Comments to CMS on  
“Ensuring Access to Medicaid Services (CMS 2442-P) Notice of Proposed Rulemaking”

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*We envision a day when all older adults, people with disabilities, and their families have the legal, health social, and financial care they need to live their best lives. NAELA will shape, support, and inspire the national legal community.*

July 3, 2023

The Honorable Xavier Becerra  
Secretary of Health and Human Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure  
Administrator Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

**Re: Ensuring Access to Medicaid Services (CMS 2442-P) Notice of Proposed Rulemaking**

Dear Secretary Becerra and Administrator Brooks-LaSure:

As advocates for older adults, people with disabilities, and their families, we appreciate the opportunity to comment on this Notice of Proposed Rulemaking (NPRM), focused on “Ensuring Access to Medicaid Services.”

The National Academy of Elder Law Attorneys (NAELA) is the only professional, non-profit association of attorneys that conditions membership on a commitment to the Aspirational Standards for the Practice of Elder and Special Needs Law Attorneys. Extending beyond the benchmark set by the American Bar Association’s Model Rules Professional Conduct, these standards recognize the need for holistic, person-centered legal services to meet the needs of older adults, people with disabilities, and their caregivers. Supporting the dignity and independence of these vulnerable populations is at the center of what we do.

NAELA strongly supports the Biden-Harris Administration’s efforts to improve access to care for Medicaid beneficiaries, especially for older adults, people with disabilities, and those receiving long-term services and supports (LTSS) including home-and community-based services (HCBS). We are generally supportive of the policies CMS has proposed in the above-referenced NPRM and urge CMS to finalize these policies as expeditiously as possible so that beneficiaries and their representatives can benefit from them. We offer comments below on specific elements of these proposals that are focused on older adults and persons with disabilities. Additionally, we outline areas where CMS could take additional action to ensure access to care, including HCBS.

In addition to our own comments provided below, we refer you to the comments submitted by our colleagues at the Disability and Aging Collaborative as well as the Consortium for Constituents with Disabilities. We thank them for their thoughtful work in responding to these proposals and align ourselves with their comments.

### **Medicaid Advisory Committee and Beneficiary Advisory Group (§ 431.12)**

NAELA is supportive of CMS's proposed changes to the requirements governing Medical Care Advisory Committees (MCACs), including the proposals to rename these committees "Medicaid Advisory Committees" (MACs) and create a Beneficiary Advisory Group (BAG). We thank CMS for including in the list of member types that should be represented in the committees, "members representing or serving Medicaid beneficiaries [in] the following categories... (4) health or service issues pertaining specifically to people over age 65; and (5) health or service issues pertaining specifically to people with disabilities."<sup>1</sup>

Notably, under the proposal, one of categories that must be represented in the MACs is "(1) members of State or local consumer advocacy groups or other community-based organizations that represent the interests of, or provide direct service, to Medicaid beneficiaries."<sup>2</sup> Although we support this inclusion, we ask that CMS modify the requirement slightly to state that legal professional organizations that represent the interests of, or provide direct service to, Medicaid beneficiaries be included in (1) referenced above. Alternatively, we ask that CMS require states to consider elder or disability law attorneys who represent the interests of or provide direct service to Medicaid beneficiaries for inclusion. One or both changes would ensure that the legal interests of some of the most vulnerable Medicaid beneficiaries and their families are represented on the committee.

### **Person-Centered Service Plans (42 CFR 441.301(c), 441.450(c), 441.540(c), and 441.725(c))**

NAELA is generally supportive of CMS's proposals to strengthen person-centered service planning and incident management systems in Medicaid HCBS. For example, CMS is proposing to:

- Codify a minimum performance level for states to demonstrate that a reassessment of functional need, including changes in circumstances, is conducted annually for at least 90 percent of individuals continuously enrolled in the state's HCBS programs for 365 days or longer.
- Require states to demonstrate that they reviewed the person-centered service plan and revised the plan as appropriate based on the results of the required reassessment of functional need every 12 months, for at least 90 percent of individuals continuously enrolled in the state's HCBS programs for 365 days or longer.
- Require states to report on annually on the percentage of beneficiaries continuously enrolled in the State's HCBS programs for 365 days or longer for whom a reassessment of functional need was completed within the past 12 months and who had a service plan updated as a result of a re assessment of functional need within the past 12 months.

We agree with CMS that these actions will strengthen the person-centered service planning process, and better ensure that beneficiaries receive timely reassessments of functional need and appropriate adjustments to their care plans. We ask that as CMS is working with states to implement these requirements, it ensure that the documentation submitted to demonstrate compliance is publicly available in an accessible, understandable format for beneficiaries.

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<sup>1</sup> 88 FR 27968

<sup>2</sup> 88 FR 27969

We also wish to draw CMS's attention to the need for transparency regarding the functional assessment tools that states use to develop and update person-centered service plans. As CMS is aware, states have flexibility regarding the specific functional assessment tools that they use to determine functional eligibility for long-term services and supports and to create care plans. States that use managed care plans to deliver LTSS often allow plans to use a tool of their own choosing. As documented by the Medicaid and CHIP Payment and Access Commission (MACPAC), there is limited information about these tools, in part because they are typically considered proprietary.<sup>3</sup>

Unfortunately, like MACPAC, we find in our experience working with beneficiaries that there is little transparency regarding these assessment tools, including the specific tools themselves, their underlining algorithms and methodologies, and how they arrive at values to inform a beneficiary's service plan. The private companies that state and Medicaid managed care organizations contract with to develop and deploy these tools often refuse to share information about these tools with an end user, even in a due process hearing.

Ensuring transparency and accountability regarding how these tools are used is essential in ensuring that beneficiaries' service plans accurately reflect their functional needs. Although we acknowledge that CMS has not sought to address this particular issue in this NPRM, we ask CMS to consider doing so in the final rule or through future rulemaking as part of its work to strengthen person-centered service planning and improve access to high quality HCBS.

**Access Reporting Requirements (§§ 441.303(f)(6), 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii))**

NAELA supports CMS's proposals involving new requirements for states to report on key HCBS access issues, including on the number of people on HCBS waiting lists, and the average amount of time from when homemaker, home health aide, or personal care services are initially approved to when those services began for individuals newly approved to begin receiving services within the past 12 months. We believe that bolstering these reporting requirements is a necessary step to the larger goal of reducing HCBS wait lists through expansion of HCBS programs.

As CMS works with states to carry out these reporting requirements, CMS and states should ensure that reporting documentation is made publicly available in an accessible and understandable format for Medicaid beneficiaries and HCBS applicants.

**Additional Comments**

As CMS continues its work to improve access to care for Medicaid beneficiaries, including high-quality long-term care and HCBS pursuant to the Biden-Harris Administration's priorities and recent Caregiving Executive Order,<sup>4</sup> we ask that it consider several additional actions discussed below. We believe these actions are addressable through CMS's existing statutory authority.

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<sup>3</sup> Medicaid and CHIP Payment and Access Commission (MACPAC), 2016. "Functional Assessments for Long Term Services and Supports." <https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf>. Accessed June 15, 2023.

<sup>4</sup> Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers. April 18, 2023. <https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/18/executive-order-on-increasing-access-to-high-quality-care-and-supporting-caregivers/>.

First, CMS should build on its December 2021 State Medicaid Director letter<sup>5</sup> by encouraging and incentivizing states to create new, targeted income and resource disregards to address the institutional bias and expand access to HCBS. To the extent that it is not already doing so, CMS should provide states with detailed technical assistance and a roadmap to update applicable state plan amendments and related procedures to operationalize this guidance.

Second, CMS should work with states to expand the circumstances in which HCBS are provided promptly and then subsequently approved for payment. While we acknowledge that statutory barriers prevent the use of presumptive eligibility for HCBS services in many circumstances, we believe there are opportunities to expand the extent to which prompt access to HCBS are available. This could be accomplished by one or more of the following administrative actions, each of which should be accompanied by detailed technical assistance to encourage and incentivize states to reform their HCBS programs:

- Encouraging states to take advantage of Section 1115 demonstration authority to provide presumptive eligibility for certain populations. Rhode Island and Washington have done so. This may include encouraging states that have authorized their HCBS programs under Section 1115 authority to provide presumptive eligibility for certain populations or encouraging states to transition or create new HCBS programs under Section 1115 authority.
- Interpreting Section 1915(c) of the Social Security Act more broadly to allow states to receive federal financial participation (FFP) for services provided prior to the development of the service plan in certain circumstances — perhaps through development of a regulatory pathway for certain groups who are very likely to be ultimately determined eligible.
- Outlining through subregulatory guidance the manner in which states may recognize presumptive eligibility using state-only funds while waiting for full approval and development of a service plan, after which the state can receive FFP retrospectively for the interim HCBS coverage period.

### **Conclusion**

We thank CMS again for its commitment to ensuring that high-quality care for Medicaid beneficiaries is available and accessible, and for its thoughtful consideration of the important issues discussed in the NPRM. We appreciate this and future opportunities to work with CMS. We welcome the opportunity to engage with you on our policy suggestions and priorities moving forward. If you have any questions or would like to set up a discussion, please reach out to Michael Knaapen, NAELA's Director of Public Policy and Alliance Development, at [MKnaapen@naela.org](mailto:MKnaapen@naela.org).

Sincerely,

Michael Knaapen

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<sup>5</sup> CMS, SMD# 21-004, RE: State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services," Dec. 7, 2021, <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21004.pdf>