National MLTSS Health Plan Association

CMS Make Your Voice Heard RFI

Understanding Provider Experiences

CMS wants to better understand the factors impacting provider well-being and learn more about the distribution of the healthcare workforce. We are particularly interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, documentation and reporting requirements, operations, or communications on provider well-being and retention.

Recommendations for CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations.

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and take risk for long-term services and supports (LTSS) provided under Medicaid. Our members assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Our members currently cover a large majority of all enrollees in MLTSS plans and integrated plans, including national plans and regional and community-based plans.

Through the COVID-19 public health emergency (PHE), the shortage of direct care workers to provide home and community-based services (HCBS) has grown into a crisis hindering providers' and MCOs' ability to meet the long-term care needs of beneficiaries. We further describe the beneficiary impacts in later sections of this response. Below, we offer some suggestions on how CMS could support HCBS providers address the direct care workforce crisis and generally meet the needs of LTSS beneficiaries.

Continue the Enhanced HCBS FMAP

The American Rescue Plan Act (ARPA) authorized CMS to provide states with an enhanced 10% Federal Medical Assistance Percentage (FMAP) for HCBS, which states were required to enhance their Medicaid-funded HCBS programs. Most states provided some form of immediate provider relief through enhanced rates or funding for staff retention and recruitment activities, which helped stabilize providers facing unprecedented challenges. CMS should consider making the enhanced FMAP permanent, so states can continue to invest in rates and workforce retention strategies needed to keep pace with growing national demand for HCBS.

Analyze Geographic Disparities in Staffing

While the direct care workforce crisis is impacting providers nationwide, anecdotal evidence suggests that there are geographic disparities in the availability of direct care workers, particularly in historically underserved urban and rural areas. Therefore, we recommend CMS gather and analyze county or zip-code level data to identify areas where Medicaid HCBS and Medicare home health providers are unable to provide adequate staffing to serve their communities. CMS may consider targeting additional activities to support providers in these areas to address the unique challenges faced by their workforce. For example, rural providers have noted the lack of available public transportation causes staff to incur additional costs as they use their personal vehicles to travel longer distances between clients. Providing additional funding to support safe transportation to and from patient homes, in addition to supporting recruitment, training, and retention measures would help ease workforce disparities.

Improve State Contract Review

MCO negotiated contracts with provider organizations are reviewed by states prior to implementation. However, states offer little transparency to MCOs or providers during their reviews, particularly when approvals are

significantly delayed. Delays in review may prevent providers from implementing new value-based purchasing arrangements, changes to risk delegation, or receipt of quality incentives in a timely manner. To help improve providers' experience with Medicaid contracts, we recommend CMS provide technical assistance to states to improve their turnaround time, communicate review status updates, or allow retroactive implementation of contract changes after approval is granted.

Advancing Health Equity

CMS wants to further advance health equity across our programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs (such as food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

MCO SDOH Support

Managed care plans are uniquely positioned to identify and address social determinants of health (SDOH) and equity related challenges among their members. Addressing SDOH needs may allow plans to better retain members otherwise susceptible to being disenrolled from Medicaid. For example, individuals experiencing homelessness would not be able to receive notices that request additional information, resulting in termination due to procedural reasons. MCOs also offer a host of value-added services to address SDOH needs in their membership, such as nutrition classes, peer support services, and employment assistance. However, how such services are accounted for in MLR calculations remains unclear, with plans often funding SDOH-related services out of their administrative expenses. The MLTSS Association recommends CMS release clear guidance describing how plans can account for SDOH-related activities as quality improvement activities, so they are appropriately categorized in MLR calculations and plans can fully implement these benefits to address the equity-related needs of beneficiaries.

Coordinate Affordable Housing

For many low-income individuals with disabilities, the opportunity to receive home and community-based services (HCBS) is dependent on their ability to find and afford accessible community housing. However, they are forced to navigate multiple, uncoordinated affordable housing programs to access existing services, and Medicaid programs are not allowed to pay for rent subsidies or room and board costs. While during the COVID-19 pandemic, some states and plans created alternative programs that helped provide safe housing to high need individuals, a coordinated, national initiative led by CMS could broadly address the housing and economic factors that drive reliance on nursing facility care.

Coordinate Affordable Broadband

An increasing number of assistive technologies, as well as access to telehealth medical care require Medicaid beneficiaries to connect to broadband and high-speed internet. However, there are disparities in access to internet, particularly in rural and other underserved areas. We suggest that Medicaid allow for braided funding from Medicaid and other federal, state or local programs for internet service when use of internet can effectively support the consumer's needs. For example, the Lifeline program and the Emergency Broadband Benefit could be utilized to provide critical access to affordable phones and broadband for beneficiaries.

Integrate Behavioral Health

Individuals with behavioral health needs often also have physical health needs and experience disparities related to social needs. Further, individuals with behavioral health often require assistance with activities of daily living or instrumental activities of daily living, overlapping with LTSS needs. Medicaid managed care lies at the nexus of these areas of overlap, and is uniquely positioned to provide coordinated, whole person care to improve

outcomes, costs, and quality. As such, we support state efforts to carve-in behavioral health care services and LTSS into MCO contracts. Such integrated care products can offer opportunities for shared savings, improvements in clinical outcomes, and reduced health disparities.

Network Adequacy Standards

Traditional MCO network adequacy standards rely on time and distance. The rigidity in these standards may not best account for the variety of circumstances beneficiaries find themselves in and consequently fail to ensure equitable access to a high-quality network of providers. CMS should encourage the development of flexible network adequacy requirements that help MCOs facilitate value-based purchasing arrangements with certain groups of providers to incentivize high quality care and promote innovative models of care delivery. For example, in rural, less densely populated regions of the country, rather than investing in large provider options, plans should look to more innovative, targeted models of service provision relying on self-direction or smaller, more nimble agency models. Rural HCBS provision should include compliance standards focused on access, stabilization of providers, and quality of the outcomes individuals are experiencing. New Mexico allows for different models of network adequacy for urban vs. rural areas. In addition, disparities in commutes to access care also exist within urban areas. Although it is important to consider driving times, significant portions of city populations do not have access to a car and depend on public transportation systems. CMS should consider building in commuting times on mass transit systems into travel time.

Understanding the effects on underserved and underrepresented populations when community providers leave the community or are removed from participation with CMS programs.

Direct care workers play a critical role in serving some of the most vulnerable members of our communities. However, ongoing shortages, exacerbated by the COVID-19 pandemic, translate into reduced access to HCBS and the ability for individuals to live within the community and receive the services they need. Our member organizations rely on a critical component of the health care work force, including Personal Care Attendants (PCAs), Direct Support Professionals (DSPs) and other homecare professionals that assist individuals with functional limitations to maintain their independence and quality of life by assisting with activities of daily living (ADLs) like bathing, dressing, and feeding. By addressing these needs, the HCBS workforce keeps individuals with functional limitations out of more costly nursing facilities and hospitals. However, a 2022 survey of HCBS providers showed that over 80% had turned away patient referrals, over 60% of providers were discontinuing programs, and over 90% reported they were struggling to meet quality standards due to staffing shortages. As a result, individuals with disabilities are waiting longer, receiving lower quality services, and relying on informal caregivers for support. Access to a robust direct care workforce is critical to ensure enrollees with disabilities, frailty, and other serious health conditions receive the care that they need in the community.

The availability of a qualified, competent, and stable direct care workforce plays a critical role in supporting people with disabilities to accomplish their goals and have equitable access to their communities. It is critical that direct care workers have the confidence, ethical decision-making skills, empowerment, guidance, and latitude necessary to provide quality support, receive compensation that is commensurate with job responsibilities and have access to a career path aligned with ongoing professional development. To alleviate workforce shortages, the MLTSS Association recommends CMS consider several strategies:

1. Ensure direct care workers and front-line supervisors have opportunities for needed training, mentoring, and professional development.
2. Provide credentialing opportunities, career pathways, and ongoing competency-based training and mentoring to create incentives for direct care worker participation. Encourage the development of statewide career advancement pathways for direct care workers based on the completion and demonstration of CMS' core competencies, with career lattices (with corresponding increased wages)

for individuals who have been deemed by a neutral third-party as proficient in demonstrating competency areas.

3. Ensure direct care works reflect the racial and ethnic diversity of the beneficiaries that they serve.

Recommendations for how CMS can promote efficiency and advance health equity through our policies and programs.

Dual Eligible Special Needs Plans

Individuals who are dually eligible for Medicare and Medicaid are by definition lower-income, racially and ethnically diverse, and experience disproportionate rates of chronic illness, behavioral health conditions, and social risk factors than those who are eligible for only one program. We recommend CMS consider developing policies that better integrate Medicare and Medicaid programs, particularly for Dual Eligible Special Needs Plans (D-SNPs) so that these beneficiaries have more equitable access to their healthcare benefits. To expand access to integrated D-SNPs, CMS should create a new special enrollment period for dually eligible beneficiaries in Original Medicare to enroll in an integrated care product (D-SNP or MMP) on a continuous (monthly) basis. We also recommend that CMS expand default enrollment authority beyond newly eligible beneficiaries to all dually eligible beneficiaries. Moreover, we recommend that the expanded authority should apply to any HIDE-SNP and FIDE-SNP entities that have a Medicaid contract which covers, at minimum, a comprehensive set of long-term services and supports as well as home and community-based services with reasonable state-specified service exclusions and carve-outs. Highly Integrated D-SNPs (HIDE-SNPs) and Fully Integrated D-SNPs (FIDE-SNPs) which meet current requirements for performance indicators could default enroll dual eligible beneficiaries into the HIDE-SNP or FIDE-SNP if the beneficiary is enrolled in Original Medicare and in the HIDE/FIDE's parent company's Medicaid managed care organization.

CMS should recognize the barriers of communicating the unique benefits of D-SNPs to beneficiaries and work with stakeholders to develop communication tools that outline the value of integrated products. For example, CMS can include additional information on the benefits of D-SNPs within the Medicare and You Handbook and update the Medicare Plan Finder with information on integrated care products. CMS should also consider developing materials targeting caregivers, who often make health coverage decisions on behalf of the beneficiary. We also recommend that CMS collaborate with other stakeholders and develop national educational materials on the benefits of integrated care. These materials should translate the responsibility placed on D-SNPs to holistically manage the care of beneficiaries as well as outline the tailored supplemental benefits provided.

Expand Application of the Frailty Adjuster

We recommend CMS apply the frailty adjuster to all highly integrated products to incentivize development of plans to address the unique disparities faced by dually eligible beneficiaries. The distinction between FIDE SNPs and other SNP plan types (HIDE and Coordination-only) generally stems from state policy decisions in the management of their Medicaid services, and not demographic or acuity makeup. The beneficiary demographic and acuity scores between across D-SNPs are very similar. Thus, the disproportionate financial impact of high acuity frail individuals is faced by all types of D-SNPs. Yet many cannot avail themselves of the policy solution for that problem for reasons outside of their control. While we recognize that the parameters of the frailty adjuster are outlined in statute, we nevertheless encourage CMS to consider any and all options within their regulatory authority to either extend its application, or to create alternative solutions available to other SNPs.

Improve Data-Sharing and Coordination Between States and Plans

CMS should also encourage the sharing of information between state Medicaid agencies and MLTSS plans to improve care coordination, health equity-related data collection, and beneficiary experience. CMS could add a standard set of elements to 834 enrollment files across states to facilitate better care coordination for the member, including Medicare program enrollment and plan information for dually eligible beneficiaries and the

reason for disenrollment. This will help plans to better coordinate with a dually eligible member's Medicare plan, resulting in a more seamless experience for beneficiaries.

Additionally, we recommend CMS encourage states to directly collect cultural competency training data from providers and beneficiary language preferences when they first enroll in Medicaid. This data can then be shared with plans, who can then contact the beneficiary in their preferred language and connect them to providers with better cultural competency.

Improve Cultural Competency of Workforce

CMS should consider approaches to increase cultural competency in and delivery of linguistically appropriate care among all providers, including direct care workers. CMS can encourage and fund state Medicaid programs to offer cultural competency/humility training for all providers, and the development of local pipeline programs that recruit individuals from the communities they would serve.

Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibility and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

Assistive Technologies

There are numerous examples of technologies used throughout the COVID-19 PHE that have enabled HCBS participants to maximize their personal autonomy. For example, using sensory technology to monitor when someone with cognitive limitations or memory loss leaves their bed and returns to bed in the middle of the night; or, "Med Minders", which capture data on individual medication uptake and contacts a family member or neighbor when a medication has not been taken as scheduled. One plan has been piloting the increased use of technology to support individuals at home while reducing the reliance on additional staff and have seen the same or better outcomes with supporting individuals versus having paid staff continuously onsite. Additionally, we believe it would be sensible to allow states to reimburse for virtual communications and technologies to support service provision and address direct service professional workforce shortages under certain circumstances (but not substitute necessary in-person supports that lead to inclusion). Some examples include incidental/episodic events that occur and require urgent guidance/support (employment, housing, welfare & safety, transportation).

Telehealth

The increased flexibility around telehealth has been invaluable, especially for those with complex conditions for whom limiting risk of exposure to the virus has been critically important. The use of telehealth enhances the opportunity for primary care providers and specialists to meet with individuals with disabilities, making access to care readily available. Providers experience a reduction in missed visits while patients can safely access virtual care in a timely fashion. CMS approved Appendix K waivers that allow Case Managers to engage with participants and monitor service plans by virtual visits where face-to-face encounters are typically required. These changes not only keep enrollees and their care teams safe, well, and connected, but also reduce administrative and travel expenses. Importantly, this flexibility allows Case Managers to remain engaged with enrollees and maintain close contact with the individuals who would be at risk for isolation, abuse, neglect, and exploitation. CMS should ensure states are developing protections to ensure effective consumer engagement via telehealth as well as promote health and safety and equitable access. CMS and states should collaborate to ensure guardrails that protect program integrity in telehealth, as would occur with in-person care.

Housing Coordination

The need for housing—other than nursing home care—has been made especially apparent during the COVID-19 pandemic. Some states have created programs that provide and/or make connections to safe housing for high-need individuals, and health plans have played a critical role in those efforts. In California, Project Roomkey is a FEMA and state-funded program that provides secure hotel and motel rooms for vulnerable people experiencing homelessness. Commonwealth Care Alliance (CCA) worked with local and state governments to turn hotels in Massachusetts into isolation and recovery sites for individuals who tested positive for COVID-19 and needed a safe place to isolate. In Minnesota, the Housing Stabilization Services program was recently approved after several years of development efforts. Those who qualify for services will get help finding a place to live and making sure a home is safe, accessible, and ready for move-in, as well as receive assistance negotiating with potential landlords.

These programs are examples of facilitating access to temporary or long-term housing during the pandemic, but one key limitation within the current system is the inability to use Medicaid room and board expenditures towards rent and rental assistance. New flexibilities for Medicare Advantage (MA) plans through Special Supplemental Benefits for the Chronically Ill (SSBCI) allow for subsidies for rent, assisted living communities, and utilities. A similar level of flexibility should exist within the Medicaid program.

Eligibility Redeterminations

As the federal COVID-19 PHE ends, and states begin restarting Medicaid eligibility redeterminations, we believe CMS should consider other flexibilities and strategies particular to the LTSS population in eligibility determinations. Determining eligibility for LTSS can be a complex process. States must first determine if individuals meet income eligibility criteria and functional eligibility requirements, which are assessed using a variety of different functional assessment tools. The overall volume of redeterminations could create a bottleneck for conducting functional assessments, causing delays and gaps in coverage for the LTSS population. We recommend that CMS consider these limitations in developing timeline for completing redeterminations and encourage states to share with MCOs any information that may inform a functional assessment.

Recommendations for CMS policy and program focus areas to address health disparities, including requested waivers/flexibilities to make permanent; any unintended consequences of CMS actions during the PHE; and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE.

CMS, state and local governments responded to the COVID-19 PHE with a suite of resources and supports, including modifying or waiving certain regulatory or programmatic requirements for the delivery of LTSS. The full scope of these flexibilities has been a critical tool for states, providers, and plans to effectively respond to the challenges in delivering LTSS created by COVID-19. Some of these modifications have proven to be highly effective at supporting individuals with disabilities during an exceptionally challenging time and warrant further consideration to be made permanent. Below we highlight a few of the COVID-19 PHE flexibilities that CMS should consider making permanent.

Assistive Technologies

Leveraging technology within individuals' homes to support outcomes and reduce the reliance on unnecessary (or unwanted) direct care professional staff is an area of tremendous growth given the impact of the COVID-19 pandemic. When technology can be leveraged to support individuals with disabilities in place of staff, resources can be reallocated to support other individuals with more intensive needs or who are currently waiting to receive services. While the desires and preferences of participants should always drive the decision of when and whether to use technological supports, there are beneficiaries who prefer using technology to grow their own independence and reduce reliance on paid staff. We generally believe that expanding the use of video and telephonic services to deliver and manage care has created benefits during the COVID-19 pandemic and holds promise for future efforts.

CMS implemented new opportunities for individuals with disabilities to access a variety of assistive technologies during the COVID-19 PHE. The flexibility for the individual, with their care planning team, to determine which device(s) would best meet their service needs successfully helped many individuals access essential healthcare and community-based services. Preserving the flexibility to allow individuals and care planning teams to determine which evidence-based assistive technologies best support the individual's needs and goals, within guardrails established by states, will allow individuals with disabilities to continue to access new and innovative technologies developed in the future.

Telehealth

As federal and state governments consider the permanency of telehealth flexibilities, we strongly encourage stakeholders to further include requirements to ensure the accessibility of these services for individuals with disabilities alongside adjusting current quality measure standards. For example, within the context of accessibility, telehealth services should be able to accommodate the needs and preferences of individuals who may have difficulty hearing or seeing. Quality standard specifications will also need to consider, at a minimum, how to recognize the delivery of telehealth services in their calculations going forward.

Self-Directed Services

During the COVID-19 PHE some states elected to expand which services may be self-directed (including respite, medication administration, personal support, and transportation) and allowed family members to serve as paid caregivers in more situations. We support continuing these expansions with the acknowledgement that additional parameters and guardrails should be put into place to address program integrity concerns such as financial conflicts of interest and misrepresented needs and services delivered.

Paid Family Caregivers

States also modified requirements and allowed family caregivers to be paid for care they are providing. Encouraging states to continue this practice, consistent with the amount of care indicated through the assessment process, when desired by and in the best interest of the enrollee provides an opportunity for the participant to receive care and services from a trusted source of their choosing and helps to create sustainable options for the caregiver workforce. For example, the Washington State Community First Choice Option (CFCO) allows Medicaid beneficiaries to receive personal care in community-based settings, choose their caregivers, and hire family members to provide their care. This option improves the ability to age in place and reduces the reliance on brick-and-mortar long-term care settings. However, it will require oversight and guardrails to ensure beneficiary protections.

Provider Enrollment

CMS and states implemented new flexibilities that enabled expedited enrollment of HCBS providers such as temporarily waiving training and site visit requirements and expediting application reviews. We recommend that CMS and states consider reinstating these flexibilities during future circumstances where there is an acute need for HCBS providers (e.g. after a natural disaster) or in areas where there are chronic and critical shortage of available providers.