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Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
Disabled and Elderly Health Programs Group
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Via email: jodie.sumeracki@cms.hhs.gov

Re: HCBS Rebalancing and Nursing Home Diversification

Dear Ms. Sumeracki,

Thank you for the opportunity to participate in your June 24, 2020, call on Home and Community Based Services (HCBS) Rebalancing and Nursing Home Diversification. As the national trade associations representing health insurance providers at the state and federal level who serve hundreds of millions of Americans every day, we welcome the opportunity to provide input on HCBS, rebalancing, and nursing home diversification. America's Health Insurance Plans, Association for Community Affiliated Plans, Alliance of Community Health Plans, Blue Cross Blue Shield Association, Medicaid Health Plans of America, and the National MLTSS Health Plan Association collectively represent the significant majority of health plans providing coverage to Medicaid beneficiaries with long term services and supports (LTSS) needs.[1] We hope that the details shared throughout this submission are helpful as you continue to gather information.

Even before the COVID-19 crisis, health insurance providers were exploring modifications that would allow people seamless access to providers and services. Health insurance providers have launched innovative approaches to care and have called on Congress to help break down barriers to service delivery, including enhancing in-home care and services.

As the COVID-19 crisis continues to impact Americans across the nation, older adults and people with disabilities are especially at high risk. People who live with medically complex health conditions, older adults, and those who require assistance with activities of daily living (ADL) need support to manage their health and safety. Health insurance providers have taken decisive action, offering additional access to essential health care and services during this unprecedented time.

Health insurance providers are committed to ensuring enrollees have access to the services they need during the COVID-19 public health emergency (PHE) and beyond; providing additional support and personal protective equipment (PPE) to caregivers, personal care attendants and direct support professionals; expanding access to telehealth, food items and meals; and increasing flexibility in Medicaid benefits.

As federal and state governments implemented emergency procedures, health insurance providers quickly adjusted their processes to better serve enrollees. Thanks to the quick and decisive actions of

[1] www.ahip.org; www.communityplans.net; www.achp.org; www.bcbsa.com; www.medicaidplans.org, www.mltss.org

the states and the Centers for Medicare & Medicaid Services (CMS), service delivery continued for the people requiring consistent access to needed long-term services and supports (LTSS). Certain flexibilities have allowed critical services to seamlessly continue for individuals who require LTSS and should extend beyond the COVID-19 pandemic. Some of these important flexibilities include:

1. **Case Manager Visits and Person-Centered Planning Team (PCPT) Meetings:** 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. This flexibility was also extended to apply to PCPT meetings and plan development. These changes not only limit the risk for COVID-19 exposure and 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. Continuing telehealth flexibilities beyond the PHE can be a positive development for many participants and teams, but there should be some guardrails to ensure health and safety as well as equitable access, including tools to protect enrollees from fraud or abuse that might otherwise be detected during an in-person visit. States should seek public input on their plans to make services delivered via telehealth a permanent option, while maintaining program integrity, to address any stakeholder concerns.
2. **Primary Care Physician (PCP) and Specialist Visits:** 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 providers to meet with individuals residing in long-term care (LTC) facilities, rural areas, or those experiencing access issues for a myriad of reasons, making access to care readily available. Providers experience a reduction in missed visits while patients can safely access virtual care in a timely fashion[2]. As with case management visits, CMS should ensure states are developing protections to ensure effective consumer engagement via telehealth as well as promote health and safety and equitable access. States should seek public input on their plans to make services delivered via telehealth a permanent option in order to address any stakeholder concerns. CMS and states should collaborate to ensure guardrails that protect program integrity in telehealth, as would occur with in-person care.
3. **Nurse Practitioners (NP) and Physician Assistants (PA):** Allowing NPs and PAs to practice at the top of their license by providing primary care in LTC settings has alleviated strains on resources and allowed physicians to concentrate on areas in need of their expertise. Making these changes permanent and therefore improving access help to improve access, close gaps in care and improve consumer satisfaction.
4. **Paid Family Caregivers**: During the COVID-19 crisis, states 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. This option improves the ability to age in place and reduces the reliance on brick and mortar LTC settings. However, it will require oversight and guardrails to ensure beneficiary protections.

[2] Since deploying patient-engagement technology, Community Care Physicians has achieved a 35% improvement in its no-show rate. Healthcare IT News, May 27, 2020

5. **Coverage of Assistive Technology Tools:** CMS has said that states can add coverage for items like smart tablets using Appendix K waivers. This flexibility creates access to valuable, evidence-based tools that provide multiple opportunities to support enrollee health, including medically necessary telehealth visits and access to employment, education, and social visits. Because affordable broadband and high-speed Internet is not available everywhere and is particularly limited in rural and other underserved areas, CMS should also allow payment of Internet service when use of technology is medically appropriate, evidence-based, and can effectively support the consumer's needs. In order to ensure consumers can use available tools and that access is equitable for all, CMS should include technology tool training for consumers and caregivers when needed.
6. **Alternative Settings Payments:** CMS has approved waivers to allow facilities, including nursing facilities (NF), intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDD), psychiatric residential treatment facilities (PRTF), and hospital NFs, to be fully reimbursed for services rendered in an unlicensed facility. There may be situations where this arrangement remains useful after the PHE; however, considerations should be made to ensure that individuals are provided ongoing opportunity to transition from institutional care into the community, or if continued facility-based care is necessary, that robust survey and certification processes ensure the health and safety of participants as well as continued transition planning if community living is the individual's preferred living choice. In either setting—alternative setting or community setting—CMS should work with stakeholders to ensure appropriate protections against fraud, waste, or abuse to keep consumers safe and mitigate risks to the Medicaid program caused by bad actors.
7. **Increase the Use of Adult Day Programs:** Continue allowing Adult Day Programs to offer expanded services, including participant outreach, meal delivery, and other services that can assist individuals with remaining safely in the community beyond the PHE.
8. **Supplemental Pay for Direct Care Workers:** Several states have allowed for pandemic premium pay for direct care workers, including self-directed workers, to compensate them for the essential health services they provide to people with disabilities.
9. **Expanded Self-Direction:** A few states have expanded services included in self-direction such as transportation, home-delivered meals, companion services, and homemaker services. Continued and increased use of these services can be important for maintaining health and safety after the PHE.

Looking ahead and considering the COVID-19 related challenges experienced in congregate settings, it is important to address the future of long-term care in a variety of areas. During the stakeholder call held on June 24, 2020, many possible solutions were discussed. Health insurance providers have made significant investments in developing person-centered approaches to providing LTSS and are an excellent source for ideas that could be considered and may be supported by CMS. Our members have developed a robust list of suggestions for rebalancing HCBS and nursing home diversion. Those suggestions include the following.

1. **Affordable, Integrated, Non-Congregate, Community-Based Housing (Crisis and Long-Term):** The COVID-19 crisis highlighted some of the challenges of enrollees remaining in nursing homes because of barriers to locating affordable, accessible housing as well as the needed services and supports. Additionally, the ability of people with disabilities and older adults to live in the community is often unrecognized. The challenges they experience are largely due to inadequate funding support for HCBS. There is also a misconception that people will be safer in a 24-hour congregate care setting. Medicaid, the primary payer of nursing home care and intermediate

care facilities (ICF), is unable to pay for room and board in HCBS. The combination of lack of availability and a lack of payment mechanism results in individuals remaining in a nursing home or an ICF where people are socially isolated and segregated from their community, friends, and family, resources are strained, and physical distancing is impossible, therefore potentially resulting in negative health outcomes.

Medicare Advantage (MA) allows MA plans to pay subsidies for rent, assisted living communities, and utilities under new flexibilities offered as Supplemental Benefits for the Chronically Ill (SSBCI).CMS should work with other federal agencies (both within HHS – such as ACL, OCR, ASPE, SAMHSA -- as well as HUD, DOJ, VA, SSA, USDA) to coordinate on a Living and Aging in Community initiative that addresses Social Determinants of Health (SDOH) to reduce unnecessary institutionalization, particularly for individuals who have primarily non-medical support needs, such as personal assistance services or experiencing housing or economic insecurity, that are driving the reliance on nursing facility care.

The need for alternative housing—other than nursing home care—has crystallized during the COVID-19 pandemic, and it is essential that we examine and develop plans for delivering both affordable and accessible housing, and home and community based services that are scalable during a crisis. Some states, such as California, Massachusetts, and Minnesota have created alternative options that provide safe housing to high need individuals and health plans have played a critical role as partners in those efforts. In California, Project Roomkey is a FEMA/State-funded program that provides secure hotel and motel rooms for vulnerable people experiencing homelessness. It provides a way for people who don't have a home to stay inside to prevent the spread of COVID-19. In Butte, Los Angeles and Fresno Counties, Health Net has successfully worked with hospital discharge planners and local housing authorities to transition MLTSS members experiencing homelessness, who are COVID-19 negative, to safe Project Roomkey hotel and motel sites. This collaboration allowed the hospital to decompress hospital emergency rooms and in-patient beds at the height of the pandemic, while at the same time ensuring safe community transitions for those in need. During the COVID-19 crisis Commonwealth Care Alliance (CCA) worked with local and state governments to turn hotels in Massachusetts into low-acuity quarantine and recovery centers for marginally housed individuals who tested positive for COVID-19. CCA also helped patients find housing and access addiction services, and enrolled eligible patients into Medicaid after discharge. 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. The program also pays for a variety of tenant services, such as early identification of behavioral conditions and tenant training designed to prevent evictions.

2. **Proactive Transitions Between Settings:** CMS should work with stakeholders to develop a proactive framework that supports seamless transitions between settings, including advanced care planning, early discharge planning, and coordinated care transitions, preventing crises and engaging beneficiaries, caregivers and families. This approach enables care teams to use predictive analytics to identify individuals at the highest risk of poor transition outcomes and to provide access to an advocate to work synergistically with primary care and other providers. This would help divert hospitalized individuals from placement in nursing homes for post-acute care by educating and supporting hospital clinicians, discharge planners, and other members of care teams about transition options and the recent flexibilities in home health. A person's

home, with necessary services and supports, must be recognized as the preferred alternative in our health care system for supporting members requiring long-term care.

3. **Incentivize Transitions:** CMS, in partnership with other agencies, could fund pilot programs that help states to incentivize transitions of care. Providing states the funding and flexibility to incentivize proactive transitions of care would support the goals of rebalancing.
4. **Reduce the Unnecessary Number of Individuals in Nursing Facilities:** Discharging individuals with the lowest medical needs and/or activities of daily living (ADL) and instrumental activities of daily living (IADL) needs to home and community-based settings with the supports and services they need, and separating remaining individuals who may be COVID-19 positive (either recovering or newly infected) from other residents could help reduce pressure on nursing facilities and unnecessary institutionalization.
5. **Repurpose Institutional and Nursing Facility (NF) Capacity:** In the short term, while dealing with the effects of the PHE, facilities with reduced use could be repurposed to assist more people in need. NF kitchens and staff could be repurposed to prepare and deliver meals to older adults and people with disabilities or use transport vans to assist with non-emergency medical transportation. Additionally, NFs that have capacity could repurpose separate wings in existing space with completely different staff for medical respite for people experiencing homelessness, transition beds for survivors of interpersonal violence, or laboratory/training sites for local universities with nursing or physical therapy/occupational therapy (PT/OT). Finally, where nursing facilities are experiencing minimal use, the facilities could be adapted for low-income families.
6. **Incentivize New Business Opportunities:** As care continues to shift away from institutional settings, there will be a continued and pressing need for providers to serve individuals at home and in the community. Incentivizing organizations that are interested in shifting their business model from focusing on institutional services to HCBS would encourage new development and accelerate the prioritization of people living at home and in their communities.
7. **Training and Support:** HCBS technical assistance and training contracts could be used to support states in their efforts to divert and transition people from institutional settings, including how to operationalize best practices, use data to target their efforts, and learn from peer states who have been successful. It is also important to support training for all staff (e.g., hospital, clinical providers, state, Managed Care Organizations (MCO)) on LTSS and community options that prioritizes presenters and trainers who are people with disabilities, older adults, and other people with lived and personal experience to offer strategies and problem-solving approaches related to LTSS, from both the perspectives of the aging and disability communities, to allow for better person-centered care and informed decision making. MCOs welcome the opportunity to partner with states and HHS to provide training to our teams. CMS should also ensure LTC ombudsman programs focus on both nursing home residents and people receiving HCBS, and support training for LTC Ombudsmen on working with younger people with disabilities, abuse and neglect in HCBS settings, and enhance their ability to address quality of care in all settings.
8. **Partnerships:** CMS should encourage and support the creation of partnerships with community-based organizations that can provide a variety of supports to individuals living in the community, including housing or residential option providers to facilitate transitions back to the community or diversion form institutional placement, food security-focused organizations, and organizations that can help with utility payments or home modifications. CMS could offer support to community-based organizations to enhance their technology and data systems for better coordination and delivery of care and services. CMS could ensure that local community organizations such as area agencies on aging (AAA) and centers for independent living (CIL) are

supported as key potential partners for this work and are adequately resourced to assist more people.

9. **Social Determinants of Health (SDOH):** Collaborate with the Medicare-Medicaid Coordination Office (MMCO) and focus on developing Medicare-funded diversion approaches and adequate reimbursement for supplemental benefits that will allow MA plans to address SDOH and reduce the likelihood of spend-down to Medicaid. CMS could support the development and deployment of tiered eligibility methodology to provide low-cost benefits to targeted members to keep members in the community and reduce deterioration in health and functional status. For individuals residing in nursing facilities, redesign activities and programs within NF settings that address or support SDOH, so that individuals are maintaining, gaining, or possibly regaining skills that can support the transition to home and community-based options.
10. **Value Based Payments (VBP):** CMS could implement incentives for providers and plans to facilitate the adoption of VBP arrangements with LTSS and HCBS providers, including behavioral health. For example, benchmark payments for staying out of a NF for six months, one year, and beyond or timely implementation of new services. A similar approach could be taken to incentivize transitions to the community from all congregate settings.
11. **Actuarially Sound Rates:** CMS could support Medicaid financial analysis and rate development that allows for equity in the care provided in LTC facilities versus via HCBS by incorporating the cost of room and board, geographic weighting, and need for adequate wages and hazard pay for staff (whether licensed or para-professional). Rates should also take into consideration that historical cost-reporting methodologies for HCBS have not kept up with the complexity and reality of cost-of-care delivered in HCBS. Rates should also include projected costs for covering new technologies and models of care delivery in cases where historical data are not available.
12. **Adapting Pre-COVID Requirements to Align with New Realities:** Requirements that made sense pre-COVID-19 now present unnecessary challenges. CMS should consider updates to align requirements to the new delivery of care system. Changes such as adapting staffing ratios and time and distance access/network requirements to acknowledge the use of technology, in order to expand access to members with less complex needs, would allow for compliance without unnecessary burden. Additionally, allowing investments that support HCBS redesign as well as the SDOH investments that offset some HCBS needs – including the introduction of digital member engagement tools – to be counted in the medical loss ratio would reflect the current needs and care for the HCBS population.
13. **Collaboration:** Providers should be incentivized to collaborate across settings, including for supporting home and community as first-choice options instead of admission to congregate settings. Additionally, rehabilitation should be incentivized to discharge enrollees to home as a successful outcome, with penalties for transitions to long-term residence in an institutional setting. Consider treating post-acute admissions to LTC facilities differently in readmission avoidance incentives/penalties by increasing payment to providers for individuals who transition home and do not re-admit as compared to individuals who transition to LTC facilities and do not re-admit.
14. **Pilot Programs:** Pilot programs should be launched that support alternative living arrangement options such as opportunities for older adults to share residency and life experience with college students, young professionals or young families, similar to Shared Living for people with I/DD. Another option includes older adult life-sharing arrangements that structure supportive services around serving the entire household holistically, not based solely on individuals' and family members' discrete needs but instead maintaining flexibility across members of the household as needed. Another option is a pilot that allows flexibility for non-emergency medical

transportation to grocery stores and pharmacies for those in the community living in food and/or medical deserts.

15. **Infection Control Audits Expanded and Strengthened:** CMS should extend the required onsite infection control surveys to all congregate care facilities that house people with disabilities and older adults (and not just limit them to nursing homes). If any facility is cited for infection control deficiencies at the "immediate jeopardy" level, residents in those facilities should be immediately transitioned out of the facility and into alternative home and community-based settings with adequate supports and services.
16. **Increased Acuity in HCBS:** CMS should work with stakeholders to develop standards of in-home care delivery for individuals with complex medical and social needs to ensure safety at home for those beneficiaries. Expanding the use of HCBS will result in higher acuity individuals remaining at home and it is important to create standards that will keep people safe while at home. CMS should also evaluate the true cost of HCBS for high acuity beneficiaries and adjust the rate setting methodology to reflect those costs.
17. **Increase Access to Community-Based Palliative and Hospice Care:** CMS should work with states to develop accessible and community-based palliative and hospice care options along with actuarially sound rate-setting. Individuals facing serious illness and end of life should have the opportunity to live peacefully and supported in the setting of their choice.

Health insurance providers stand ready to serve as a resource to CMS as the agency continues its efforts to rebalance towards HCBS and divert people away from institutional settings. We welcome the opportunity to form a workgroup with our Federal, State, provider, and consumer advocate partners to develop real solutions that have a near-term and long-term impact for individuals requiring these services. We hope that CMS will consider piloting public-private partnerships that can explore innovative solutions to long-standing challenges. While the COVID-19 crisis has presented many challenges, it has also shown us that fast, decisive action is possible and given us a valuable opportunity to work together.

We thank you for this opportunity to provide comments and look forward to working with you. Please do not hesitate to contact us at any time with questions or for further information at:

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Sincerely,

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