National
MLTSS
Health Plan Association

National MLTSS Health Plan Association: Regulatory and Programmatic Flexibilities to Maintain or Discontinue Following the COVID-19 Pandemic

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Background

The Center for Medicare and Medicaid Services (CMS) along with state and local governments have responded to the COVID-19 public health emergency with a suite of resources and supports for the health care system. One of the core components of these resources and supports includes modifying or waiving certain regulatory or programmatic requirements for the delivery of certain services and items under the Medicaid and Medicare programs. With respect to the Medicaid programs, CMS has primarily worked with states on these modifications through the Section 1135 waiver process to modify broad requirements. In terms of changes to long-term services and supports (LTSS), CMS has worked with states via Appendix K submissions to specifically modify 1915(c) programs and through state plan amendments (SPAs) for broader LTSS changes.

The full scope of these flexibilities has been a critical tool for states, providers, and managed long-term services and supports (MLTSS) plans to effectively respond to the challenges in delivering LTSS created by COVID-19. As MLTSS plans have had more time to implement these flexibilities, certain modifications have proven to be highly effective and warrant further consideration to be made permanent. However, other flexibilities have presented themselves as unsustainable.

The purpose of this document is to put forward the series of flexibilities that should be made permanent past the public health emergency period alongside the flexibilities that should be discontinued, based on the experiences of MLTSS plans.

We recommend the following to be made permanent:

- The expansion of telehealth to perform care management functions such as patient assessments, delivery of behavioral health services, and to triage patient needs.
- Supplemental pay for direct care workers, assuming there is an appropriate rate adjustment for managed care plans;
- The ability to deliver LTSS in care settings and through care modalities (i.e. telehealth) beyond what is currently allowed; and
- The expansion of self-directed care to include more services and to allow for family members to serve as paid caregivers, alongside additional guardrails.

We recommend the following to be discontinued:

- Waivers of limits on the maximum number of individuals that can be served within certain LTSS care settings
- Suspensions or delays of reporting incidents; and
- Limits on in-home visitors.

Flexibilities to Make Permanent

Expansion of telehealth

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. MLTSS plans have had positive experiences with tele-care management in the context of members with limited mobility and transportation options. Additionally, the ability to provide tele-care management visits rather than a face-to-face visit has increased the efficiency of care managers as it generally reduces travel time to and from different beneficiary locations.

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 difficulty hearing or seeing. Quality standard specifications will also need to consider, at a minimum, how to recognize the delivery of telehealth services since they are generally not counted towards certain numerator and/or denominator calculations at the moment.

Finally, post-pandemic modifications to the expectations set forth by HIPAA should be extended to health plan care managers. The current waivers of certain HIPAA regulations only apply to certain providers within certain geographies; care managers from health plans are explicitly carved-out from these flexibilities. There should instead be a consistent set of expectations for all entities so that they can equally take advantage of new telehealth technologies and services.

Supplemental pay for direct care workers

The ability to provide reimburse direct care workers at a higher base rate, to add supplemental payments in addition to the base rate, and to tier payments based on patient acuity during COVID-19 have all helped MLTSS plans retain the current LTSS workforce. Moving forward, we encourage the federal government and states to maintain these flexibilities for MLTSS plans and to provide appropriate consideration for these increased labor costs within the payment rates of MLTSS plans. The COVID-19 pandemic has created LTSS workforce issues by generally exacerbating ones which were already present before the PHE. Difficulties with retaining direct care workers stem from several issues, including current payment levels and the need to create ladders for career progression. These issues point to the need for maintaining these increased payments so that the stakeholder community can constructively support the workforce beyond the pandemic.

Delivering LTSS in expanded service settings and service modalities (i.e. telehealth)

The ability to provide LTSS in non-traditional services has served the stakeholder community well within the context of COVID-19 as beneficiaries have been required to quarantine in their immediate surroundings but still maintain their LTSS needs. Going beyond COVID-19, the ability to provide LTSS in non-traditional settings would also be helpful to address the individual circumstances of individuals with functional limitations. This could include providing LTSS in locations such as crisis housing and shelters and providing respite care in institutional facilities. Notably, from a Congressional perspective, the CARES Act has also temporarily allowed HCBS to be provided in acute care hospitals during the pandemic.

Expanding service modalities to include two-way, real-time interactive communication between the member, distant site physician practitioner, and care manager has also been of great use in certain situations that extend beyond the pandemic. They include (but are not limited to) using telehealth for personal care services that require verbal cueing, monitoring, and behavioral support consultation.

Expanded access to self-directed services

Some states have also expanded the extent to which beneficiaries can self-direct certain services beyond what is currently available while also allowing family members to serve as paid caregivers in more situations. These self-directed service expansions include respite, medication administration, personal support, and transportation. 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. Additional protections could include prohibiting marketing and advertising aimed at individuals eligible for self-directed services, limiting the extent to which an individual can serve as both a beneficiary's "designed representative" in matters related to their care alongside their role as a caregiver, and to limit the scope of individuals/entities able to serve as fiscal intermediaries on behalf of beneficiary for the purposes of billing and payment.

Flexibilities to Discontinue

Waivers of limits on maximum number of individuals served in settings

As discussed previously, COVID-19 has placed a strain on the existing LTSS workforce, including an increased strain on workers who are able to provide services but must do so with a reduced amount of support from staff that would normally be available. We recognize that some states have waived limits on the maximum number of individuals served in certain settings to accommodate those staffing pressures. However, moving beyond COVID-19, we strongly believe those waivers should not continue. We are concerned that extending these waivers would create patient safety and quality issues in the long-term.

Limits on in-home visitors

Other states have also placed limits on the number of visitors and/or workers that may interact in-person with beneficiaries due to concerns with spreading COVID-19. We understand the rationale for these limits in the context of a pandemic but do not believe they should be maintained under normal circumstances. These visitation limits could lead to increased costs by requiring the authorization of overtime pay for certain staff and may also create delays in care and necessary care management services. Within the context of increased overtime, we also encourage Medicaid programs to remove penalties for authorizing additional overtime as we believe there are better approaches to managing costs rather than blunt penalties.

We recommend that HCBS staff are instead allowed to transition back to providing visits in a manner similar to visitation guidance already released by CMS for long-term care facilities. Within this guidance, CMS has continued to emphasize the importance of outdoor visitation but has provided a path to enable indoor visitation, assuming providers meet certain criteria.

Suspended or delayed incident reporting

Some states have also suspended or delayed the timelines for certain providers to report incidents related to the health, safety, and status of beneficiaries. This generally fits within the context of minimizing administrative burden for providers during the pandemic so they may instead focus their attention on providing care. Past the pandemic, these suspensions and delays should be removed as they pose a long-term risk to the well-being and safety of beneficiaries.