National
MLTSS
Health Plan Association

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Dear Acting Deputy Administrator Costello and Director DeBoy:

On behalf of the National MLTSS Health Plan Association, we write to you to provide feedback and recommendations on the implementation of Section 9817 of the American Rescue Plan Act (ARPA) of 2021. As you are aware, Section 9817 increases federal reimbursement of Medicaid home and community-based services (HCBS) by ten percentage points from April 1, 2021 through March 31, 2022, provided states "supplement, not supplant" existing state funds expended for HCBS.

The National MLTSS Health Plan Association represents health plans that contract with states to provide long-term services and supports (LTSS) to beneficiaries through the Medicaid program. Our members currently cover the majority of all enrollees in MLTSS plans and assist states with delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a focus on ensuring beneficiaries' quality of life and ability to live as independently as possible in the community. Member organizations include Aetna Inc., AmeriHealth Caritas, Anthem, Centene Corp., Commonwealth Care Alliance, Inclusa Inc., L.A. Care Health Plan, Lakeland Care, Molina Healthcare, UPMC Health Plan and VNSNY CHOICE.

We want to thank CMS for the efforts it has taken to date to help address the impact of COVID-19 on the LTSS system, and HCBS specifically. We are particularly appreciative of the Center's implementation of Appendix K waiver flexibilities, Section 1135 waiver flexibilities, further guidance on directed payments, and other resources. With the passage of the ARPA and Section 9817, Congress has provided a critical source of supplemental funding for states to ensure their HCBS systems can maintain their viability during the pandemic. In the absence of such funding, a broad swath of HCBS providers would be at risk of no longer being able to maintain business operations, which would exacerbate an already severe HCBS provider shortage.

Based on CMS's recent listening session with the stakeholder community, we recommend the following principles as CMS considers the implementation of the new funding stream:

- Disbursement of funds to states should begin as soon as possible and be based on a simple and streamlined process so that states can in turn quickly distribute the funds to the HCBS system;
- Use of funds should be solely focused on directly enhancing, expanding, and strengthening HCBS;
- States should address the disproportionate impact of COVID-19 on HCBS beneficiaries dually-eligible for Medicare and Medicaid; and

- CMS should encourage states with MLTSS programs to leverage their MLTSS plan partners in the distribution of these funds given MLTSS plans' unique data streams and connections with the HCBS provider community and beneficiaries.

Below we offer additional detail on these key areas of implementation.

Process for States to Receive Funds and Demonstrate Compliance

First and foremost, we recommend that CMS develop a simple and streamlined process to ensure that the funds are disbursed to states as soon as possible. This will allow states to begin disbursing the funds to address the urgent and emergent needs of individuals receiving HCBS, their caregivers, and providers. States must also have a consistent and predictable cash flow from these funds so that they can in turn create consistent expectations for recipients of the funds. We encourage CMS to provide a set schedule and expectations around when and how states will receive this additional funding (e.g., on a monthly or quarterly basis).

We would also emphasize the critical importance of establishing reporting requirements to ensure that the use of these funds is solely focused on directly "enhancing, expanding, or strengthening HCBS" and to "supplement, not supplant" existing levels of funding. CMS should develop fiscal accountability mechanisms to ensure that the funds are directly used for the purposes for which they are intended. Additionally, we believe there is an opportunity to measure the impact of these funds on advancing the broader goals of the HCBS system (e.g., rebalancing, bolstering the direct care workforce, etc.). Therefore, CMS should encourage states to consider approaches for evaluating their investments to provide evidence for continued investments in the future.

With respect to the implementation of the "supplement, not supplant" requirement, we would caution against an approach that would result in a similar set of unintended consequences arising from the maintenance of effort (MOE) standards under the Families First Coronavirus Recovery Act of 2020. The initial implementation of the MOE standards did not allow for states to move members between eligibility categories and "froze" enrollment. Following from this enrollment "freeze", states paused previously scheduled eligibility re-assessments. This pause on re-assessments has created a significant backlog for states and MLTSS plans. To avoid creating the same backlog for the HCBS system, guidance around the "supplement, not supplant" requirement should allow for changes in beneficiary eligibility based on assessed level of need and changes in overall eligibility.

Leveraging the Value of MLTSS Plans

We strongly recommend that CMS encourage states to utilize their MLTSS plan partners to aid in the distribution of these funds. The process and responsibility of developing criteria to inform the distribution of funds and the distributions themselves should rest with states. However, in states with MLTSS programs, MLTSS plans are an integral part of their LTSS systems with unique data streams and connections to the provider community and to their members and therefore should play a key role in these efforts. MLTSS plans can play a role in helping monitor and guide the distribution of funds to ensure they are being used to "enhance, expand, or strengthen HCBS." For example, MLTSS plans are well-positioned to help:

- Assess current and ongoing provider needs for additional funding and resources;
- Monitor the implementation and use of the funds on a provider level;
- Aid states in distributing the funds by providing plan-specific data that would inform or help populate a states' pre-developed criteria, such as targeting providers who serve higher-risk

populations, have experienced significant financial losses, have been forced to temporarily close their facilities, etc.; and
- Coordinate between providers regarding the use of these funds so that their use is complementary to the overall goal of supporting beneficiaries during the pandemic.

Additionally, CMS should allow states to designate MLTSS plans as eligible recipients of the funds for the purposes of "enhancing, expanding, or strengthening HCBS." We offer specific examples of allowable uses of the funds below.

Addressing the Disproportionate Impact of COVID-19 on Individuals Dually Eligible for Medicare and Medicaid

According to CMS data, individuals dually eligible for Medicare and Medicaid are at higher risk for severe COVID-19 infection and are hospitalized with COVID-19 at a rate three times higher than Medicare-only beneficiaries.[1] We recommend that CMS encourage states to invest funds into developing interventions that speak to the unique needs of this population receiving HCBS. This could include further integrating and coordinating between the Medicare and Medicaid systems, coordination between primary, post-acute, and HCBS providers, and enhancing data notification systems to alert relevant entities to a change in condition or placement in an institutional setting.

In general, we believe that any efforts to strengthen the LTSS system should work in complement and parallel with efforts to advance integration between Medicare and Medicaid for dually eligible beneficiaries. Approximately three-quarters of Medicaid LTSS users are dually eligible for Medicare and Medicaid.[2] As states identify ways to spend the additional funding, CMS should encourage states to consider the potential impacts of their investments on furthering integration and future opportunities to advance the aligned goals of rebalancing and integration in tandem.

Allowable Uses of Additional Federal Funds

We strongly recommend CMS establish clear guardrails to ensure that this additional funding is used to directly support individuals receiving HCBS, their caregivers, and providers in line with the Congressional intent of the legislation. CMS should encourage states to consult with beneficiaries, plans, providers, and other members of the HCBS stakeholder community in directing these funds so that they can assist with addressing the specific needs of the local communities. As part of these efforts to address local needs, CMS should encourage states to recognize the disproportionate impact of the pandemic along racial lines and potentially include investments to address disparate outcomes. In addition to allowing funds to be passed through MLTSS plans, below we recommend several key examples of interventions that "enhance, expand, or strengthen HCBS" and should be considered allowable uses for these funds. Please note that these examples are non-exhaustive and should not represent the only possible uses of these funds.

- **Leveraging technology to increase access to care and independence** – Given that HCBS providers and the direct care workforce are already overstretched, using the funds to purchase both assistive technology and everyday technologies (e.g., internet access) can increase members' access to high-quality care and support their independence. Examples of these technologies could

[1] The Centers for Medicare & Medicaid Services. 2020. *Preliminary Medicare COVID-19 Data Snapshot*. Retrieved from https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf

[2] Mathematica Policy Research. 2019. *Medicaid 1115 Demonstration Evaluation Design Plan Update: MLTSS Final Outcomes Evaluation.* Retrieved from https://www.medicaid.gov/medicaid/downloads/final-eval-dsgn-mltss.pdf

include devices such as smartphones, computers, and internet access, or non-technological devices such as eyeglasses, wheelchair transfer boards, and adaptive cooking equipment.

- **Increasing access to COVID-19 vaccines** – Many individuals with LTSS needs are facing barriers to accessing COVID-19 vaccines. States should be allowed to dedicate this funding to support the more intensive logistics needed to vaccinate these individuals (and their immediate family members in situations when they collocate the same home), including homebound participants, such as scheduling vaccine appointments, transportation to vaccine sites, direct support services needed to attend vaccine appointments, development of and connection to in-home vaccination options, and education about the importance of receiving the vaccine.
- **Bolstering workforce protections for direct care workers –** Recognizing the disproportionate impact of the pandemic on these essential workers, we recommend states be allowed to use the funds for supports for direct care workers (DCWs) such as higher wages, hazard and overtime pay, sick leave, purchase of protective equipment, and other related expenditures. MLTSS plans can potentially play a role in passing funds to and monitoring providers.
- **Offering incentive payments for hiring and recruiting direct care workers** – States should be allowed to use these funds to recruit and train additional HCBS workers, as well as to connect workers to specific providers or specific beneficiaries, depending on the states' systems.
- **Providing supports for family caregivers** – Families continue to play a key role in providing support for participants with LTSS needs during the pandemic. We recommend that states be allowed to use the funds on caregiver supports, such as training and respite programs.
- **Transitioning members out of nursing facilities** – Given that many individuals are being moved from hospitals to nursing facilities (NFs) due to hospital overcapacity, we recommend that states be allowed to provide funding to support transitioning participants from NFs into the community, or diverting them from NFs initially (e.g., technology to support transitions, rental subsidies).
- **Offering incentives for repurposing facilities** – CMS should allow states to use the funds to offer incentives for repurposing adult day centers and nursing facilities. For instance, states can use the funding to support ideas that re-engineer adult day centers so that participants will want to return to programs. States could also provide incentives to NFs for repurposing their assets for HCBS (e.g., repurpose kitchen facilities and staff to provide home-delivered meals).
- **Enhancing infrastructure that supports HCBS delivery, such as information technology systems** – We recommend that states be allowed to use this funding for investments in infrastructure such as enhancing systems for data exchange for the dual-eligible population. CMS should encourage states to be mindful of ongoing costs associated with infrastructure investments.

Relatedly, we recommend for CMS to structure the allowable uses of the funding such that the funds are *not* spent on activities that only incidentally "enhance, expand, or strengthen" HCBS. In general, a "direct, not incidental" framework might be helpful in structuring the guidance. Other stakeholders have stressed the importance of being able to use the funds for administrative purposes and we generally support this use. However, we believe that administrative spending should be allowable only when incidental to specific interventions for members, caregivers, direct care workers and providers. For example, in implementing a new HCBS rebalancing program related to reducing COVID-19 risk for nursing facility patients, a state may need to hire staff or consultants to manage and implement the program. Given that the hiring of the staff or consultants (and its associated administrative cost) is incidental to the broader program, this would be an allowable use of the funding. However, a general staff hire without any tie to a specific initiative should not qualify.

Timeline for State Appropriation, Disbursement, and Use of Funds

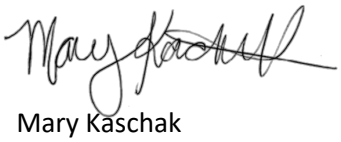
The statute establishes that the increased FMAP is available for services that are provided during the HCBS program improvement period, defined as April 1, 2021 through March 31, 2022. However, the statute makes no reference to when states must use these additional funds. We suggest that CMS clarify that states can use the funding beyond the end of the program improvement period, provided that the funding is spent on HCBS-related activities or services to address the immediate needs of the system due to the COVID-19 public health emergency. The timeline for funds to be expended should be designed to allow sufficient time for claims runout and reconciliation while balancing the intent of the funds to address the impact of the pandemic.

Conclusion

We appreciate the CMS's ongoing recognition of the critical role of the HCBS system during the COVID-19 pandemic and its provision of much-needed funding support through the ARPA 2021. This funding represents an immense opportunity to support HCBS recipients, caregivers, and providers during the pandemic and help ensure the long-term viability of the HCBS system. MLTSS Association members are well positioned and committed to work with CMS, states and providers to ensure the additional funding support for HCBS achieves maximum impact.

Thank you for your consideration of our comments. We and our members stand ready as a resource for CMS and welcome the opportunity to discuss any of our recommendations further if needed. If you have any questions, please contact Mary Kaschak at mkaschak@mltss.org.

Sincerely,



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