National
MLTSS
Health Plan Association

Submitted electronically via HCBSComments@aging.senate.gov

April 26, 2021

The Honorable Bob Casey
Chairman, US Senate Special Committee on Aging
United States Senate
G31 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Sherrod Brown
United States Senate
503 Hart Senate Office Building
Washington, DC 20510

The Honorable Maggie Hassan
United States Senate
324 Hart Senate Office Building
Washington, DC 20510

The Honorable Debbie Dingell
United States House of Representatives
116 Cannon House Office Building
Washington, DC 20515

RE: Discussion Draft of the Home and Community Based Access Act (HAA)

Dear Chairman Casey, Senator Brown, Senator Hassan, and Representative Dingell,

On behalf of the National MLTSS Health Plan Association, we write to commend you for your significant leadership to advance the interests of high-need, complex care communities across the country. The discussion draft of the Home and Community-Based Services Access Act (HAA) represents a historic step toward shoring up and prioritizing critical home and community-based services (HCBS) and the families, neighbors, and professionals that provide them within our broader long-term care system. Building on your efforts, we offer additional policy proposals that we believe further this goal for your consideration.

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. 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.

As you note, the current HCBS systems exist through a patchwork of various waivers that do not serve all people in need of LTSS. This is despite the efforts of the HCBS stakeholder community who has worked diligently over the past four decades to expand access to HCBS and rebalance services from institutional sites of care to the community. In 2014, the stakeholder community reached a notable milestone when more than half of all Medicaid LTSS expenditures went to HCBS compared to under ten percent in 1985. MLTSS plans have played a significant role in this trend to rebalance towards HCBS and

support beneficiaries, as evidenced by findings from various studies highlighting the role of MLTSS plans in rebalancing.[1]

Building on the progress and lessons learned over the last four decades, we believe the HAA has the potential to dramatically transform the current system to better serve beneficiaries, caregivers, providers, states, and managed care organizations. **We would like to offer the following high-level considerations to enhance and expand the impact of the HAA**:

I. We recommend that the HAA include direct incentives and additional resources to assist stakeholders with the process of transitioning beneficiaries and rebalancing towards HCBS. The HAA provides an incentive for states to rebalance towards HCBS by providing a one hundred percent federal medical assistance percentage (FMAP) for such services and not institutional LTSS, but more explicit mechanisms would help continue the trend toward HCBS;

II. With respect to the core set of standardized HCBS, we believe there should be additional services that fall within the benefit package, such as home-delivered meals (among others further detailed below). Additionally, a core set of HCBS services presents the opportunity for the LTSS industry to deploy a standardized functional assessment tool, which would significantly improve the administration of LTSS. A standardized assessment tool would also lead to better data collection efforts, especially for the purposes of establishing and reporting standard quality measures;

III. We encourage the HAA to include additional flexibility for the Secretary of Health and Human Services (HHS) to minimize any unintended interruptions in beneficiary access to or coordination of care as a result of state re-procurement of HCBS contracts when they transition to a standardized system;

IV. With respect to workforce development, we believe it is essential to enhance the capacity of the existing HCBS workforce through telehealth flexibilities and technology investments along with expanding and incentivizing a more robust workforce to meet increased demand. Congress should also consider establishing HCBS Innovation Grants to establish and test new models of workforce development and career advancement;

V. We encourage the HAA to include additional considerations for how the Medicaid system can better interface and integrate with opportunities to provide beneficiaries access to safe and affordable housing. A key challenge in expanding access to and rebalancing towards HCBS is the availability of affordable and accessible housing. These proposals could be included directly within the HAA or part of a broader package, such as President Biden's American Jobs Plan; and

VI. We encourage the HAA to include additional policies that advance the integration of the Medicaid and Medicare programs, given that 75% of LTSS users are beneficiaries dually eligible

[1]Center for Medicare and Medicaid Services (CMS). Saucier, Paul; Kasten, Jessica; Amos, Angie. Do Managed Care Programs Covering Long-Term Services and Supports Reduce Waiting Lists for Home and Community-Based Services? Available at < https://www.medicaid.gov/medicaid/downloads/1115-ib6-508-mltss-hcbs-waiting-lists.pdf>

for Medicare and Medicaid.[2] Improvements in the integration of Medicare and Medicaid lead to direct benefits for current and future HCBS beneficiaries.

Below we offer additional details and technical comments on the above considerations.

Incentives to Rebalance Towards HCBS

A core feature of the HAA is to provide the new standardized HCBS benefit with a 100% FMAP. This 100% FMAP for HCBS serves as an incentive for states to rebalance services towards HCBS given that institutional services would be at a lower FMAP than HCBS services. As mentioned earlier, the process of encouraging the LTSS system to rebalance towards HCBS has been a multi-decade effort and the 100% FMAP would be a significant step forward. However, there should be additional programs that facilitate this rebalancing and keep beneficiaries safe and healthy in their new setting.

For example, the Money Follows the Person (MFP) program provides funding and support for states to transition individuals living in institutional care settings into settings that are more integrated with their community. In addition, the program aims to encourage states to create policies to allow funding for LTSS to "follow the person" across their preferred care setting. Since the beginning of the program's operations in 2007 through December 31, 2019, MFP has helped transition over 100,000 individuals from institutional settings of care back into their homes and communities.[3] Given the 100% FMAP, the bill should consider an incentive structure that would help promote the important aims of the MFP programs. The program has put into place unique flexibilities for states to use the enhanced funding for purposes such as purchasing furniture for a beneficiary's new community dwelling and paying a rent deposit. The program also places a notable focus on the process by which states and MLTSS plans transition an individual from an institutional setting back into their home or community setting, requiring them to provide adequate follow-up services to ensure that the beneficiary does not return to their institutional setting due to a lack of support.

Additionally, for states that choose to use MLTSS programs to administer their HCBS programs, the HAA should require states to update their MIPAA agreements to assure effective coordination between plans and should encourage collaboration between the states and MLTSS plans to develop payment mechanisms that provide incentives for safe and stable transitions.

We have previously provided CMS further detail and comments on potential programs to enhance rebalancing efforts. These comments can be found here.

Standardized HCBS System

With respect to the core set of defined services, we believe the HAA should include an additional set of key services that would directly improve HCBS. Namely, we recommend the HAA include in its HCBS benefit package supports to address food insecurity such as home-delivered meals, nutritional counseling, and other supports. We also recommend including physical therapy, occupational therapy, speech, respiratory therapy, skilled maintenance and other therapies, dentistry, tele-dentistry, optometry, podiatry, medication administration and management, and specialized medical equipment or supplies (including durable medical equipment) not otherwise covered. Finally, we recommend including adaptive/assistive technology and aids, as well as employment skills development and employment assistance (including benefits counseling),

[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

[3] https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-2019-transitions-brief.pdf

Additionally, we support the ability for beneficiaries to self-direct their HCBS and recommend that the HAA provide funding to support the development of directories or registries that connect workers and beneficiaries and support individuals in finding, hiring, and retaining workers. At the same time, we strongly encourage the HAA to put into place beneficiary safeguards that would reduce instances of fraud, waste, and abuse. We specifically recommend that the HAA:

- Prohibit marketing and advertising aimed at individuals eligible for self-directed services,
- Create safeguards to assure family members do not abuse the system when they serve as both a beneficiary's caregiver and their "designated representative" in matters related to their care, and
- Limit the scope of individuals/entities able to serve as fiscal intermediaries on behalf of the beneficiary for the purposes of billing and payment.

Separately, the HAA allows states to use their own functional assessment tools for the purposes of determining eligibility and level of need. We would recommend that the HAA facilitate the construction of a common functional assessment tool. The LTSS system currently has several assessment tools that do not offer consistent measurements of functional limitations nor do they have a standard definition of certain activities of daily living (ADLs). A standardized HCBS benefit with a core set of services presents an opportunity for the system to collectively transition towards a common assessment that would greatly simplify administration and ensure equitable access across programs. Additionally, a common assessment instrument would allow stakeholders to collect a standard set of data elements that would then inform a comparable set of quality measures to evaluate the quality of HCBS within and across states. This could be done with flexibility allowing states offering a richer benefit to add data elements. The HAA represents a critical opportunity to address key gaps in national research and data collection regarding HCBS. The HAA should include requirements and funding for research and data collection, to take place at the state level, to better understand workforce issues and develop solutions. The legislation should ensure robust funding for a quality reporting infrastructure.

Within one year of enactment, the Secretary of Health and Human Services should issue regulations on a core set and supplemental set of HCBS quality measures, leveraging existing NCQA and LTSS HEDIS quality measures. The MLTSS Association, in partnership with other health plan associations, has already shared comments with CMS regarding a recommended measure set for Medicaid-funded HCBS.

No later than 3 years after enactment, CMS should issue regulations that require states to annually report on a mandatory base set of measures. Required measures should reflect, to the extent practicable, the full array of HCBS services and HCBS recipients. States retain the authority to add additional reported measures appropriate for their programs. The HCBS measure set should be reviewed on an ongoing basis to identify gaps in HCBS measurement and to prioritize measure development.

Necessary funds should be provided to the Secretary to provide technical assistance to states, health plans, and providers, including assistance with:

- Meaningful use of HCBS measures to improve quality and outcomes; and
- Initiatives to promote health equity, including the use of measures to address equity, including disaggregation by race, ethnicity, disability status, age, sex, sexual orientation, gender identity, primary language, and rural/urban environment.

Additionally, states should receive 100% FMAP for administrative activities related to adoption of HCBS quality measures, including consumer and other stakeholder engagement as well as data and quality reporting infrastructure.

Flexibility to Ensure Continued Levels of Access and Continuity of Care
The HAA currently requires a sunset of existing Section 1915 HCBS waivers within five years after the date of the legislation's enactment. The Secretary may waive this sunset provision upon a state's request and approval from the Secretary.

We encourage the HAA to include additional language within this section to allow the Secretary to create additional exceptions for the purposes of maintaining beneficiary continuity and coordination of care. For example, states whose HCBS waivers may include services that go beyond the core defined set may choose to no longer offer those additional services and would need additional time to transition and support beneficiaries that would lose access to such services. In another case, states who currently use MLTSS programs to deliver HCBS benefits may choose to reprocure their programs given the substantial benefit changes. States might need additional time and flexibilities to ensure that beneficiary access and coordination under existing MLTSS programs can seamlessly transition into new systems.

More broadly, as the HAA leads states to reassess the delivery systems most suited to their needs, whether fee-for-service or managed care, it will be important to ensure that people continue to have access to HCBS providers. Network adequacy requirements differ across delivery systems – with FFS requirements captured in 1902(a)(30)(A) and the Access Rule while managed care requirements are controlled by managed care regulations. The HAA should ensure that provider availability and choice remain under both delivery systems during any transition phases and beyond.

In addition, we note that while the majority of HCBS waivers exist within Section 1915 authority, there are some exceptions. For example, Section 1902(e)(3), commonly referred to as the "Katie Beckett" waiver program, allows states to provide HCBS services to certain children below the age of 18. The current legislative language does not account for these types of exceptions. Thus, it may be necessary to add additional language that would apply the 5-year sunset to all applicable HCBS waiver programs outside of Section 1915.

Finally, we note that the elimination of HCBS waivers includes the potential limitation of several optional categories of HCBS eligibility that are otherwise not currently envisioned in the HAA language. For example, many states use Section 1915 authority to create special Medicaid spend-down programs for working individuals with disabilities who would otherwise be ineligible for coverage due to their income. While the proposed 100% FMAP decreases the incentives for states to eliminate these optional programs, if that FMAP were ever to change during HAA drafting negotiations, states' incentives would equally be impacted. In the event that such a change were to occur, we would recommend including in the legislation a maintenance of effort (MOE) provision that require states to keep pre-HAA asset and income requirements.

Workforce Development
The HAA invests significant resources into expanding access to HCBS through additional funding, but also recognizes that the current and future workforce will subsequently need to adapt to this increased demand. The HAA should take two broad strategies: (1) reinforce the capacity of the current workforce and (2) develop and incentivize a broader pool of direct support professionals (DSPs).

For the first strategy, the HAA should provide infrastructure investments and allow for greater use of telehealth to increase the efficiency of the workforce. Congress should provide funding and authority to facilitate states, plans and providers to address technology deficits that impact job satisfaction and retention (e.g., paper reporting). Congress should ensure that the program created by the HAA has adequate funding and authority for states to explore appropriate technology strategies that alleviate pressure on the workforce (e.g., remote monitoring where appropriate). The HAA should include funds for training the individuals leveraging services, their families, direct care workers, and others on the use of the aforementioned technology.

Additionally, in light of what we have learned from the COVID-19 pandemic, we believe it would be sensible to allow states to reimburse for virtual communications and technologies to support service provision and address DSP workforce shortages under certain circumstances (but not substitute necessary in-person supports that lead to inclusion). The ability to use telehealth during the COVID-19 pandemic has allowed case managers and certain HCBS activities to be performed remotely and without the need to travel between destinations. Some examples include incidental/episodic events that occur and require urgent guidance/support (employment, housing, welfare & safety, transportation). We also believe the sponsors of the HAA should consider a provision that incentivizes state Medicaid agencies to conduct ongoing implementation and evaluation of the use of technologies as a universally-designed option for support while simultaneously providing relief to the increased demand for support and support workers. Such an incentive could be written into the HCBS Innovation Grants section.

It is important to note that any telehealth investments should 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.

For the second strategy, payment structures, wages, and other benefits should incentivize a diverse and more robust, high-quality HCBS workforce to meet increased demand. Workforce development should include considerations around wages and benefits, education, training, and career ladders; should take into account disparities within the workforce; should include development of workforce-related policies; and should include worker-led organizations, including unions, as key stakeholders.

- The HAA should consider initiating a transition from the current hourly payment structure for personal attendant wages, which has the effect of depressing total compensation and incentives for advancement, to a payment structure rewarding quality of care. This transition could begin by testing and phasing in new approaches to payment, starting by providing bonuses and higher wages for training and certification, and progressing to quality measurement with incentive payments for achievement of quality standards and outcome targets.
- To facilitate the movement of the HCBS workforce *toward* a value-based system, the definitions of personal attendant should be reclassified under the Department of Labor to be non-medical in nature and to compensate based on quality achievement versus degree attainment. This reclassification would support the recognition of the HCBS workforce as members of the care team and incorporation into value-based models.
- Congress should direct the Bureau of Labor Statistics to create a federal designation specific to DSPs to recognize the profession and to gather data that can inform policymaking.

- A wage floor, benefits, and paid sick leave would ensure a robust workforce to meet future demands.
- Finally, the HAA could contemplate additional workforce incentives such as preferential treatment on home loans, student loans, student loan forgiveness programs, and other government programs.

Additionally, we recommend that the HCBS Innovation Grants include an emphasis on new models for DSP workforce development that involves all stakeholders (state-payer/plan-provider-DSP-participants) to provide training and certification of DSPs and enhance the capacity, competency, workplace culture, career advancement, socioeconomic advancement, and social determinants of health (SDoH) of DSPs in Medicaid-funded HCBS programs. In addition to building partnerships with academic institutions to develop programs, we recommend the establishment of a National Technical Assistance Center focused on Building Capacity of DSPs in Competency Areas. The TA Center would involve all stakeholders to support the evolution of demonstrations of new models for DSP workforce development to achieve the same aforementioned goals. The technical assistance would be based on the National Core Competencies developed by the National Alliance for Direct Support Professionals and endorsed by CMS.

Access to Safe and Affordable Housing

One of the core premises of rebalancing towards HCBS is that there is safe, accessible, and affordable housing for individuals. However, a lack of access to housing remains one of the biggest barriers to rebalancing. Therefore, this new HCBS benefit needs to be paired with expanded flexibility for states to support safe and affordable housing for LTSS beneficiaries.

The need for housing—other than nursing home care—has been made especially apparent during the COVID-19 pandemic. Some states, such as California, Massachusetts, and Minnesota 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. It provides a way for people who do not 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 isolation and recovery sites for individuals who tested positive for COVID-19 and needed a safe place to isolate. In partnership with a human service provider, CCA helped guests find new housing to move into upon discharge, access community-based and residential behavioral health services, and enroll in Medicaid.
- 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.

These programs are examples of facilitating access to temporary or long-term housing during the pandemic, but Congress should support these strategies beyond the pandemic. 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.

The nature of this flexibility and expansion of housing opportunities should play a role in this package along with President Biden's broader infrastructure package. For example, the HAA could allow states and plans to apply room and board funding to rent for homes whose construction has been facilitated through a broader infrastructure investment from the federal government (and more broadly).

Similarly, we recommend that the infrastructure package also invest in other social service programs that HCBS beneficiaries rely on, such as SNAP, TANF, WIC, and SSI / SSDI to ensure long-term rebalancing. As stated previously, access to safe and supportive housing is one of the core premises to rebalancing, but other premises include access to affordable food and other social determinants.

Advancing Integrated Care

As previously mentioned, 75% of Medicaid LTSS recipients are dually-eligible beneficiaries whose primary form of medical coverage is through the Medicare program and who receive LTSS coverage through Medicaid. The HAA's expansion of HCBS to a broader group of individuals reinforces the need to create greater opportunities to coordinate medical and non-medical services between Medicare and Medicaid. One entity with responsibility for both programs has greater opportunities and incentives to provide high-quality care in the community. An investment in advancing integrated care would help build upon an expansion of HCBS and recognize the whole-person needs of individuals with functional limitations.

Integrated care programs such as dual-eligible special needs plans (D-SNPs), Medicare-Medicaid Plans (MMPs), and the Programs of All-Inclusive Care for the Elderly (PACE) are prime examples of the benefits of integrated care for beneficiaries with LTSS needs. For example, Massachusetts' Senior Care Options (SCO) program has provided integrated care since 2004. A study comparing SCO participants and similarly complex individuals in fee-for-service Medicaid who were eligible for SCO found that the integrated program kept members in the community longer and decreased the utilization of skilled nursing facilities (SNFs).[4] Additionally, several evaluations performed by RTI on the impact of MMPs found that these plans had a positive impact on health care utilization, expenditures, and plan member satisfaction in Minnesota, Ohio, and Illinois.

Specifically, we recommend that the HAA:

I. Include additional criteria in its implementation plan grant program to require states to consider how they would integrate their expanded HCBS systems with new or existing integrated care programs;
II. Include additional investments and incentives, such as a separate grant program, for states to create or build upon their existing integrated care programs;

[4] JEN Associates (2013) "Massachusetts Senior Care Option 2005-2010 Impact on Enrollees: Nursing Home Entry Utilization." Available at: https://www.mass.gov/doc/masshealth-sco-program-evaluation-nursing-facility-entry-rate-2004-through-2010-enrollment-0/download

III. Include policies to encourage enrollment in integrated care programs, such as the expansion of the current default enrollment authority under CMS and passive enrollment currently available to MMPs;
IV. Develop beneficiary tools to help beneficiaries navigate their coverage options in the integrated care market;
V. Provide states with funds to improve their data infrastructure systems that can seamlessly accept and send data between CMS, managed care organizations, medical and non-medical providers, and beneficiaries; and
VI. Provide states with funding to counsel beneficiaries on their options for integrated products through SHIP counselors and MA brokers.

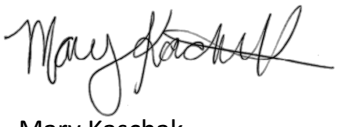
Other

The HAA currently includes references to the HCBS Settings Rule, which has the intent to "ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting." Since the finalization of the rule, CMS has provided states with several extensions to evaluate provider compliance with the requirements set forth in the rule. We understand the importance of the Settings Rule but recommend that the HAA require CMS to revisit the implementation of the regulation to address issues with several different interpretations of the requirements. Ultimately, this is to ensure that a standardized HCBS benefit is implemented through a standardized assessment of what is deemed to be compliant with the Settings Rule.

Conclusion

On behalf of the beneficiaries in need of home and community-based services which MLTSS health plans serve, we thank you for your leadership in protecting the most vulnerable among us. The National MLTSS Health Plan Association welcomes the opportunity to discuss the HAA further or how we can be of help in your continued efforts. If you have any questions, please feel free to contact me at mkaschak@mltss.org.

Sincerely,



Mary Kaschak
Executive Director