National
MLTSS
Health Plan Association

REQUEST FOR INFORMATION REGARDING: MANAGED LONG TERM SERVICES AND SUPPORTS

National MLTSS Health Plan Association

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Health Plan Association

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Re: Request for Information Regarding: Managed Long Term Services and Supports

Dear Mr. Brandon-Friedman,

Thank you for the opportunity to provide comment on the Request for Information (RFI) Regarding: Managed Long Term Services and Supports. MLTSS plans serve a diverse population of individuals with complex care needs – roughly half of their members are age 65 and older and half are individuals under age 65 with a wide range of disabilities including intellectual and developmental disabilities (I/DD), physical disabilities, cognitive impairment, severe mental illness, and behavioral health issues. Plans anticipate, identify, and meet the complex care needs of their members in a way that maintains or improves the individuals' quality of life in accordance with their goals and preferences and manages overall, efficient delivery of care.

To improve outcomes, provide high-value care for members, and achieve states' goals MLTSS plans:

- **Improve coordination for dually eligible beneficiaries.** About 75 percent of MLTSS plan members have their medical care covered by Medicare. MLTSS plans coordinate with Medicare or Medicare Advantage plans to ensure the complex care needs of these members are met.
- **Ensure members are served in the least restrictive and most community-integrated setting possible.** MLTSS health plans work with states, members, and their families to provide services and supports to enable them to transition to and remain in these more-integrated and less-restrictive settings, achieving savings for states in the process.
- **Invest in expanding and improving the LTSS workforce.** Health plans often encounter shortages of qualified direct care workers and partner with unions or other organizations in programs offering training, expanded responsibility, career ladders, and higher compensation.
- **Measure quality and are accountable to states for performance and outcomes.** The extensive information systems that health plans maintain provide information to states on measures of plan performance and quality of services.

Again, we appreciate the opportunity to inform Indiana's MLTSS program as states move to enhance Medicaid with MLTSS. Please reach out to the National MLTSS Health Plan Association if you have any questions on the information provided below.

Thank you,

Mary Kaschak
Executive Director

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Table of Contents

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National MLTSS Health Plan Association Response to Indiana RFI

1. Care Management/ Case Management/ Service Coordination

a. What care coordination requirements should be specified by the state, and what elements of care coordination approach should be left to individual MCEs? For example, should there be a consistent assessment tool used across all entities, and the same criteria for determining how many and what type of services to authorize in an individual's service plan? What are the pros and cons of more or less state direction?

Establishing and executing a well-designed model of care is the key to improving outcomes and managing expenditures for LTSS. Effective MLTSS plans distinguish themselves by the design and performance of their model of care. The National MLTSS Health Plan Association ("the Association") recommends that states incorporate the following elements into their MLTSS programs as important components of effective care coordination:

- Adopt a uniform assessment tool and requirements for administration of in-home comprehensive assessments,
- Adopt a protocol for person-centered care planning (discussed further in question 1i),
- Specify requirements for an inter-disciplinary care team that engages the beneficiary and primary caregiver (discussed further in question 1j, and
- Provide for real-time two-way connectivity of the care team and in-home caregivers (discussed further in question 5b).

Particularly for the first component, the Association recommends a common, core set of items to assess functional capabilities and limitations that would be included in all assessment instruments used by state funded LTSS providers and MCEs. A common assessment instrument would allow stakeholders to collect a standard set of data elements that would inform comparable quality measures to evaluate the quality of LTSS.

b. How can a state managed care contract facilitate the successful transition of individuals out of nursing or institutional care settings (including hospitals) to home and community-based settings? What are the best practices for diversion and/or supporting more robust/varied pathways for reintegrating individuals back into the home and community?

The COVID-19 pandemic has underscored the challenges of ensuring the safety and quality of LTSS provided in congregate settings and the importance of supporting people with disabilities of all ages in the most-integrated setting of their choice. MCEs operating MLTSS plans have made significant investments in developing person-centered planning for services and supports in the home and community settings to enable people with disabilities of all ages to remain in their homes or transition to a home or community setting from an institution when appropriate. This effort requires a state

commitment to provide adequate funding for HCBS, and to ensure that home and community settings can be as safe and supportive as congregate settings.

To achieve this end, we recommend the Indiana FSSA **work with stakeholders to develop a 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 flexibilities in home health. A person's home, with necessary services and supports, must the preferred setting for LTSS for individuals who can and would prefer to remain in their homes.

In addition, we recommend that Indiana FSSA assess and identify nursing facility residents who could be and would prefer to be supported in their own homes and undertake an effort to ensure adequate safe housing and support state funding for additional subsidized housing for individuals who could be transitioned from institutional settings. Discharging individuals with the lowest medical needs and/or ADL and instrumental activities of daily living (IADL) needs to HCBS with the supports and services they need and separating individuals who may be COVID-19 positive (at least in the near future) from other residents could help reduce pressure on nursing facilities and unnecessary institutionalization.

Some states, such as Massachusetts 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. During COVID-19, the Commonwealth Care Alliance 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.

i. With regard to person-centered support plans (i.e., plan for selecting and organizing the services and supports that an older adult or person with a disability may need to live in the community), what requirements are most effective in ensuring support plans are developed by a person trained in person-centered planning using a person-centered process and plan?

A person-centered approach to meeting an individual's LTSS needs, and the creation and implementation of a person-centered care plan are important ways to support the independence of the individual who needs services and to support their ability to control what is important in their lives. Most managed care entities (MCEs) provide extensive training for care managers in person-centeredness and person-centered planning and place great importance on developing solid skills in this area. There are several training systems and outside trainers available that plans either adopt or modify

for their own use. For example, one of the more widely used training systems was developed by Dr. Michael Smull at The Learning Community for Person Centered Practices.[1]

The Association recommends states prioritize the outcomes that are most important to achieve in the transition to an MLTSS program. For dual-eligible beneficiaries and adults with disabilities, a successful model of care is one that strives for a more holistic system that minimizes the complexity and burden for the beneficiary. Some of the operational details states should consider include:

- A single enrollment into an integrated program that covers and connects beneficiaries to service providers across the spectrum of medical care, behavioral health, and LTSS.
- A single point of contact – a connection to a care manager or other individual with responsibility and accountability for beneficiaries' care and with the authority to coordinate and direct their care. Additionally, case manager visits allow them to remain engaged with enrollees and maintain close contact with individuals who could be at risk for isolation, abuse, neglect, exploitation.
- A person-centered care plan that incorporates beneficiary goals and preferences.

j. What are best practices for sharing information to communicate about a member across a care team? What are best practices for engaging physicians and advanced practice providers in care planning and care coordination, and especially members' primary care physicians?

Communicating in real time across the care team can be challenging – models like PACE that convene interdisciplinary care team meetings are impractical for plans that serve large numbers of members. Software that links care team members can be effective for real-time messaging but are limited when it comes to more involved collaborative decision making and planning. Engaging primary care physicians in care planning and coordination also is challenging due to the demands on physicians' time and attention. To address these challenges, primary care practices with high-needs patients should employ a care coordinator who can take responsibility for addressing non-medical needs of its members and participate in care teams and interact with the care managers. Linking these with software that integrates with systems that support primary care practices and provide real-time connectivity with the rest of the care team can be effective in supporting the work of the team. States and MCEs can select the most effective technology for this purpose so that primary care physicians do not have competing systems they are expected to adopt. The adoption of these tools by physicians, advanced practice providers, and community-based organizations participating in care teams can also be subsidized via a state-MCE collaborative partnership.

2. Successful Duals and Duals Special Needs Plans (D-SNP) Coordination and Integration

Across the US, Medicaid pays for more than half of LTSS, and the nearly 12 million individuals dually eligible for Medicare and Medicaid make up about 75 percent of Medicaid LTSS users. However, only

[1] https://tlcpcp.com/

about 10 percent of dually eligible individuals are enrolled in programs that integrate Medicare and Medicaid. Without an integrated approach, beneficiaries must navigate two separate programs and enrollment processes. Blended financing that comes with integrated care creates the flexibility to provide person-centered targeted services to meet individuals' unique needs. Below is an outline of strategies to support Medicaid MLTSS plan members who may also have an MA plan or D-SNP from an unaligned organization or have Medicare FFS. The Medicaid and CHIP Payment and Access Commission (MACPAC) has also encouraged many of these strategies in an integration chapter of its June 2021 report to Congress.[2]

Adopt default enrollment

Default enrollment refers to the process by which Medicaid beneficiaries who become eligible for Medicare are enrolled in a D-SNP that is aligned with their current Medicaid managed care plan as they enroll in Medicare. Care provided for beneficiaries under the same parent organization results in an uninterrupted and coordinated transition from Medicaid-only coverage to a duals plan with supplemental benefits that are not available in Medicare FFS. Beneficiaries would continue to have freedom of choice in that they would be notified 60 days prior to the default enrollment effective date and have the opportunity to opt out and choose to enroll in Medicare FFS or another MA plan. To implement this strategy Indiana should also consider the importance of robust information technology systems to identify MLTSS plan members who will soon become eligible for Medicare.

Alignment of Medicare and Medicaid Plan Membership

Several states (e.g., Arizona, Tennessee, and Virginia) have adopted strategies to align Medicaid enrollment with D-SNP enrollment by contracting with MCEs that offer both D-SNPs and MLTSS plans. This strategy assures that states contract with organizations that offer a higher level of integration. Additionally, some states specifically require MCEs bidding for an MLTSS contract to also offer a D-SNP while other states utilize highly integrated products (i.e., FIDE-SNPs) to ensure that care is fully integrated under a single managed care organization.

Require D-SNPs to share data with MLTSS plans

States can require that D-SNPs submit data or reports to states for oversight and MLTSS plans for increased coordination. Currently, MLTSS plans with dual members who are not enrolled in an aligned MA plan do not receive medical utilization data on those members. While MLTSS plans and providers gain valuable insights into duals' health care needs and quality of life through LTSS interventions, fundamental system constraints limit their access to primary care provider and other medical utilization data. Improving MLTSS plans' access to Medicare data will allow them to better respond to and coordinate their medical and non-medical needs.

Develop tools for beneficiaries and other stakeholders to help beneficiaries navigate the integrated care market

[2] https://www.macpac.gov/publication/improving-integration-for-dually-eligible-beneficiaries-strategies-for-state-contracts-with-dual-eligible-special-needs-plans/

Multiple stakeholders have identified that a consistent issue with standing up integrated care products and further maintaining enrollment is a lack of beneficiary and provider understanding. This was a notable issue in the initial phases of certain Medicare-Medicaid Plans (MMPs). In Indiana, beneficiaries are faced with the possibility of selecting from a PACE program, D-SNP, traditional Medicare Advantage, or traditional Medicare fee-for-service, and need enough information to understand and weigh their options. State development of educational materials and review of plan materials could ensure consistency in Medicaid and Medicare benefit descriptions across the state, reducing confusion among both beneficiaries and providers. Additionally, it is valuable for states to take an active role in engaging with a range of advocacy and stakeholder groups (e.g., primary care physicians, specialists serving the target population, area agencies on aging, and other community-based organizations) well in advance of the first enrollment period to gain buy-in to MLTSS offerings from beneficiaries and providers, ease concerns about disruptions in services, and explain the added value of choosing integrated care options. Staying connected to a variety of stakeholders has shown to be beneficial in other states to increasing enrollment and retention in integrated plans.

3. Member Protections

c. Has your organization noted successes with establishing and maintaining member advisory committees for long-term services and supports? How is advisory committee feedback used to shape MCEs' policies and procedures?

As discussed above, a high level of stakeholder engagement in the transition to a new MLTSS program is an effective mechanism for building trust with the community, beneficiaries, and their families. Association health plan members have noted several successes with establishing member and multi-stakeholder advisory committees to collect robust feedback that is used to shape MLTSS programs. For example, our member health plans have developed programs that brings beneficiaries together via focus groups, surveys, workshops, online communities, and advisory group meetings to share their experiences about the care they receive. The input is subsequently used to drive initiatives that are most effective to meeting beneficiary needs, improving those aspects of member experience that are difficult and preserving those that add the most value. Some states also established statewide stakeholder councils that participated in the planning and implementation of an MLTSS program. Massachusetts convened an Implementation Council with more than 50 percent of its membership comprised of consumers and consumer advocates. Washington created a Health Home Advisory Team (HAT) for its Health Home project that included a mix of providers, consumers, consumer advocates, state and local agencies, and the domestic workers union.

In designing an MLTSS program with consumer feedback, the Association recommends that states:

- Include a sizable group of consumers in addition to consumer advocates who represent the diversity of the beneficiaries in the program;
- Provide training for stakeholder group members so they have sufficient information on the programs and operational matters to participate actively in the process;
- Provide the necessary supports (e.g., transportation, personal care assistants) for consumers to participate effectively;

- Provide training and other materials in languages and formats that communicate effectively to the diversity of the consumer population; and
- Include consumer, caregiver, consumer advocate, and provider feedback in the program evaluation.

4. Member, Caregiver, and Family Participation and Education

a. What are best practices an MCE can deploy for engaging communities and building partnerships with community-based organizations which result in an improved likelihood of individuals aging in their community of choice with access to resources and supports?

The Association recommends that states work with MCEs to develop key partnerships supporting community-based organizations to enhance their technology and data systems for better coordination and delivery of care and services. These partnerships can provide a variety of supports to individuals living in the community, including housing to facilitate transitions back to the community or diversion from institutional placement, food security-focused organizations, and organizations that can help with utility payments or home modifications.

Additionally, the final HCBS regulations[3] published by CMS set forth new requirements for states to ensure residential settings, assisted living facilities, adult day care centers, facility-based day and other habilitation settings are providing quality HCBS services to beneficiaries. With these regulations in place, states, like California, have provided grants to facilities to come into compliance. Alternatively, states may also provide transition assistance for Medicaid beneficiaries whose facilities cannot become compliant to ensure they can transfer to the most integrated setting of their choosing that is appropriate for their needs. This support for providers and plans alike ensures that beneficiaries are able to make the change while also understanding and participating in the process throughout development and implementation.

b. What are best practices to provide support and training to caregivers, including informal caregivers. How are those supports and the caregivers assessed to determine effectiveness? What are the most frequent interventions put into place following assessment of a caregiver?

During the COVID-19 pandemic, informal caregivers (e.g., family caregivers) have become the primary caregiver in many cases, particularly due to the persistent and growing LTSS workforce shortage. While most plans reported caregiver assessments as an informal process arising during the formal assessment of beneficiaries, some plans have developed formal family caregiver assessment tools in response to state contract requirements. For example, one of our member plans voluntarily adopted two screening tools to better support and involve family caregivers. The first is the American Medical Association Caregiver Self-Assessment Questionnaire. The MCE trained staff to use the tool to assess caregiver

[3] https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html

issues, such as family stability and the presence of substance abuse problems, and to identify when respite or other services are needed. Additionally, the MCE provides a caregiver toolkit that includes a list of community resources, a medication log, and checklists to prepare for doctor visits. The second tool utilized by the MCE is the AD8 Dementia Screening Interview, which promotes early detection of the disease, provides information that may be shared with the person's doctor, and encourages caregiver involvement.

c. Describe programs that are effective at enhancing member, caregiver, and family education regarding available services, including those who are navigating both Medicare and Medicaid. What are best practices for engaging family members or designated representatives, when a member's accessibility via typical outreach modes is uncertain?

As we noted in Domain Area #2, one of the greatest challenges in providing care for duals with complex care needs is locating, enrolling, and engaging both the individuals and their caregivers. States participating in the Financial Alignment Initiative (FAI) demonstration program found that they had difficulty engaging members with disabilities and their caregivers who were assigned to the plan, collaborating with MCEs to explore a range of strategies for increasing enrollment, engagement, and retention of beneficiaries. For example, Washington adjusted its payment methodology to provide a performance payment for achieving engagement rate targets, and Care Coordination Organizations adjusted their staffing models to incorporate engagement specialists.

States have also worked to maintain the involvement of existing service providers and the care coordination network that was in place to engage with consumers and their caregivers prior to the transition to MLTSS. Massachusetts required by statute that plans use geriatric service coordinators (GSSCs) provided by AAAs while Ohio required that plans partner with AAAs in coordinating services, resulting in a 70 percent enrollment rates of eligible enrollees.

One successful model is Wisconsin's family care benefit design, which offers three services that support family caregiver and member training. First, its consultative clinical and therapeutic services for caregivers is designed to improve the ability of unpaid family caregivers and paid direct support staff to carry out therapeutic interventions. Second, the consumer education and training services is designed to help an individual with a disability develop self-advocacy skills, support self-determination, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services, including education and training for designated representatives and family caregivers. Covered expenses often include enrollment fees, books, and transportation related to participation in training courses, conferences, and similar events. Lastly, Wisconsin's training services for unpaid caregivers support education and training services for individuals who provide unpaid care, companionship, supervision, or other supports to members. Training includes instruction about treatment regimens and use of equipment and other services included in the member's care plan as well as guidance, as necessary, for the member to safely remain in an HCBS setting.

d. What are best practices for engaging caregivers in the service delivery model to help improve/drive member outcomes?

A variety of techniques have been used in other states for engaging caregivers to help drive member outcomes:

- Require MCEs to include direct care workers and beneficiary designated family caregivers in the beneficiary's care team.
- Provide real-time electronic connectivity between in-home workers and the rest of the care team to facilitate two-way communication of health-related and medical information and coordination with the care team.
- Define small geographic areas of responsibility for residents with complex care needs so that outreach, engagement, and service coordination is focused on existing community resources and teams of trained community health workers who maintain contact, assist in navigation, and engage with caregivers and members.

5. Network Development and Capacity Building

a. What specific actions can the state and/or MCEs take to grow workforce capacity for self-direction, including in the areas of recruitment, training, credentialing, and hosting matching services between members and individual providers? What are the advantages and disadvantages of moving toward more self-direction, including as a mechanism for supporting caregivers?

Health plans often embrace self-direction as a tool for effectively addressing network adequacy issues in several situations:

- Rural areas where a more targeted approach is necessary,
- Situations where provider organizations become insolvent and HCBS participants wish to hire existing staff within the organization directly, and
- Instances where individuals prefer to identify, recruit, train, and hire their own support staff rather than going through a provider agency

Within self-directed care models, we recommend that states implement high standards for training requirements for direct care workers; a successful model depends on an accessible pool of capable, qualified workers. Health plans would also benefit from greater flexibility and autonomy for monitoring and managing potential risks of waste/fraud within self-direction. To develop an effective model of self-directed care, states often work with MCEs to develop internal controls and intentional investments in up-front training options and resources for individuals self-directing their care. Our member plans have confirmed that this type of model is correlated with improved participant satisfaction and quality of life outcomes and results in only a small percentage of waste and fraud.

In Tennessee, health plans have a strong collaborative relationship with state leadership on data collection to measure progress in advancing provider transformation and direct care workforce development. Health plans are contractually required to work with other plans and the state to

implement their workforce development strategies. For example, in 2018, the plans were tasked with collectively developing a single provider survey for all their providers (since many are duplicative between plans) to support data collection efforts. In 2019, TennCare implemented a new contract requirement to have designated staff for workforce development.

b. What are some emerging developments or technologies that could be used to extend capacity, while maintaining safety and quality? What are the best circumstances in which to use such extensions or what limitations should be placed on their use?

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 pandemic. When technology can be leveraged to support individuals with disabilities in place of staff, resources can be reallocated to support other individuals with support needs that may need more intensive staff supports 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 in lieu of or in addition to staff, there are participants in Medicaid HCBS programs who have expressed preferences to using technology to grow their own independence and reduce their reliance on paid staff.

MLTSS plans are increasingly pursuing technologies and other strategies for providing two-way real-time connectivity between caregivers, members, and the full care team. This connectivity alerts the care team to changes in the beneficiary's condition that can lead to a health care episode but can also be a conduit for providing information and coaching to the in-home caregiver to enable a person with relatively low levels of training to perform additional types of personal and health care services. Some examples of technologies that has enabled participants to maximize their personal autonomy is using sensory technology to monitor when someone with cognitive limitations or memory loss (e.g., Alzheimer's or Dementia) 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.

Additionally, technologies that comply with the adoption of Electronic Visit Verification (EVV), as required by the 21st Century Cures Act[4], are becoming increasingly prevalent. EVV is intended to be used as a compliance tool to ensure that HCBS that are ordered for individuals who need them are actually delivered to them. Technologies used for EVV include telephonic timekeeping, web- or phone-based applications using GPS verification, key FOBs with one-time passwords, and biometric sensors. There are several data systems becoming available – many proprietary – that expand on EVV and provide broader connectivity between the home and care teams. For example, CareHeroes is a data platform that facilitates integration of direct support workers with clinical care teams; communication between individuals seeking HCBS, direct support workers, and care managers, and EVV. Another system designed specifically for caregiver collaboration is Vela, a text-based HIPAA-secure information exchange system built around the person and their caregiver. The system enables two-way communication

[4] http://mltss.org/wp-content/uploads/2019/02/MLTSS-Assn-EVV-White-Paper-1-25-19.pdf

between the individual and all members of the care team as well as sharing of calendars, tasks, audio/video, care counseling, and coordination of LTSS.

c. As part of an MLTSS system, what specific actions can MCEs take individually and in concert with state partners, to expand the capacity and improve the quality of the direct care workforce?

Systems must offer flexibility in how people receive the services they need to achieve their life goals as articulated through a person-centered process, with greater attention being paid toward outcomes over process. **As partners in implementing the vision of state Medicaid LTSS programs, the Association recommends that MLTSS plans be given greater autonomy to provide greater incentives to reward high performers**. Plans are often incentivized (and rewarded) for producing higher priority outcomes for a larger percentage of individuals as part of network adequacy assessment. Additionally, we recommend greater state-plan-provider-consumer partnerships, that allow for additional investments in the testing of new models and strategies for supporting people with disabilities through HCBS live fully inclusive lives, be prioritized as a pathway to stimulating further innovation. Below, we've listed a few recommendations to attract quality direct care workers to an MLTSS program.

Partnerships for Innovation

Several of our member MLTSS plans work with community-based and national organizations to provide important education and develop innovative tools to expand the capacity and improve the quality of the direct care workforce. **For example, L.A. Care Health Plan partners with Alzheimer's Greater Los Angeles to offer instruction that is hosted in the plan's family resource centers and other community sites.** Alzheimer's Greater Los Angeles also trains L.A. Care staff on the fundamentals of cognitive impairment, practical dementia care management, caring for the caregiver, and available community supports.

Another member plan has partnered with ADvancing States to develop, build, and launch ConnectToCareJobs.com, an online portal that connects job seekers with employers, allowing clinical and non-clinical care workers to identify job openings and providing employers with a way to fill critical staffing gaps quickly. The website promotes the opportunity for registered facilities, agencies, organizations, and providers to identify the specific staffing needs they have for a short-term or ongoing basis. At the same time, individuals who are licensed and/or trained for various roles in these facilities and identified settings can register their availability and willingness to fill shifts. An algorithm then matches the workers and the openings in real-time. States can manage which organizations and providers are included to enable those in crisis to get preference and to monitor the matching efforts.

Review and, if necessary, revise provider reimbursement rates

The focus on rebalancing has resulted in several states examining parity with other industries that compete for the direct care workforce to ensure the ecosystem can effectively attract workers. Many states have not increased rates in many years, making it difficult to compete with an increasing number of manufacturing jobs as well as other unskilled labor opportunities that pay more. Additionally, it is not enough just to attract workers with a higher initial wage, but to build in the additional costs associated

with training, supporting, and retaining workers over time. Assuring capitation payments reflect reimbursement that supports living wages, benefits for direct care workers at or above what the market is at for the labor pool, elevated wages for services requiring advanced competencies and specialization, peer-to-peer mentoring, and intentional overtime, is crucial to not only maintaining but building a stronger, more stable direct care workforce.

On the converse, rate setting must not become so stringent as to dilute the creativity of the managed care model, particularly with respect to building in greater incentives for high performers, accelerating payments based on desired outcomes, and introducing new value-based payment methodologies. For example, the use of mandated rate bands by states could lead to a more rigid payment system that would disincentivize creative and flexible payment based on performance.

Implement standardized metrics for plans to evaluate trends in the delivery of services

Typically, state Medicaid agencies hold health plans accountable for assuring an adequate workforce. Plans, in turn, hold service providers accountable for assuring that all requests for in-home services to members are fulfilled, even when there are gaps in available caregivers. In order to adequately track and measure progress in addressing gaps in available workforce, metrics should be standardized to support the ability of plans to evaluate trends in service delivery over time. Some metrics include tracking the proportion of services delivered as compared to the proportion of services authorized; tracking the effect, impact, and client satisfaction level of gap-fill mitigation strategies; and the timeframe around initiation of new services once they are requested.

6. Provider Relationships

a. Please describe best practices, including credentialing requirements, for onboarding smaller providers and provider types who may be less familiar with managed care processes and administrative requirements. What are strategies to enroll & credential providers in an efficient and clear manner?

Credentialing Providers

Many states define network adequacy by how many credentialed providers are in the network. This minimalizes the importance of building high-quality providers. Performing at optimal quality through the embedding of evidence-based practices, integrated service delivery models, and increased competency of direct care workers can be difficult for providers. Unfortunately, most states do not consider quality ratings of individual providers when evaluating network adequacy. **States must provide a balanced direction in terms of defining and prioritizing specific services over others that lead to improved outcomes, the competencies and qualifications of front-line workers that should be required across the board as well as more specialized workforce requirements for targeted populations, and the expectations of providers to modernize their approaches to HCBS over time.**

States should theoretically already be incorporating the HCBS Settings Rule criteria into their licensing and certification requirements. While this is a positive step in the right direction toward modernizing HCBS licensing and certification, it is important that Indiana further assess the capacity of providers to:

1) accept new clients, 2) support immediate transition needs of MLTSS participants shifting from nursing home or institutional care to HCBS, and 3) gap-filling to address anticipated staff shortages. Particularly as informal caregivers have become more prominent during the COVID-19 pandemic, Indiana should consider implementing higher standards as part of re-certification or licensing renewals for existing providers while ensuring new providers coming in to the system possess these high standards.

For both small and large providers, providing credentialing opportunities, career pathways, and ongoing competency-based training and mentoring are all important to create incentives for direct care worker participation. For example, Indiana FSSA could develop 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 demonstrated competency areas.

Onboarding and Retaining Providers

MLTSS plans recognize that LTSS providers have needed to adapt to an increased demand in the direct care workforce, particularly due to the pandemic. States 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. For the first strategy, Indiana FSSA should explore the implementation of technology to alleviate pressure on the workforce; for example, remote monitoring where appropriate or greater use of telehealth across the state without substitution when in-person supports are necessary. Training for providers should include training for individuals on the use of the aforementioned technology. The ability to use telehealth allows 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 and safety, transportation). We also believe that state Medicaid agencies should 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 workers. 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. The ability to 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, the MLTSS Association has encouraged both 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. Indiana FSSA should consider providing bonuses and higher wages for certain types of training and certification and progressing to quality measurement with incentive payments for achievement of quality standards and outcome targets.

One of our members works with the State of Wisconsin Residential Quality Program (WCCEAL) on data collection and collaboration around the Assisted Living Pay for Performance and other innovative ways to recognize providers who are meeting and exceeding quality standards. Inclusa also has partnerships with Disability Service Provider Network (DSPN) to encourage/allow 1-2 bed owner-occupied homes to be included in their association, which qualifies them for access to WCCEAL. Inclusa has a focus on incorporating provider quality, adequacy, and capacity measures as part of upgrades. This includes, but is not limited to, proactive provider approaches supported through the system; provider feedback opportunities to improve communication; provider recognition within the system; availability of provider reports that encompass quality; improvement of Statements of Deficiencies (SOD) and incident management processes; and best practice reviews as part of system upgrades. Inclusa also partners with providers, through system design, to reduce duplicative documentation requirements; most specifically as they related to document of reporting incidents/events to Inclusa in a manner that facilitates export to meet the provider's documentation requirements.

7. Quality Strategy

c. What are best practices for tracking MLTSS members' health and quality of life outcomes? What are examples of good, evidence-based outcomes measures?

Stakeholders wish to collect robust, beneficiary-reported data, but this can be burdensome to providers and plans alike if not carefully crafted and administered. Several states and plans use existing surveys, namely HCBS CAHPS and NCI/NCI-AD, which are proprietary surveys that add expense to both states and health plans. For this reason, it is essential that measures of LTSS quality undergo the same scientifically rigorous testing to ensure reliable results. All measures should be fully specified, and those specifications should be made publicly available. The MLTSS Association believes the following criteria are the most important to be considered and weighed in terms of developing a specific set of measures:

- **Feasibility.** MLTSS plans should be able to implement and report on measures within reasonable efforts to do so.
- **Use/Usability.** Plans must apply and use the measures to inform changes to service provision and internal priorities for spurring systems change.
- **Scientific Applicability.** Even if a measure has been widely adopted and is being applied consistently across the country if there is no assurance that the measure has been rigorously tested for validity and reliability, then the measure may not be effectively measuring is it supposed to be and thus misleading both plans and states.
- **Alignment with Value-Based Payment Principles.** The alignment of a measure to value-based purchasing principles should be considered an additional selection criterion to ensure that there is some measure of payment for quality.
- **Beneficiary Check.** This criterion is to ensure that the measures adopted by the state align with what HCBS beneficiaries themselves feel are important indicators of quality HCBS. It is important to explore measures that provide a person-centered holistic view of quality while also considering beneficiaries' experience of care and social determinants of health.

- **Promoting Innovation.** Measures should represent a meaningful balance between burden and innovation, minimizing data collection and reporting burden and appropriately risk-adjusted to account for factors beyond the control of health insurance providers.

Measures should provide meaningful information to all stakeholders while using the most efficient and parsimonious number of measures. The measures selected should be person-centered and conceptually important to LTSS beneficiaries, including addressing their experiences and promoting health equity. We discuss specific measures for inclusion below in question 7e.

e. What are best practices for developing evidence-based quality measures across different provider types? How should measures be determined for each different provider group? What are best practices for evaluating provider performance and what determines the frequency of evaluation? What data collection and reporting practices can the state and MCEs initiate to inform and evaluate quality strategy? What can the state and MCEs do to ensure that providers are supported in the data collection and reporting process and are able to demonstrate when they have achieved performance measure targets? What are best practices around reporting and communication of quality data to provide public transparency around MLTSS program performance?

Promoting quality while building a sufficient supply of LTSS providers can be accomplished if states are in partnership with plans and other stakeholders toward this common vision, and if plans are provided greater autonomy, flexibility, and incentives to achieving solid results toward assuring access to high quality LTSS options.

The Association recommends that states provide plans some latitude to expand the capacity of existing providers and develop new provider options over time that meet higher quality standards. Plans should have the ability to require higher quality metrics among providers as a condition of remaining in the network and be allowed to eliminate low-performing providers of services from their network without penalty, so long as the plan has established a solid transition plan for impacted participants. Unfortunately, without a national framework for HCBS quality measures, states are all over the place in how they measure quality of the HCBS being provided and use this information to strengthen their systems overall. The Association provided comments[5] to CMS in 2020 in response to its HCBS Measure Set RFI and encourages Indiana to explore these recommendations in addition to the examples below in developing a robust measure set.

There are several national initiatives underway to develop and apply uniform national quality measures for LTSS and HCBS, in particular, at the National Quality Forum (NQF), the National Committee on Quality Assurance, CMS, and the Administration for Community Living to develop a set of standardized MLTSS quality measures. While the MLTSS Association continues to work with and support these

[5] http://mltss.org/wp-content/uploads/2020/11/Plan-Associations-Comment-Letter-on-HCBS-Quality-Measures-RFI.pdf

organizations and agencies, we put forward a framework and an array of proposed metrics – drawing from NQF's HCBS framework and relying on our members' vast experience implementing quality metrics. The framework we proposed and modify over time is the Model LTSS Performance Measurement and Network Adequacy Standards framework for states. The framework prioritizes five major areas:

1. Quality of Life
2. Transition to Most Integrated Setting
3. Integration Risk Factors
4. Person-Centered Planning & Coordination
5. Satisfaction

As government measure development activities proceed, the Association will work with stakeholder organizations, advocates, and government agencies on opportunities to align the measures reported by Association members and incorporate new measures where appropriate. These measures were developed with the intent of encouraging more widespread adoption of person-centered quality measures for MLTSS and greater consistency among states in what is reported. We also continue to offer ourselves as a resource for states looking to develop a standardized, comprehensive approach to MLTSS performance and network adequacy.

8. Social Determinants of Health

b. Describe how an MCE can work to identify, promote, and connect members with resources, accessible housing resources and legal services, that allow members to live fully in the community of their choice.

One of the core premises of rebalancing LTSS 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. 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 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.