

June 30, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2442-P,
P.O. Box 8016, Baltimore, MD 21244-8016

Re: Medicaid Program; Ensuring Access to Medicaid Services; CMS-2442-P

Dear Administrator Brooks-LaSure,

On behalf of the Medicaid Health Plans of America (MHPA), we thank you for the opportunity to provide input on the Ensuring Access to Medicaid Services Proposed Rule (CMS-2442-P).

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 MCOs serving more than 52 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the Association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries.

Below you will find our general comments in response to this rule, as well as detailed comments in response to specific provisions.

General Comments:

MHPA shares the Administration's stated goals of improving access to high quality services in the Medicaid program. We urge CMCS to delay implementation of this rule to ensure states can resume normal operations following the historic undertaking that is the current Medicaid redetermination process.

As we speak, Medicaid programs across the United States are in the process of redetermining the eligibility of over 92 million Americans who receive health coverage under Medicaid and CHIP. States are currently facing significant bandwidth constraints as they work through a three-year backlog with staff that have in some cases never processed an eligibility verification. The Administration is also experiencing significant pressure as it works with states to oversee redeterminations efforts and facilitate state mitigation plans. Providers are concerned about the impact of a potential increase in the number of uninsured individuals. Given the significant administrative lift related to implementing two new major regulations pertaining to Medicaid, we are concerned that the rapid implementation of new requirements could impede efforts by states to mitigate coverage losses for Medicaid enrollees. And although some provisions are likely to take effect after the unwinding period has concluded, states will be required to begin implementation in parallel with redeterminations to achieve compliance with new requirements.

Now, more than ever, states must have the resources they need to ensure coverage for individuals who are eligible for Medicaid. A reasonable implementation timeline – one that accounts for the time needed

for states to stand up systems called for in these new requirements – would help to ensure that states can focus on the task at hand before shifting their attention to structural changes to their Medicaid programs. We therefore call on CMS to delay the enforcement timeline for these provisions by at least one year to ensure that states can fully focus their efforts on their mitigation plans in the context of their redeterminations’ efforts.

Detailed Comments:

Person-Centered Service Plan

MHPA aligns with CMS’s goal of ensuring that Medicaid enrollees who are eligible for 1915(c) waiver coverage have their needs assessed and reassessed on a regular basis. It is crucial that enrollees be reassessed on an ongoing basis to ensure that they receive the necessary supports needed to help them live their best lives. We note that Medicaid MCOs are currently providing these assessments and reassessments.

We recommend that CMS exempt from the proposed requirement that at least 90 percent of individuals continuously enrolled in the 1915(c) waiver for at least 365 days will be reassessed at least annually situations in which a member is unable to be reached or if a member refuses to participate in the annual reassessment. We recommend CMS align with the [Part C Technical Specification Document](#) that provides an exclusion when the plan is unable to reach the member for an annual health risk assessment.

Incident Management System

MHPA supports the intent of this proposal and believes that it is important to ensure vulnerable populations that receive home and community-based services (HCBS) are protected. To ensure consistency in how any new or existing requirement would be interpreted across states, CMS should provide technical assistance, including for States that already have these programs in place. For example, we note that in some instances, it is required that plans categorize the refusal of service as a critical incident and investigate all such incidences, even those arising from when a beneficiary refuses services multiple weeks in a row. In these incidents, it is important to balance safety and protection while respecting an enrollee’s right to refusal and choice. Technical assistance from CMS could help states understand and interpret CMS guidance and intent on a more uniform basis.

CMS should create a finite list of critical incidences to reduce burden on States, plans, providers, and beneficiaries. Further, this will also help to differentiate between types of incidences that will require further intervention.

HCBS Payment Adequacy

MHPA supports the goal of the proposal to increase payment amounts for certain direct care workers to improve access to HCBS for Medicaid beneficiaries. However, we are concerned that this requirement could have unintended consequences, including incentivizing certain agencies to refuse to serve Medicaid patients, which will compound access troubles. In addition, narrowing this requirement to 1915(c) services rather than a broader application including 1905(a) services could have the effect of incentivizing the use of personal care services where home health aides and homemaker services might be more appropriate for the enrollee’s needs. Overall, we believe this provision may unintentionally reinforce the existing “institutional bias” for long-term services and supports.

From a direct care perspective, we are concerned that the provider groups who are least likely to be able to comply with these requirements are “mom and pop” providers who typically serve diverse and

underserved populations in targeted geographic areas. The scale and specializations, including language translation abilities and cultural competencies that differentiate these smaller provider groups would make it more difficult to meet an 80% payment threshold, versus a larger provider group that benefits from efficiencies of scale. We are concerned that this requirement will have the potential to exacerbate consolidation issues which are already prevalent in the provider community and are contributing to rising costs in the Medicaid program. If smaller provider groups are unable to meet these standards, we may see additional closures which could further exacerbate the severity of the HCBS workforce shortage.

We also have concerns with this provision from an operational perspective. We seek clarity on the role of Medicaid MCOs in the monitoring and tracking of this requirement, especially given that while MCOs retain control over payment for the service, they are unable to control payment rates for the direct care workforce.

Overall, we believe that a holistic approach to incentivizing individuals to participate in the direct care workforce would be beneficial. CMS should consider supporting approaches that address payment levels as well as career progression, training opportunities, and social supports for individuals serving in this workforce.

Finally, we raise potential legal concerns with the approach CMS has laid out in this provision. We express concern that Section 1902 of the Social Security Act and Section 2402 of the Affordable Care Act may not grant CMS the authority to impose a wage pass-through threshold. We are also concerned that CMS has not conducted an adequate long-term impact assessment on the cost implications of increased wages as required under the Regulatory Flexibility Act. While we applaud CMS for taking steps to alleviate challenges with the direct care workforce, we recommend that CMS consider alternative approaches.

HCBS Measure Set

MHPA believes that engagement from individuals with disabilities is critical to ensure that services are delivered in a way that meets their needs. We are concerned, however, that many of the measures in the HCBS measure set are derived from responses to surveys. We recommend that survey tools be offered in multiple languages and pathways for collecting insights from individuals who are non-verbal should be accounted for. We also want to ensure that as the surveys are fielded, they are administered in such a way that individuals with all levels of health literacy will be able to respond accurately. We believe that CMS should initially focus on survey-related measures that are meaningful to the population and consider the individual's ability to understand and communicate their specific needs.

We recommend that any participant survey related measures be left up to the State to select based on the populations serviced under the specific 1915(c) waiver.

Dual-reported measures should be taken into consideration in this measure set and ensure they align with other CMS programs.

CMS should consider a minimum set of mandatory measures and limit them as is proposed for the MAC QRS. Further, we suggest that CMS allow States flexibility to utilize voluntary measures in addition to the minimum mandatory measures, as appropriate. This will be important in States that already have implemented measures that may not be included in the mandatory measure set. This approach will minimize disruption to the quality-related work that is currently being undertaken by many of the State Medicaid programs.

We recommend the following measures as mandatory under the HCBS Quality measure set.

- MLTSS-1: Long-Term Services and Supports Comprehensive Assessment and Update (LTSS-CAU)
- MLTSS-2: Long-Term Services and Supports Comprehensive Care Plan and Update (LTSS-CPU)
- MLTSS-3: Long-Term Services and Supports Shared Care Plan with Primary Care Provider (LTSS-SCP)
- MLTSS-4: Long-Term Services and Supports Reassessment/Care Plan Update after Inpatient Discharge (LTSS-RAC)
- MLTSS-5: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls
- MLTSS-6: Long-Term Services and Supports Admission to a Facility from the Community
- MLTSS-7: Long-Term Services and Supports Minimizing Facility Length of Stay
- MLTSS-8: Long-Term Services and Supports Successful Transition after Long-Term Facility Stay

The remaining measures proposed in the NPRM should be voluntary measures that states could collect.

Medicaid Advisory Committee (MAC) and Beneficiary Advisory Group (BAG)

MHPA supports the proposals to redefine the MAC and to add the BAG. We believe that it is important to have the lived experience of beneficiaries to ensure that their voice is heard in implementing policies.

Once again, thank you for the opportunity to provide comments on the Ensuring Access to Medicaid Services Proposed Rule (CMS-2442-P). Supporting access to care and services for Medicaid beneficiaries is of paramount importance to MHPA. We appreciate the opportunity to share our perspective to address access challenges and barriers and look forward to continuing to work with CMS and our state partners to make a meaningful difference in the lives of Medicaid beneficiaries.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Vice President, Government Relations and Advocacy