Public Comments

Centers for Medicare and Medicaid Services (CMS) Proposed Rule on Medicaid Regulation of Managed Care

Comments Submitted by PHI
27 July 2015

Comments prepared for PHI by Allison Cook, PHI New York Policy Associate

400 East Fordham Road, 11th Floor
Bronx, NY 10458
Tel: 718.402.7766 ■ Fax: 718.585.6852

E-mail: **info@PHInational.org** ■ **www.PHInational.org**

PHI Comments in Response to Proposed Rule by the Centers for Medicare and Medicaid Services (CMS) on Medicaid Regulation of Managed Care

PHI (Paraprofessional Healthcare Institute) works to transform eldercare and disability services. We foster dignity, respect, and independence—for all who receive care and all who provide it. As the nation's leading authority on the direct-care workforce, PHI promotes quality direct-care jobs as the foundation for quality care. For 25 years, PHI has worked with eldercare and disability service providers, policymakers, and advocates throughout the country to improve the quality of both care and jobs through workforce and curriculum development, coaching and consulting services, policy advocacy, and research on direct-care trends.

PHI applauds the efforts by the Centers for Medicare and Medicaid Services (CMS) to modernize the regulations that govern Medicaid managed care in this country. In that spirit, we offer thoughts on those provisions and recommend additional provisions to ensure high quality care by creating a high quality, stable direct-care workforce. Direct-care workers provide daily support to older adults and people living with disabilities, helping them bathe, dress, eat, and negotiate other daily tasks. They are a lifeline for those they serve and for families struggling to ensure quality care for their loved ones.

Today's direct-care workforce includes home health aides, personal care aides, and certified nursing assistants, representing a spectrum of settings, scope of work, skills, and vocations. The managed care regulations set standards and boundaries for the long-term services and supports (LTSS) system in which direct-care workers perform their essential roles. Therefore, in order for Medicaid enrollees to receive quality LTSS, the regulations should account for the realities and needs of the direct-care workforce.

Direct-care workers make up 27 percent of the total U.S. healthcare workforce,[1] and have the greatest amount of interaction with LTSS enrollees on a daily basis. Consequently, they have a profound impact on the quality of care and quality of life of Medicaid enrollees. With 10,000 baby boomers turning 65 every day,[2] we will need 1.3 million new direct-care workers by 2022.[3] This growth in the sector reinforces the need for regulations that speak to this workforce.

Furthermore, older adults in the community who have significant functional limitations are nearly five times as likely to enroll in Medicaid, and those living in facilities have even higher rates of enrollment.[4] Taken together, it is clear that a significant percentage of Baby Boomers will likely receive their LTSS services through Medicaid. Unfortunately, this increase in demand is exacerbated by chronically high

[1] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics (March 25, 2015).May 2014 National Employment and Wage Estimates United States. Retrieved from: http://www.bls.gov/oes/
[2] Cohn & Taylor (December 10, 2010), "Baby Boomers Approach 65 – Glumly." Accessed at: http://www.pewsocialtrends.org/2010/12/20/baby-boomers-approach-65-glumly/ on July 22, 2015.
[3] U.S. Department of Labor, Bureau of Labor Statistics, Employment Projections Program (December 19, 2013). "National Employment Matrix, 2012-2022". Accessed at: http://www.bls.gov/emp/ep_table_108.htm
[4] Congressional Budget Office (June 2013), "Rising Demand for Long-Term Services and Supports for Elderly People." Accessed at: http://www.cbo.gov/sites/default/files/44363-LTC.pdf on July 22, 2015.

rates of turnover among direct-care workers[5] and decreased labor participation among women ages 25 to 54 – the current demographic pool for direct-care workers.[6]

To meet this growing demand, we must invest in training, wages, benefits, and other innovations that relate to the direct-care workforce. Research continually shows that proper training for direct-care workers decreases their intent to leave their jobs while increasing their care skills and, ultimately, the quality of care they provide.[7] Research also shows that proper wages and employment benefits decrease turnover among this workforce.[8,9] Combined, better training and adequate compensation will help attract and maintain a quality workforce for the years ahead, which will ensure that enrollees receive the quality, person-centered care that CMS envisions through the proposed regulations.

This document summarizes our review of the proposed regulations[10] and includes specific comments organized by each section of the proposed regulations. Four overarching themes from our review are:

1. For Medicaid enrollees to access high quality long-term services and supports (LTSS), the wages, benefits and training needs of direct-care workers should be explicitly considered in rate setting, quality measures, and other key aspects of the regulations.
2. While these regulations should manage costs in an improved managed care system, they should also acknowledge that cost-effectiveness should not compromise the quality of care that enrollees receive. Proposed quality changes – including those in workforce training, job quality, and workforce stability – require an initial investment in resources and infrastructure.
3. To ensure that the improvements specified in these regulations become standard practice, we encourage stronger monitoring, enforcement, and accountability mechanisms at the state and federal level—notably in the areas of workforce support and training.
4. The unique needs of the LTSS population and the direct-care workers that serve them necessitates additional rules and regulations that are specific to this population.

---

[5] American Health Care Association (2014), "American Health Care Association 2012 Staffing Report." Accessed at: http://www.ahcancal.org/research_data/staffing/Documents/2012_Staffing_Report.pdf on July 22, 2015.

[6] U.S. Department of Labor, Bureau of Labor Statistics (December 2013), "Labor force projections to 2022: the labor force participation rate continues to fall." Accessed at: http://www.bls.gov/opub/mlr/2013/article/labor-force-projections-to-2022-the-labor-force-participation-rate-continues-to-fall.htm on July 22, 2015.

[7] Luz & Hanson (May 4, 2015). "Filling the Care Gap: Personal Home Care Worker Training Improves Job Skills, Status, and Satisfaction." *Home Health Care Management & Practice*.

[8] Morris (2009), "Quits and Job Changes Among Home Care Workers in Maine." The Gerontologist, 49(5):635-50.

[9] Banijamali, Hagopian, & Jacoby (2012), "Why They Leave: Turnover Among Washington's Home Care Workers." Seattle, WA: SEIU Healthcare 775NW. Accessed at: http://seiu775.org/report-turnover-among-wa-home-care-workers/

[10] These comments address proposals laid out in the "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability" Public Inspection document released on the Federal Register by CMS on June 1, 2015 (https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered). Foing forward, this document will be referred to as the "Proposed Regulations" and any page numbers cited in these comments refer to page numbers in this document.

Marketing

Appropriate marketing should prevent enrollees from switching plans unintentionally or from not fully understanding the consequences. An unintentional switch can disrupt the valuable relationship that has been steadily built between an enrollee and a direct-care worker. This relationship is so valuable because, once developed, it provides the direct-care workers with a clear, personal understanding of the enrollee's care needs and preferences, and allows the worker to quickly detect potentially dangerous changes in an enrollee's health conditions.

***PHI Recommendation*:** CMS and the state[11] should enhance enforcement of marketing rules that make certain enrollees only switch plans when they fully understand the consequences of transitioning to a new plan. This type of enforcement would preserve the existing enrollee-worker relationships and thereby maintain the continuity of care. Examples of enhanced enforcement could include: empower enrollees to be their own advocates by requiring states to annually inform enrollees of marketing rules; requiring states to establish a process to collect and analyze enrollee feedback on marketing issues; and expanding the scope and funding of the ombudsman program to assist with the enforcement of marketing rules.

PHI Recommendation: The marketing guidelines should be required to be culturally and linguistically competent to guarantee that enrollees do not experience a disruption in their care because of language or cultural barriers—which would sever the established relationships with their direct-care workers.

Appeals and Grievances

Appeals and grievances are valuable processes that empower enrollees to contest plan decisions. An effective appeal and grievance system should prevent care from being compromised while these decisions are being contested by making sure that essential care is not interrupted and protecting the enrollee-worker relationship.

***PHI Recommendation*:** CMS should consider the potential negative consequences of giving the state the option to institute a recoupment policy upon an adverse State Fair Hearing decision. Because enrollees only qualify for Medicaid if they have limited finances, many could not afford to reimburse the plan. Therefore, a recoupment option could dissuade enrollees from appealing their cases and potentially disrupt the enrollee-worker relationship. Additionally, when combined with the focus on cost savings, this policy might create the wrong incentives for certain plans to reduce necessary care for enrollees and reduce hours for workers.

PHI Recommendation: CMS should not require enrollees to exhaust internal plan appeals before filing for a State Fair Hearing. This requirement creates an additional barrier to receiving necessary care, including care provided by direct-care workers. Since many enrollees do not know that they have the option to proceed to a State Fair Hearing, or how to undertake this process, requiring the exhaustion of internal appeals will likely diminish access to care. At a minimum, we recommend that the results of internal appeals be systematically monitored and that this policy be reassessed in a year to determine

[11] We use the term "state" to refer to all states.

whether internal appeals are a meaningful step. Additionally, if internal appeals are required, we recommend that all adverse plan decisions be automatically forwarded to State Fair Hearings and that enrollees be provided with specific guidance about the process, as is currently provided through the Advance Beneficiary Notice in Medicare.[12]

Medical Loss Ratio (MLR)

The medical loss ratio (MLR) influences plan spending, which factors into the contracted rates between plans and providers. Our experience working with providers in various states around the country shows that these rates—and the dynamics in implementing them—shape the type of compensation, benefits and training that direct-care workers ultimately receive from providers. Therefore, the MLR also impacts direct-care workforce stability and job quality. For these reasons, PHI supports the proposed MLR, and recommends implementation that supports high quality care for enrollees by incentivizing the creation and maintenance of a stable, well-trained, and properly compensated workforce.

PHI Recommendation: The MLR numerator should include the costs associated with direct-care workforce training, which directly impacts the care that enrollees receive.[13]

PHI Recommendation: CMS should account for telehealth in "activities related to Health Information Technology and meaningful use," which are part of the calculation of the MLR numerator.[14] Home care agencies and other LTSS providers are increasingly using telehealth to better coordinate and manage care while allowing aides to immediately notify nurses and care managers of important changes in a client's condition—effectively enhancing their care. These types of telehealth practices will increase in the years ahead and should be explicitly addressed in the regulations.

Setting Actuarially Sound Capitation Rates

We noted earlier that the rates that plans receive largely determine the rates that plans set with their network providers – which, in turn, determines what a provider can invest in its workforce in areas such as training, wages, and benefits. Therefore, the rate setting process must adequately consider the compensation necessary to recruit and maintain a sufficient workforce, the payments necessary to provide initial and ongoing training, and the other costs associated with being a quality provider/employer. Additionally, the rate-setting process should account for the ongoing policy developments across the country, such as those that are raising wages for low-income workers, as well as those that are re-examining workloads, overtime protections, and working hours. Accounting for these costs in the rate-setting process will ensure that direct-care workers can effectively help achieve Medicaid's goals of quality care, community integration, and continuity of care.[15, 16]

---

[12] *Medicare Interactive,* "Advance Beneficiary Notice." Accessed at: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=191 on July 21, 2015.
[13] Luz & Hanson (May 4, 2015); Morris (2009); Banijamali, Hagopian, & Jacoby (2012)
[14] Proposed Regulations, page 49
[15] Proposed Regulations, page 80
[16] Proposed Regulations, page 84

PHI Recommendation: CMS should require timely payment of rates and rate adjustments to plans, ensuring that plans can pay providers – including LTSS providers – in a timely manner. Delayed payments from CMS and the state payment inhibit the ability of LTSS providers to invest adequately in the workforce, which can lead to lower quality training, lower wages and benefits, and increased turnover. For example, our experience in various states shows that because of delays at the national and state level, managed care plans and their providers often wait more than a year for rates to be finalized, threatening the financial solvency of providers and the care they provide. Moreover, policy changes to wage and hour rules might occur after a rate is established, which necessitates mid-year updates to avoid the same financial and quality of care issues. Timeliness should also be defined and enforced in this instance.

PHI Recommendation: CMS and the state must specify workforce costs – including wages, health insurance, paid leave, training, and other costs – when setting and adjusting rates. Additionally, the state should publicly report workforce data such as turnover, staffing statistics, and vacancy rates in order to promote transparency and provide accountability for considering workforce costs. If the direct-care workforce does not have adequate training, wages, and benefits, an enrollee's access to quality care will also suffer. Moreover, state officials should reexamine the timeliness of data when determining rates. For example, basing rates upon the previous year's costs would be insufficient when the minimum wage is increased or if the Fair Labor Standards Act (FLSA)[17] no longer excludes home health aides. If these wage changes are not accounted for in the rate-setting process, LTSS providers might be forced to cut important areas that impact quality of care, such as training for direct-care workers.

PHI Recommendation*:* CMS and the state should employ measures that build the quality of providers as employers when setting rates and making quality adjustments. With the current focus on cost reduction, our experience across states shows that many plans tend to contract with providers that agree to the lowest rates, which often translates to low wages, thin benefits, reduced training, and ultimately, decreased workforce stability. We know that a quality provider should be a quality employer—one that provides good training, advancement opportunities, and adequate wages and benefits, and a supportive work environment. All of these factors should be considered when setting rates.

PHI Recommendation: CMS and the state should create mechanisms to examine the details of plan ownership and control, ensuring both competence and ethical management throughout the system. A strong plan system is essential to a well-managed direct-care workforce. PHI applauds the inclusion of plans and related entities in federal database check requirements.[18] However, plans are not required to report when individuals who have ownership or controlling interest in these plans have been convicted of a criminal offense related to that person's involvement in a Medicaid or Medicare program – a provision which is required of providers.[19] As one approach, CMS can consider implementing a

[17] PHI, "Home Care Workers Deserve Minimum Wage & Overtime." Accessed on July 24, 2015 at: http://phinational.org/campaigns/home-care-workers-deserve-minimum-wage-protection

[18] Proposed Regulations, page 115

[19] 42 CFR 455.106. Accessed on July 8, 2015 at: http://www.ecfr.gov/cgi-bin/text-idx?SID=56f2b37fb87cb14f2908947397591cb9&mc=true&node=sp42.4.455.b&rgn=div6

"character and competence" rule that requires owners to demonstrate an untarnished history in healthcare and to have not been convicted of a related crime.[20]

PHI Recommendation: When setting rates, CMS and the state should consider how time and distance standards[21] affect direct-care workers and their travel needs. In rural areas, as well as in certain suburban and urban areas, direct-care workers must travel for considerable amounts of time and/or distance to provide care to enrollees. Time and distance standards will vary across states and therefore, we recommend that each state undertake a review of the travel needs of direct-care workers – such as mileage, car maintenance, or public transportation fares – when travelling to provide enrollees with supports and services. Workers should then be reimbursed for these job-related costs.

Beneficiary Protections

Direct-care workers are key in actualizing beneficiary protections, such as continuity of care, community integration, and person-centered care. Therefore, the relationship between workers and enrollees should be maintained when desired by the enrollee, and supports for the direct-care workforce should be widely understood as essential to enhancing beneficiary protections.

PHI Recommendation*:* CMS should reconsider requiring mandatory enrollment in Fee for Service (FFS) Medicaid for 14 days before an individual is enrolled in a managed care plan. PHI applauds CMS' vision to allow for meaningful choice. However, switching coverage twice within this short period of time could cause greater confusion among enrollees. Further, it will likely disrupt continuity of care – a goal of the proposed regulations – when enrollees and direct-care workers have established a strong relationship.

PHI Recommendation: Instead of creating a new beneficiary support system, CMS and the state should expand the scope and practice of the ombudsman program through enhanced funding, training, and cross-program communication. PHI applauds CMS' effort to create a robust, comprehensive beneficiary support system. With the proper regulations and funding, ombudsman programs could be expanded to support this effort within an enhanced managed care system. A properly supported, independent ombudsman program could support the various needs of enrollees including appeals and grievances, monitoring and reporting on improper marketing, and helping enrollees make meaningful choices between plans – thereby ensuring that enrollee-worker relationships are maintained.

PHI Recommendation: For LTSS services, CMS and the state should include a quality of life component in the definition of "medical necessity" for determining when services are appropriate. This quality of life measurement can ensure that the term "medical necessity" does not unnecessarily prevent enrollees from receiving the services they need. For example, a physician who does not specialize in geriatrics might not understand the benefits that authorizing home health aide services can have for an enrollee who is older and has functional limitations.

PHI Recommendation: CMS and the state should require plans to conduct a caregiver assessment that determines caregiver burden, assesses their knowledge, ability, and willingness to provide care, and

[20] New York State Department of Health, "Certificate of Need Criteria." Accessed at: https://www.health.ny.gov/facilities/cons/more_information/review_criteria.htm on July 21, 2015.
[21] Proposed Regulations, page 169

provides training *prior* to including caregiver services in a care plan. While the direct care workforce provides the majority of the paid hands-on care, family and informal caregivers provide the majority of overall care for their loved ones. Too often, providers implicitly rely on these caregivers without adequately assessing their ability to perform the functions expected. A caregiver assessment will improve the quality of care for the enrollee and ensure that direct-care workers are utilized when necessary. Additionally, rates should consider the cost of training assessors to properly administer an assessment tool and to facilitate planning related to caregiving.

PHI Recommendation: CMS and the state must ensure that there is an adequate direct-care workforce to fulfill the promise of Medicaid: authorizing health services that are "sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished."[22] PHI recommends that workforce measures – including number of workers, stability of workforce, and average compensation – be systematically tracked and publicly reported. [23] For rate setting, these measures will ensure that a trained direct-care workforce can meet the growing needs of enrollees. Further, the state and individual plans should track and publicly report the authorized services that were not delivered, which can be an indicator of insufficient workforce capacity that limits quality and access.

PHI Recommendation: CMS should better enforce timeframes for prior authorization requests,[24] especially for durable medical equipment and other supportive devices. This equipment is necessary for enrollees to receive – and direct-care workers to provide – care safely and properly. Direct-care workers experience high rates of on-the-job injuries, often resulting in extended absences from work.[25] For example, if an enrollee's wheelchair repair is not approved for three weeks, an aide could hurt her back when trying to transfer the enrollee from the bathroom to the bedroom. Better adherence to prior authorization timeframes will help prevent delays in receiving and maintaining necessary equipment, and support direct-care workers in providing quality care to enrollees.

PHI Recommendation: The state should explicitly include transition of care protections that allow enrollees to continue receiving care from their existing direct-care workers. This would promote quality and continuity of care, as well as workforce stability – all of which are essential for LTSS enrollees. For example, when mandatory Medicaid Managed Long Term Care was implemented in New York City, enrollees were allowed to keep their aides for a year if they wished, which helped maintain stability for both enrollees and direct-care workers. Additionally, this approach ensured that "self-directed" (or "consumer-directed") enrollees could continue managing their own personal care. PHI recommends that

---

[22] 42 CFR 438.210 (3)(i). Accessed on July 8, 2015 at: http://www.ecfr.gov/cgi-bin/text-idx?SID=a1979da39e287ab3f2fb8af52616bdb3&mc=true&node=se42.4.438_1210&rgn=div8

[23] CMS National Direct Service Workforce Resource Center (February 2009). "The Need for Monitoring the Long-Term Direct Service Workforce and Recommendations for Data Collection." Accessed at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/workforce/downloads/monitoring-dsw.pdf

[24] 42 CFR 438.210(d). Accessed on July 23, 2015 at: http://www.ecfr.gov/cgi-bin/text-idx?SID=a1979da39e287ab3f2fb8af52616bdb3&mc=true&node=se42.4.438_1210&rgn=div8

[25] US Department of Labor, Bureau of Labor Statistics, Injuries, Illnesses, and Fatalities Program (December 2014). "Nonfatal Occupational Injuries and Illnesses Requiring Days Away From Work, 2013." Retrieved from: http://www.bls.gov/iif/

CMS include direct-care workers in the transition of care protections and that New York City be drawn upon as a model.

PHI Recommendation: CMS should require the state tie the plan's initial health assessment[26] to the transition of care requirements, including protections that allow enrollees to retain their direct-care workers. Transition of care protections should last until the timeframe set by the state expires, or until an initial health assessment is conducted and a care plan is implemented – whichever is later. This will ensure that direct-care workers are not forced to leave their enrollees without proper supports in place.

PHI Recommendation: CMS and the state should each create a plan to address the connectivity of LTSS providers to the broader health information system. There has been too little state or federal investment to allow LTSS providers to participate in the health information system. However, LTSS providers could contribute vital information that would help reduce unnecessary hospitalizations and ER use. Moreover, PHI has found that home care aides are able to provide important and timely information related to symptoms and conditions – contributing directly to better health outcomes for their clients.

PHI Recommendation: CMS and the state should specifically address the credentialing of LTSS providers. Certain states do not require that all LTSS providers – such as home care agencies providing personal care services – be licensed. CMS should require that licensing be instituted in all states, which would be an important means of credentialing LTSS providers, especially home care providers. Additionally, CMS and the state should specify that credentialing LTSS providers should account for governance and leadership issues, as well as the financial viability of the organization. This approach will help ensure that workers are properly supervised and compensated and that they can continue to provide care in the long term. Finally, CMS and the state should utilize the credentialing process to set training standards for the direct-care workforce. For example, Arizona requires providers that direct-care workers be trained prior to contracting with Medicaid plans[27] – a requirement that CMS should strongly consider.

Modernize Regulatory Standards

The regulatory standards established by CMS and the state are designed to guarantee that Medicaid provides enrollees with quality, person-centered care. In order to meet that promise, these standards should also address the direct-care workforce, as workers are key in this care system. Regulatory standards that support and monitor the direct-care workforce, such as personal care aide training requirements, can ensure that direct-care workers are properly equipped to provide quality, person-centered care. As previously stated, these standards should be monitored and reported to ensure adherence.

PHI Recommendation: CMS should require the state to include the direct-care workforce in network capacity assessments. The proposed regulations state that network adequacy includes the "number and types of health care professionals needed to provide covered services."[28] This should include assessing

[26] Proposed Regulations, page 158
[27] Arizona Healthcare Cost Containment System, "Direct-care Worker Training and Testing Program." Accessed at: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/429.pdf on July 22, 2015.
[28] Proposed Regulations, page 178

the capacity of network LTSS providers, as well as their direct-care worker vacancies to ensure that LTSS providers consistently have sufficient direct-care workers to provide enrollees access to care. Additionally, states should track delays in receiving authorized services among enrollees, since these delays can signal insufficient workforce size and an inadequate network.

***PHI Recommendation*:** CMS and the state should monitor staff vacancies among providers – such as vacancies in direct-care workers, physicians, and nurses – instead of relying on enrollee-to-provider ratios.[29] This metric, coupled with a report on authorized services that were not delivered, provides a more accurate picture of network capacity.

PHI Recommendation: CMS should require that a plan's network and directory include and denote providers who specialize in geriatrics. Our experiences shows that providers who specialize in geriatrics or who have personnel with a background in geriatrics generally have a strong understanding of the important role of LTSS and direct-care workers. Further, many enrollees in need of LTSS are older adults, and providers should know how to provide care in a manner that addresses their unique needs.

PHI Recommendation: CMS and the state should include quality of life and workforce measures, not just medical measures, in their quality assessment frameworks. LTSS are designed to provide person-centered care in a manner that improves quality of life, so any assessment should monitor these aspects. Additionally, achieving LTSS quality goals relies on direct-care workers to provide that care. Therefore, measures that address direct-care workforce training (including workers under the self-direction option), compensation, and turnover should also be included.

PHI Recommendation: CMS should mandate a minimum ratio of state staff contract managers to enrollees. Many states do not currently have the capacity to adequately monitor plans and analyze the data that has been collected—a role that staff contract managers can play. A ratio will ensure that the state has this capacity and that important quality and workforce measures are made publicly available within a reasonable timeframe.

***PHI Recommendation*:** Plan readiness reviews should include testing provider billing systems before beneficiaries are enrolled, as well as ensuring that plans have dedicated billing staff to deal with provider issues. LTSS providers often lack the infrastructure to properly bill plans, since many previously only contracted with their state. If readiness reviews do not account for issues such as testing of the billing system, LTSS providers will struggle with billing concerns, potentially leading to an inability to make payroll, disruptions in the provision of services, and unnecessary closures. Our experience in New York showed that these issues emerged when the state switched to mandatory Medicaid Managed Long Term Care for the personal care services population. Additionally, CMS should require readiness reviews to verify that plans have the dedicated staff to deal with provider billing issues, providers know how to readily reach that staff, and the staff responds to provider issues within a week. In our experience, too many providers have been left for weeks without a response from plans, only to learn that their billing had passed the timeliness requirement of their contracts. These issues can and should be dealt with prior to a mandatory start date.

[29] Proposed Regulations, page 182

PHI Recommendation: CMS and the state should require that provider directories include types of specialization, office hours, and whether they are accepting new patients—information that is essential for both enrollees and the workforce that provides critical care. These directories should also include LTSS providers who specialize in certain populations, such as adults with disabilities, or in certain diseases, such as Alzheimer's disease and other forms of dementia. Finally, these access issues should be assessed when determining network adequacy.

PHI Recommendation: CMS should reassess its policy that denies federal matching funds for initial, pre-service training for personal care aides.[30] As previously discussed, a properly trained direct-care workforce is essential in a system that seeks to provide enrollees with quality, person-centered care. We strongly recommend that CMS include training funding in rates and end its prohibition on pre-service personal care aide training.

Implementing Statutory Provisions

The implementation of statutory provisions, including data reporting, ensures that regulations are monitored and implemented properly. This creates an environment where direct-care workers can provide enrollees with quality, person-centered care.

PHI Recommendation: CMS should require the state to collect and report more detailed encounter data. PHI applauds the specific inclusion of capitated plans in encounter data reporting.[31] However, for the state and CMS to conduct meaningful analysis, this data needs to be more granular, and include variables such as the specific care provided by each provider across plans. Once analyzed, this data could facilitate improved monitoring and rate setting. One timely example: when the U.S. Department of Labor's decision to extend wage and overtime protections to home care aides goes into effect, states will need information on the number of hours worked, travel time, and overtime, among other variables, in order to properly set rates. Otherwise, states will be unable to budget for costs and providers will be unable to meet the demand for care.

Conclusion

PHI applauds the inclusion of new LTSS standards in the proposed Medicaid Managed Care regulations. The direct-care workforce is a critical component of enhancing care for older adults and people with disabilities while helping them remain in the community. We encourage CMS to include additional provisions that address this workforce in the final regulations. We look forward to participating in future discussions on these regulations.

If you have any questions or would like to further discuss these comments, please contact Robert Espinoza, PHI Vice President of Policy at respinoza@PHINational.org or at (718) 928-2085.

[30] CMS (August 2013), "Coverage of Direct Service Workforce Continuing Education and Training within Medicaid Policy and Rate Setting: A Toolkit for State Medicaid Agencies." Accessed at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/workforce/downloads/dsw-training-rates-toolkit.pdf.

[31] Proposed Regulations, page 254