



Advancing Equity through MLTSS Programs

FEBRUARY 2023



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Impact 120

The ADvancing States **MLTSS Institute** was established in 2016 in order to drive improvements in key managed long-term services and supports (MLTSS) policy areas, facilitate sharing and learning among states, and provide direct and intensive technical assistance to states and health plans. The work of the Institute will result in expanded agency capacity, greater innovation at the state level, and state/federal engagement on MLTSS policy.

ADvancing States represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support long-term services and supports for older adults and individuals with disabilities.

Impact 120 is a boutique strategy consulting firm dedicated to promoting health and quality of life across the lifespan, especially for individuals who need LTSS. Impact 120 supports mission-driven organizations to grow, plan, innovate, and inspire system change. For more information, visit www.impact120.com.

Thank you to leaders in the following organizations who contributed to this issue brief by providing relevant materials or sharing their expertise:

- Arizona Health Care Cost Containment System
- CareSource
- CMS Medicare-Medicaid Coordination Office
- Collective Insight
- Commonwealth Care Alliance
- Community Living Equity Center at the Lurie Institute for Disability Policy
- CVS Health/Aetna Medicaid
- Delaware Department of Health and Social Services
- Elevance Health
- MassHealth
- Minnesota Department of Human Services
- Molina Healthcare, Inc
- Pennsylvania Department of Human Services
- Tennessee Division of TennCare
- UnitedHealthcare Community and State
- Wisconsin Department of Health Services

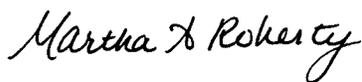
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Managed long-term services and supports (MLTSS) is now the Medicaid delivery system in half the states. States seeking to modernize and improve their long-term services and supports systems continue to use managed care plans to help them achieve their goals.

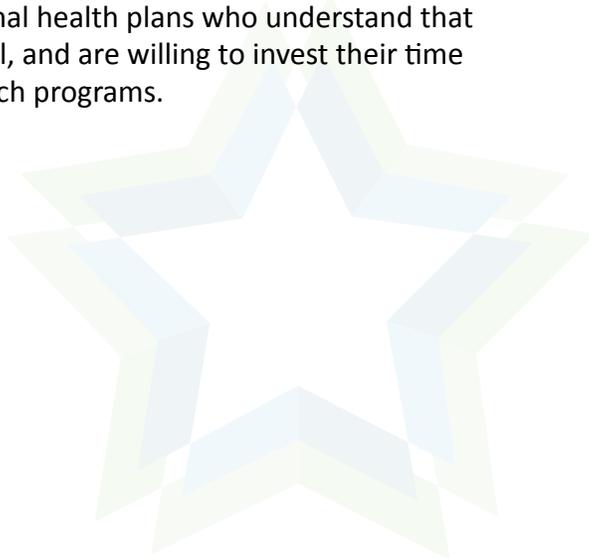
Operating an efficient and effective MLTSS program requires thoughtful program design, capable health plan partners, strong state oversight, and appropriate accountability mechanisms. ADvancing States has been deeply engaged in providing technical expertise and assistance to our member states as they plan, design, implement, and evaluate their MLTSS programs through our MLTSS Institute. The Institute, created in 2016, brings together state MLTSS directors with health plan thought leaders to drive improvements in key MLTSS policy issues and facilitate sharing and learning among states.

The Institute has published nine issue briefs in the past six years and is pleased to present the first exploration of how MLTSS programs can help states advance equity for their LTSS recipients. We are excited to shine a light on such an important and timely topic and hope that it will spark conversations.

I remain deeply grateful to our visionary Board of Directors, state long-term services and supports leaders, and thought leaders at national health plans who understand that well-run, high-quality MLTSS programs benefit us all, and are willing to invest their time and resources to support the implementation of such programs.



Martha Roherty, Executive Director
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Executive Summary

Equity is at the forefront of Medicaid program priorities for many reasons, including the way in which the COVID-19 pandemic shined a spotlight on significant disparities in the healthcare system and the Biden Administration’s positioning of equity as a top priority across all government programs. Many consumers who require long-term services and supports (LTSS) through Medicaid experience barriers in achieving their highest quality of life, due to the intersectional impact of disability and age, when combined with race, ethnicity, language, sexual orientation, gender identity, and geography. Equity is not only about equal access to services or counting individuals served; it is about leveling the playing field by eliminating policies, practices, attitudes, biases, and cultural messages that reinforce differential treatment of groups of people who have been marginalized, and creating policies and practices that improve outcomes for those who have been underrepresented and devalued. Managed long-term services and supports (MLTSS) programs can enhance state capacity to create more equitable programs for consumers by:

- Defining clearer roles and responsibilities across a complex system with numerous stakeholders.
- Driving rigorous data analysis and quality improvement.
- Providing flexibility to innovate and invest in communities.
- Sharing best practices from other states.
- Bringing resources and insights from outside of Medicaid.



By reviewing existing literature and conducting interviews with numerous leaders from MLTSS states and health plans, we sought to understand how the managed care delivery model can be used to build more equitable LTSS programs and to identify current promising practices. Five primary themes emerged from our research and discussions:

- 1) It's hard to address equity if we cannot measure it.
- 2) Equitable MLTSS programs require a diverse network of culturally competent providers and community partners.
- 3) States can use a variety of existing tools to align MLTSS plan efforts with equity-related goals.
- 4) To understand inequities, MLTSS plans must authentically engage members through multiple modalities.
- 5) Person-centered planning can advance equity by addressing barriers at the individual consumer level.

A description of current research and examples of promising practices is provided for each of these areas, as well as recommendations for policy consideration. Additional research is needed to enhance our understanding of the intersectional impact of disability and age with other demographic factors, and to establish and share best practices to advance equity across Medicaid LTSS programs.



Introduction

For 2022, both ADvancing States' Board of Directors and the MLTSS Institute Advisory Council agreed to research promising practices to advance equity through MLTSS as a priority focus. While equity is a longstanding issue, a confluence of factors has increased the urgency to address it, especially the significant disparities highlighted through the COVID-19 pandemic.

Inequity is costly to our society and can lead to poor health outcomes. Inequities currently account for approximately \$320 billion in annual health care spending, which could grow to \$1 trillion or more by 2040.¹ Concurrently, the population of consumers using LTSS will significantly grow; for example, the number of older adults with LTSS needs is expected to rise from 6.3 million in 2015 to an estimated 15 million in 2050.² Home and community-based services (HCBS) are already inadequate to meet consumer needs as 37 states continued to have waiver waiting lists for one or more groups of Medicaid recipients in 2021.³ But equity is not only about equal access to services or counting individuals served; it is about leveling the playing field by eliminating policies, practices, attitudes, biases, and cultural messages that reinforce differential treatment of groups of people who have been marginalized, and creating policies and practices that improve outcomes for those who have been underrepresented and devalued.

Our focus for this issue brief is to explore how states and MLTSS health plans are collaborating to support consumers who experience barriers due to disability and age as well as race, ethnicity, language, sexual orientation, gender identity, and geography. By reviewing existing literature and conducting interviews with numerous leaders from MLTSS states and their health plan partners, we sought to understand how the managed care delivery model can be used to build more equitable LTSS programs.

Equity is about leveling the playing field by eliminating policies, practices, attitudes, biases, and cultural messages that reinforce differential treatment of groups of people who have been marginalized, and creating policies and practices that improve outcomes for those who have been underrepresented and devalued.

It's important to acknowledge the broader context in which MLTSS programs exist. Before we discuss intersectionality, we must note that the whole population of persons with LTSS needs can experience inequities due to ableism and ageism in our society. Because Medicaid LTSS eligibility criteria and covered benefits vary significantly by state, there are some structural inequities in access to services based on geography, age, and disability type.⁴ Additionally, it is difficult to talk about equity in LTSS programs without acknowledging the workforce that provides essential daily services to support consumers, with most of the workforce being women and people of color. The ADvancing States MLTSS Institute published an issue brief detailing workforce challenges in 2019.⁵ The COVID-19 pandemic has further exacerbated such challenges. In a recent issue brief, MACPAC noted that “despite limited data to quantify the extent of the shortage, there is evidence that an insufficient supply of HCBS workers has led to providers being unable to take on new clients, vacancies in the workforce, and unmet beneficiary need.”⁶

This analysis is not intended to be exhaustive; we have conducted a scan to understand what work is currently being done across several MLTSS states and health plans. We recognize that there is still significant work ahead.



Defining Equity

Several health plans and states shared in interviews that they are using the Robert Wood Johnson Foundation’s definition of health equity as a foundation for defining their own organization’s efforts:

“Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”⁷



The Center for Medicare & Medicaid Services (CMS) released its current strategic plan with a pillar for health equity, defined as *“the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.”⁸*

Some states and health plans also reference the Healthy People 2030 Framework developed by the U.S. Department of Health and Human Services (HHS) Office of Disease Prevention and Health Promotion (ODPHP), which has the overarching vision of *“A society in which all people can achieve their full potential for health and well-being across the lifespan.”⁹*

To contextualize this issue brief within LTSS, it is important to note that outcomes for consumers who use LTSS go beyond typical definitions of “health” to be inclusive of all aspects of quality of life (e.g., community integration, employment, housing). Therefore, we will use the broader term “equity” throughout this issue brief. Additionally, because the social determinants of health (SDoH) are already highly integrated into LTSS processes and benefits structures, we will not focus on SDoH as a separate avenue for improving equity.

Available Data on Equity in Medicaid LTSS

While there is research on equity in Medicaid as a whole, few resources focus on equity within and across Medicaid-funded LTSS programs. One study of fee-for-service Medicaid enrollees showed that among consumers receiving home and community-based services (HCBS), Black consumers were more likely to be hospitalized than white consumers, and the gap widened among Black and white consumers with dementia.¹⁰ A literature review by the National Center on Advancing Person-Centered Practices and Systems (NCAPPS) identified racial disparities in prevalence, treatment, and outcomes among persons with brain injuries.¹¹ Below, we have summarized research on three topics that are highly relevant to understanding equity for consumers who receive Medicaid LTSS — access to LTSS, disparities for persons with disabilities, and disparities for those who are dually-eligible for Medicare and Medicaid.

Access to LTSS: A study published at the start of the COVID-19 pandemic highlighted existing barriers to the provision of quality LTSS for consumers from racial and ethnic groups that have been historically marginalized, which were likely to be exacerbated by COVID-19: “1) cumulative health disparities for minority populations over the life course, 2) unequal clinical care and quality of life for nursing home users from communities of color, 3) impediments to quality experienced by low-English proficiency nursing home users, 4) inordinate impact on care quality due to challenges faced by an LTSS workforce that is disproportionately composed of immigrants and racial/ethnic minorities, and 5) disparities in home and community-based services.”¹²

Recent research shows disparities in access to HCBS based on geography, age, and disability type.

Recent research shows disparities in access to HCBS based on geography, age, and disability type. A recent analysis of waiver waiting lists by Kaiser Family Foundation shows that people with intellectual/

developmental disabilities (I/DD) comprise almost three-quarters (73%) of the total waiver waiting list population in the U.S. but comprise less than half of the Medicaid LTSS consumer population. People with I/DD waited 67 months on average, compared with an average of 2 months for older adults and 30 months for children with complex medical needs.¹³ Another study illustrated gaps in HCBS access for consumers in rural areas, which complicates rebalancing efforts.¹⁴

Disparities for persons with disabilities: There is significant evidence that people with disabilities face discrimination and often experience barriers to achieving health, well-being, and quality of life. For example, several studies describe a lack of access to primary and preventive care:

- Individuals with disabilities experience significant inequities in access to high-quality health care services due to factors such as clinician biases and inaccessible medical environments.¹⁵ One recent study in *Health Affairs* found that only 40.7% of physicians were very confident about their ability to provide the same quality of care to patients with disability, and just 56.5% strongly agreed that they welcomed patients with disability into their practices.¹⁶
- According to a recent community survey by the National Association of Councils on Developmental Disabilities, conducted in partnership with UnitedHealthcare, 36% of individuals with disabilities have delayed or missed needed health care in the last year.¹⁷
- The CDC’s Division of Human Development and Disability reports that “compared to people without disabilities, people with disabilities have less access to health care, have more depression and anxiety, engage more often in risky health behaviors such as smoking, and are less physically active.”¹⁸
- The CMS Office of Minority Health notes that “women with disabilities are less likely to receive regular breast and cervical cancer screenings and are more likely to have cancer and then be diagnosed at a later stage, than women without disabilities.”¹⁹



In addition to challenges accessing healthcare, people with disabilities often experience barriers accessing integrated, competitive employment and accessible housing, which can be exacerbated for people of color. In a recent issue brief, UnitedHealthcare noted studies that show that black, indigenous, and people of color with disabilities are 40% more likely to be unemployed, 42% more likely to live in poverty, and 38% more likely to report fair or poor health as compare with their white peers.²⁰

Individuals dually eligible for Medicare and Medicaid: Approximately three-quarters of individuals receiving Medicaid LTSS are dually eligible for Medicaid and Medicare.²⁰ CMS’ office focused on dually eligible individuals — The Medicare-Medicaid Coordination Office (MMCO) — identified in its FY2021 Report to Congress several health disparities among those who are dually eligible, including a higher incidence of chronic conditions (such as diabetes), higher rates of hospitalizations from COVID-19, and unmet social needs. In 2020, 48% of dually eligible individuals were from a racial or ethnic minority group.²²

ATI Advisory and Arnold Ventures recently released detailed demographic data on dually eligible individuals, noting that, “Dual beneficiaries are more likely to be Black or Hispanic, low income, under age 65, and unmarried than are Medicare-only beneficiaries. Integrated culturally competent approaches are critical for advancing equitable health outcomes.”²³ Within the dually eligible population, members of historically marginalized racial and ethnic groups often experience additional barriers. For example, dually eligible individuals are nine times more likely to have limited English fluency. Also, “Black dual beneficiaries with 2+ ADLs are more likely to live alone than other groups with similar complex care needs,” which increases the risk of falls and the likelihood of being admitted to a nursing facility.

Taken together, the available research suggests that consumers in MLTSS programs are disproportionately likely to experience inequities in the healthcare system and beyond, which can be compounded by additional demographic factors such as race, ethnicity, and sexual orientation. Further research is needed to enhance our understanding of the intersectional impact of disability and age with other demographic factors.



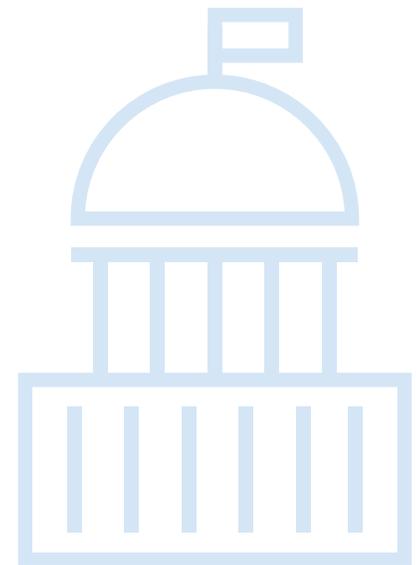
The Role of Managed LTSS Health Plans in Supporting State Equity Goals

Interviews with State Medicaid Directors by Kaiser Family Foundation (KFF) and Health Management Associates (HMA) highlight health equity as a priority, “Several states noted that while health equity had been a priority before, the pandemic helped to “move the needle” and allow for difficult conversations to take place.”²⁴ Medicaid leaders continue to see disparities in outcomes, especially those related to maternal health, mental health, and COVID-19. From a Medicaid LTSS perspective, the COVID-19 pandemic highlighted quality issues in nursing facilities, and corresponding workforce and access issues in HCBS.

The Biden Administration set equity as a priority for all government-sponsored programs, including Medicaid. A 2021 Executive Order states, “It is therefore the policy of my Administration that the Federal Government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality....The Federal Government’s goal in advancing equity is to provide everyone with the opportunity to reach their full potential.”²⁵

As previously noted, CMS’ Strategic Plan includes a pillar on health equity, with efforts ranging from data collection, innovation models, and quality improvement. CMS’ release of the HCBS Quality Measure Set in July 2022 highlighted the promotion of equity as a primary use case. To that end, it is strongly recommended that states stratify their data on “key demographic and other beneficiary characteristics, such as race and ethnicity, sex, age, rural/urban, disability, and language.”²⁶

While Federal agencies are aligned around equity as a priority, a diversity of political climates at the state level leads to varying approaches. Depending on priorities of each administration, some Medicaid leaders may be limited in their ability to focus on equity in a holistic way. In those instances, a focus on health disparities or specific dimensions of equity (e.g., geographic vs. race/ethnicity) may still be possible.



Managed care can advance state equity goals by:

- Defining clearer roles and responsibilities across a complex system with numerous stakeholders
- Driving rigorous data analysis and quality improvement
- Providing flexibility to innovate and invest in communities
- Sharing best practices from other states
- Bringing resources and insights from outside of Medicaid

Through our interviews with MLTSS state and health plan leaders, we identified several consistent themes about how a managed care delivery system can help states advance their equity goals:

- **Managed care helps define clearer roles and responsibilities** across a complex system with numerous stakeholders. State Medicaid Agencies can use their RFP process and managed care contracts to set expectations for health plans, while health plans can define expectations and/or incentives for providers within their network. Other stakeholders, such as tribes and community-based organizations, can have a clearly defined role as well.
- **Managed care plans can bring rigor around data analysis and quality improvement.** Data is essential to improving equity, and plans often bring additional data analytics tools, capacity, and expertise. Plan quality improvement processes can provide structure as disparities are identified and addressed.
- **Managed care plans have flexibility to innovate and invest in communities.** As health plans leverage available data to identify gaps, they can address those gaps by defining value-added services, offering in-lieu-of-services, tailoring their programs and member resources, partnering with local organizations, and applying person-centered processes at the individual level. Additionally, large plans typically have foundations and other channels for engaging with and investing in local communities.
- **Multi-state plans can share best practices from other states.** As health plans identify promising practices to improve access and outcomes in one community, they can bring those lessons learned across state lines to other communities with similar barriers.
- **Multi-product plans bring resources and insights from outside of Medicaid.** Plans with non-Medicaid lines of business may bring unique resources to contribute to equity efforts, such as those companies that also own provider groups, digital health tools, commercial insurance businesses with employer partners, and retail/pharmacy operations. For example, interviewees reported leveraging training and workforce initiatives from other parts of the company to benefit Medicaid members.

Health plan leaders cited several reasons their companies are investing in improving health equity, in addition to contractual requirements and RFP commitments (described in Theme 3 below). It is important to note that systemic change requires long-term investments which may not generate an immediate return. We heard from several plan leaders that a focus on equity is aligned with their organization’s mission, and disparities must be addressed to improve member outcomes and quality. In the context of an MLTSS program, if the goal is to enable members to live as independently as possible, it requires the health plan to understand and address the individual and systemic barriers they face. To the extent that states and plans have aligned financial incentives around preventing institutionalization, there is a clear business case for ensuring that members receiving HCBS have access to services that meet their daily needs and are delivered in an accessible, culturally competent manner.

Although MLTSS health plans have the potential to deliver significant value to states, it’s important to note that there remain program decisions at the state level which can considerably impact equity, such as benefit and waiver design and the eligibility process. Justice in Aging’s recently released equity framework for California lists five stages of HCBS program design and delivery, of which two are typically outside of a plan’s purview (program design, awareness and enrollment in HCBS). That leaves three stages (provider availability, assessment for/authorization of services, provision of HCBS) where states and plans can collaborate to improve equity.²⁷ Additional examples of steps that can be taken at the state level are available in Justice in Aging’s issue brief on New Jersey.²⁸

There is a clear business case for ensuring that members receiving HCBS have access to services that meet their daily needs and are delivered in an accessible, culturally competent manner.



Opportunities to Advance Equity through MLTSS

Across interviews and published writings on this topic, five primary themes emerged. To advance equity, state MLTSS leaders and health plans are focusing their efforts on data, partnerships, program structure, and consumer engagement. In addition, person-centered planning enables MLTSS health plans to address barriers at the individual level.

Theme 1: It's hard to address equity if we cannot measure it

Every state and health plan interviewee mentioned challenges in the quality of their data on consumer race and ethnicity, and only a few organizations are beginning to collect data on sexual orientation and gender identity. A recent review of state Medicaid

data conducted by NORC at the University of Chicago showed that most states are missing race and ethnicity data for significant percentages of Medicaid enrollees.²⁹ Organizations that are actively collecting data across these different demographic dimensions mentioned very high rates of “unknown” and “other.”

Most states are missing race and ethnicity data for significant percentages of Medicaid enrollees.

When each stakeholder group — states, health plans, providers — has incomplete consumer demographic data, it is difficult to determine which system should be the source of truth and how data should be shared. Several interviewees shared the view that health plan data should be the most complete and current, and health plans should provide demographic data back to states. Additionally, while Medicaid agencies follow Office of Management and Budget (OMB) guidance, several organizations mentioned significant discrepancies in how demographic data is collected among other Federal agencies which can flow into state systems, such as CMS (for consumers dually enrolled in Medicare), the Social Security Administration (SSA), and the Internal Revenue Service (IRS).

All interviewees agreed that data should ideally be self-reported by consumers. However, consumers, especially those from groups that have been historically marginalized, may hesitate to self-identify. Interviewees discussed the need for

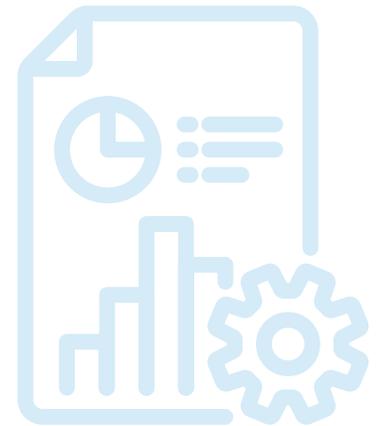
particularly thoughtful discussions around helping consumers with “invisible disabilities” (particularly those with mental health disabilities and substance use disorder) identify as having a “disability.” Interviewees also discussed consumers’ hesitance to report their sexual orientation or gender identity to government entities out of fear of judgment or discrimination. A report by the Urban Institute, American Benefits Council, and Deloitte, funded by Elevance Health, emphasized the importance of building consumer trust and community engagement.³⁰ Consumers should understand why the information is requested and how it will be used. The questions should be asked in plain language with enough choices for people to find one or more categories that represent their identity.

Despite all the challenges listed above, a relative lack of data is not holding states and health plans back. Interviewees agreed that their organizations must start addressing known equity issues while improving data in parallel.

Promising practices in data collection

States are investing in improving data collection during the Medicaid enrollment and eligibility process as well as coordinating with health plans to share up-to-date information. KFF and HMA found that many states are using at least one specified strategy to improve race, ethnicity, and language data completeness.³¹ MLTSS state leaders that we interviewed described employing several strategies, for example:

- Refining the questions asked and data elements collected to maximize response rates
- Collaborating with enrollment entities to provide guidance and training on how best to request this information from consumers
- Supplementing Medicaid data with data collected from other state and local agencies (e.g., public health entities)
- Cross-walking data elements and transferring data bi-directionally between the state and health plans
- Requiring plans and/or providers to collect and/or submit demographic data
- Leveraging existing Health Information Exchanges (HIEs) to exchange data between states, plans, and providers



Unlike other Medicaid populations, because almost all MLTSS members receive ongoing care management and/or service coordination, this creates a cadence of regular opportunities to ensure all demographic data for the member is complete and accurate. As states and MLTSS plans invest to improve demographic questions on Nursing Facility Level of Care (NFLOC) and comprehensive assessment forms and harmonize the data elements stored in information technology systems, care managers and service coordinators can create a trust-based relationship in which LTSS members feel comfortable self-identifying.

Recommendations

Our recommendations include actions that can be taken at the national, state, and health plan level:

National:

- **Align definitions across Federal programs** (e.g., Medicare, Medicaid, Administration on Community Living, SSA, IRS, Census Bureau) to improve consistency and incorporate best practices for how consumers self-identify. We applaud CMS' goal to "expand and standardize the collection and use of data, including on race, ethnicity, preferred language, sexual orientation, gender identity, disability, income, geography, and other factors across CMS programs"³² but look for broader alignment between CMS and other Federal agencies.
- **Add a field in the standardized enrollment transaction report (e.g., the 834 file) for sexual orientation and gender identity data.** To the extent that Medicaid 834 files are an important source of truth for demographic information, there is work to be done to create a space for sexual orientation and gender identity information (which is not currently included) for states who choose to collect it.

States:

- **Improve Medicaid application forms and train consumer-facing staff and partners** to improve data collection during the enrollment and eligibility process. Person-centered practices begin prior to accessing services. Creating an inclusive, welcoming, and conversational environment when assisting in completing Medicaid applications helps build trust and openness to share personal details. Although race and ethnicity remain optional fields during the Medicaid application process, response rates can significantly improve when the question is asked in a clear manner and consumers understand why the information is helpful to improve programs and services. The Health Research and Educational Trust (HRET) Disparities Toolkit available through the American Hospital Association is an NQF-endorsed resource that can be used to guide the collection of race, ethnicity, and language data.³³
- **Collaborate with other state and county programs** to obtain missing demographic data. The COVID-19 pandemic illustrated the value of cross-agency collaboration and data exchange.
- **Improve any state-required needs assessment and screening forms** (e.g., NFLOC, LTSS Comprehensive Assessment) to align with data definitions in other forms and maximize consumer willingness to respond. As an example, Michigan's Medicare-Medicaid Plans (MMPs) will be required to use a new standardized Level I assessment form that includes questions about housing, food security, transportation access, race, ethnicity, and gender identity.

Continues.

Recommendations *Continued.*

MLTSS plans:

- **Improve health plan-developed assessment and screening forms and train all staff who are collecting member data to improve data** collection on an ongoing basis. Care managers, community health workers, member service representatives, and other member-facing staff members can all build trust by asking for this information in an appropriate manner and providing clear options to consumers.
- **Provide comprehensive data back to the state.** Similar to how plans often have more current contact information for members, plans that have more complete demographic data can ensure that it is securely saved and can be provided back to the state.
- **Use health plan data to identify disparities and inform state partners and providers.** One plan discussed future efforts to improve provider-facing reports so that providers can understand disparities within their patient panels.

Theme 2: Equitable MLTSS programs require a diverse network of culturally competent providers and community partners

State and health plan leaders agree that a truly equitable MLTSS program requires plans to go beyond “obvious” partner organizations, whether that means enabling smaller, underrepresented providers to participate, working across and beyond numerous provider associations, and collaborating with local community partners to supplement the formal provider network. As an example, one plan convened a partnership with a disease-focused association and a local cultural organization to improve access to education, screening, and services for an under-served population. In some states, arrangements between states, health plans, and tribes enable American Indian and Alaska Native (AI/AN) individuals with LTSS needs to receive culturally- and linguistically-appropriate care coordination and additional services. MLTSS plans can consider strategies to improve access for under-served groups, such as bolstering understanding of consumer-directed service options, promoting the availability of culturally-tailored day services and meals, expanding peer support opportunities, and collaborating with community organizations to provide care coordination in additional languages not spoken by health plan staff.

A truly equitable MLTSS program requires plans to go beyond “obvious” partner organizations.

In particular, several interviewees noted the need to support small provider businesses that are owned or operated by people who represent the consumer community and have lived experience (e.g., persons who identify with racial/ethnic minorities, persons with disabilities). Minnesota allocated nearly \$25 million in Medicaid HCBS funds from the American Rescue Plan Act (ARPA) to “Supporting the Capacity of Providers Serving Rural and Underserved Communities.” The state notes that its goal is to “increase the number and capacity of providers, so that people who receive services have the opportunity to receive services from providers who may have shared histories, languages, cultures and norms.”³⁴

Several interviewees noted the continued importance of provider training on accessibility, implicit bias, and cultural competency/humility across providers of all sizes and types. Leaders from one state emphasized the importance of including “invisible disabilities” in all required training curricula for health care professionals.

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Case Study: Elevance Health

Elevance Health is building equity into its provider network approach across all provider types and aligning incentives to reward providers who demonstrate a focus on equity. As part of this approach, Elevance Health is offering free training content for continuing education credit, featuring diverse individuals with personal and lived experience from groups that have been historically marginalized leading the training topics (e.g., disability, neurodiversity, LGBTQ+, race, rural). Additionally, Elevance Health is making numerous community investments to advance health equity and diversify the healthcare workforce, such as scholarships for students at Historically Black Colleges and Universities (HBCUs), Hispanic-Serving Institutions (HSIs), and tribal colleges and universities.



Recommendations

- **Where possible, remove administrative barriers for small, underrepresented providers.** State leaders spoke about creative structures for ARPA-funded grant programs that provide flexibility for small providers to participate.
- **Be intentional about provider types to be included in equity-related initiatives.** Where appropriate, ensure that all provider types are reflected (i.e., HCBS providers, not just physical health providers). Provider outreach, education, surveys, and advisory councils should either be fully inclusive of LTSS provider types, or LTSS providers should have dedicated resources.
- **Create space for MLTSS plans to innovate.** In addition to setting network standards, states can use the RFP process to encourage creative provider initiatives and community partnerships. Innovative partnerships to promote equity can be included in questions about population health, care coordination, value-based payment, and quality.
- **Invest in programmatic and physical accessibility.** There is still significant work to make healthcare settings and programs accessible for consumers with all types of disabilities.
- **Measure HCBS access via service fulfillment and consumer experience surveys.** Measuring access and network adequacy in MLTSS is a difficult task even when only focused on the capacity of services to meet functional, physical, and behavioral health needs across a particular geographic area. When layering the need for care to be delivered in an accessible way that is culturally appropriate, it becomes even more difficult to assess network quality. Electronic Visit Verification (EVV) data can be used to provide a near-real-time view of service gaps, and consumer experience surveys such as the National Core Indicators for Aging and Disabilities (NCI-AD™) and the Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services Survey (HCBS CAHPS®) provide another way to ensure that services are actually delivered as intended.

There is still significant work to make healthcare settings and programs accessible for consumers with all types of disabilities.



Theme 3: States can use a variety of existing tools to align MLTSS plan efforts with their equity-related goals

As states define equity-related priorities, they can leverage the health plan RFP process, contract, and quality infrastructure to ensure health plan alignment with those priorities. State leaders interviewed shared that their teams have limited capacity and/or expertise to oversee health plans' day-to-day operations in this realm, so they rely on multiple

States can leverage the health plan RFP process, contract, and quality infrastructure to ensure health plan alignment with those priorities.

structures and external partners (e.g., their External Quality Review Organizations) to align incentives and supplement their oversight of health plan efforts. Several state leaders mentioned requiring plans to obtain the National Committee on Quality Assurance (NCQA) Distinction in Multicultural Health Care or Health Equity Accreditation as a foundation.

Through RFPs, states can position equity as a priority and encourage health plans to exceed requirements and innovate. State leaders also noted that equity can be infused into many existing requirements of

MLTSS plans, such as those pertaining to care coordination, staffing, and quality. The requirement to have a cultural competency plan, for example, can be augmented to address population-specific needs or actions. From a quality perspective, reporting on CMS' HCBS Quality Measure Set will likely take a significant focus in the coming years. As more state measures require stratification by race, ethnicity, and other demographic data points, it helps state and plan leaders to prioritize investments in improving the underlying data.

RFP Process

Several states highlight equity as a primary program goal in recent RFPs, for example:

- **New Mexico Turquoise Care RFP (released in 2022):** "Identify groups that have been historically and intentionally disenfranchised and address health disparities through strategic program changes to enable an equitable chance at living healthy lives."
- **Indiana Managed LTSS RFP (released in 2022):** "Understand, measure, and address health inequities in care and access."
- **Delaware Medicaid Managed Care RFP (released in 2021):** "Member focus: The MCO shall help improve the quality of care and health outcomes for members. This shall include, but not be limited to, providing whole person, person-centered care; engaging with communities; identifying and addressing Health-Related Social Need (HRSN); and advancing Health Equity."

Some states are asking questions about health plans' equity-related experience and initiatives. The most direct example is from a recent Minnesota Family and Children Metro RFP, which asked health plans, "How does your organization address structural racism? What steps have you taken to become an antiracist organization? How do you plan to improve your systems and processes to be more antiracist?"³⁴

Indiana’s Managed LTSS RFP asked about equity from a care coordination and provider network lens, namely:

- Describe how your organization ensures that your provider network delivers culturally competent and culturally sensitive services to meet all members’ needs?
- How will your organization ensure care coordinators and service coordinators render culturally competent and equitable care coordination that includes collaboration with members and caregivers?

Contract Requirements

In the KFF and HMA report on Medicaid priorities³⁵, states reported setting requirements for Medicaid health plans to address health equity, including:

- Having a health equity plan in place
- Health equity reporting requirements
- Staff training on health equity and/or implicit bias
- Seeking beneficiary input or feedback to inform health equity initiatives
- Having a Health Equity Officer
- Achieving NCQA’s Multicultural Health Care (MHC) Distinction

Our research uncovered additional examples of health plan requirements, such as:

- Other required health plan positions that could promote equity such as a Member Advocate/Non-Discrimination Officer for Indiana MLTSS and an Accessibility and Accommodations Compliance Officer for Massachusetts One Care.
- In Arizona, plans must submit a deliverable with a disparity analysis by line of business (acute, Serious Mental Illness (SMI), LTSS).
- In Pennsylvania, Community HealthChoices plans are required to participate in Regional Accountable Health Councils that have a goal to “promote health equity and eliminate health disparities.”³⁶

Quality Infrastructure

Several states are infusing equity into their quality programs and initiatives, whether specific to MLTSS or across the full population. In Michigan’s current ‘three-way’ contract for their Financial Alignment Initiative (FAI), quality improvement is specified as “quality care that enables Enrollees to avoid preventable disease, manage chronic illnesses and disabilities, and maintain or improve health and quality of life, and that addresses the Social Determinants of Health to reduce Health Disparities experienced by different subpopulations of Enrollees and ultimately achieve Health Equity.”³⁷ Significant financial withholds are tied to quality measure performance for dually-eligible consumers

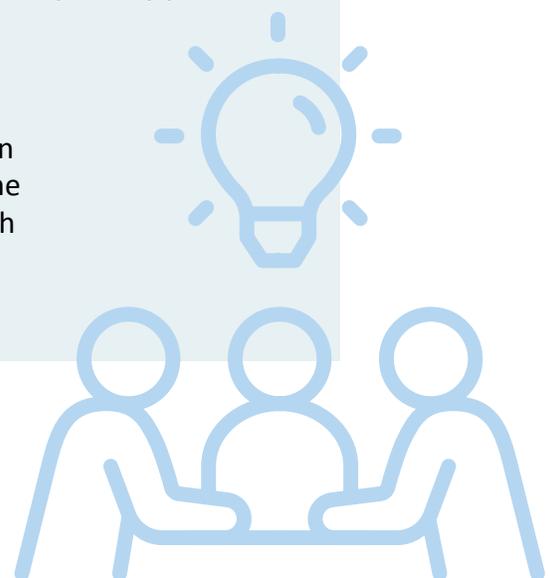
A critical measure of quality is consumer experience, including consumer viewpoints about their quality of life as well as the quality of their health plan, providers, care coordination experience, and medical and LTSS benefits.

across the FAI. Knowing that dually-eligible individuals have a higher prevalence of diabetes, CMS worked with Ohio and South Carolina to develop a quality withhold based on improvements in the percent of enrollees with diabetes who had an A1C lab test that showed their average blood sugar is under control.³⁸

A critical measure of quality is consumer experience, including consumer viewpoints about their quality of life as well as the quality of their health plan, providers, care coordination experience, and medical and LTSS benefits. States that collect consumer survey data most commonly use the NCI tools or HCBS CAHPS, either administered at the state or health plan level. Delaware shared that they are investing in oversampling to segment their NCI-AD survey results data by race, ethnicity, age, language, urbanicity, and sex (gender identity data is not available at this time).

Recommendations

- **States should encourage plan innovation.** Contract requirements, accreditations, and mandatory quality reporting provide a foundation but are not sufficient to achieve equity goals. To the extent that plans bring resources and insights from other states and lines of business, RFPs become an opportunity to demonstrate how requirements will be exceeded. Structures such as cross-plan workgroups, learning collaboratives, and community/regional councils can become forums for ongoing collaboration and innovation. As mentioned, some states are additionally using HCBS ARPA funds to fuel community innovation and improve LTSS provider capacity.
- **Be intentional about requirements and initiatives that are specific to MLTSS.** To the extent that states aspire to advance equity within the MLTSS population, general cross-Medicaid efforts may be inadequate. One interviewee shared that MLTSS efforts may become deprioritized relative to other important equity initiatives, such as those for maternal health. States should specify where there is an MLTSS-specific focus needed within broader efforts and resources at the program level (e.g., cultural competency plan, Health Equity Officer).
- **Make sure incentives are aligned to advance equity.** Continuously monitor available data to ensure that well-intentioned requirements or initiatives don't worsen disparities or create new disparities. As an example, some value-based payment models designed to improve health outcomes have unintentionally excluded providers and consumers from under-served communities.³⁹



Theme 4: To understand inequities, MLTSS plans must authentically engage members through multiple modalities

Virtually all MLTSS and FAI programs include foundational requirements for member engagement and education, such as convening an advisory council, conducting annual member experience surveys, operating member services hotlines, offering materials in accessible formats, and documenting member complaints. The Center for Consumer Engagement in Health Innovation provides an overview of how plans in the FAI have implemented consumer advisory councils, as well as a case study of the Massachusetts One Care Implementation Council.^{40,41} To exceed contract requirements and more deeply engage with consumers, health plan and state leaders note several important success factors:

- 1) **Soliciting feedback from a representative, diverse group of members:** Those who come forward to participate in advisory councils or respond to surveys often do not represent the full diversity of enrolled members in terms of disability types, race, ethnicity, age, sexual orientation, gender identity, and geography. One state, whose advisory council mostly included consumers with physical disabilities, undertook efforts to improve racial diversity and recruit people with mental health conditions, intellectual/developmental disabilities, and older adults.
- 2) **Enabling consumers to fully participate:** Consumers need support in order to offer meaningful input on complex programmatic issues without having a background in health policy. In addition to using plain language and providing disability-related accommodations, plans should provide any background information, educational materials, or training needed for consumers to participate.
- 3) **Offering multiple channels for engagement:** Consumers will have varying preferences for how they engage with their health plan, and they may only feel comfortable expressing their views in certain forums. Several interviewees noted how the pandemic-induced shift to virtual and hybrid meetings has enabled different consumers to participate in advisory council discussions. Other interviewees noted that consumers appeared more willing to express their views in consumer-only meetings.
- 4) **Becoming a consumer-oriented organization:** As health plans increasingly embrace diversity, equity, and inclusion in their organizational structures, processes, and cultures, it can create more forums for understanding consumer experiences. Several health plans also noted how staff with lived experience can build trust-based relationships with consumers and elevate consumer input within the organization.



Case Study: Wisconsin Department of Health Services Division of Medicaid Services

Organizations that serve Medicaid enrollees, like Wisconsin’s Division of Medicaid Services, are taking a critical internal look at their own organization to be better positioned to build equitable programs for consumers. The Division formed a workgroup, revised its mission statement, and is now following the Institute for Health Improvement’s equity framework for Health Care Organizations, beginning with the first component to “Make Health Equity a Strategic Priority for the Health Care Organization.”⁴² Efforts are underway to diversify the Division’s workforce and enhance leadership development opportunities for people of diverse backgrounds.

Case Study: Commonwealth Care Alliance

In addition to consumer advisory councils, Commonwealth Care Alliance (CCA) has invested in several initiatives for members to engage, such as:

- CCA’s Member Voices program, run in conjunction with the Center to Advance Consumer Partnership (CACP), engages members as paid advisors. CCA and CACP maintain a database of several hundred members across diverse demographic groups who are available to provide input on programs and policies.
- CCA is currently partnering with the Robert Wood Johnson Foundation to incorporate an equity lens in member journey mapping, ensuring that the needs of under-represented groups are understood through this process. CCA also includes community-based organizations (CBOs) in the process to better understand their role and how to partner more effectively.
- To improve their member newsletter, CCA created focus groups and conducted interviews in multiple languages to understand communication preferences and interests and provide tailored content for specific ethnic and cultural member groups.
- CCA gathered input from members through multiple channels on a new screening tool to understand members’ SDoH needs. The revised tool will be piloted across a randomly selected group of members by Community Health Workers who are receiving training in emphasizing person-first language and empathetic inquiry.



Recommendations

- **Keep investing in consumer and provider engagement.** Continued state and health plan investment beyond the first years of a new MLTSS program is essential to ensure that diverse voices are amplified, and the current program continues to meet changing needs. Some plans and states provide advisory council members with a small stipend to compensate them for sharing their time, guidance, and expertise. This has helped to elevate the value of the input offered and enable participation among people who could not otherwise afford to give their time.
- **Accept input from multiple stakeholders.** Understanding that feedback should come through many forums and channels, it is important to couple individual experiences with group discussions and program-level data. Trusted community partners may bring insights that consumers cannot share directly with plans and states.
- **Include consumers and providers in the development of equity frameworks and priorities.** Several health plans and states discussed how advisory councils and community stakeholders are actively participating in developing and implementing their organization's equity-related initiatives.
- **Practice self-awareness as an organization.** Processes like journey mapping bring transparency to unintended barriers that health care organizations may have created for consumers which perpetuate disparities.
- **Embed diversity, equity, and inclusion in your organization's culture and processes.** Several interviewees spoke about the value of a diverse workforce with lived experience, with staff at all levels who reflect the member population. Illinois is currently seeking a minority-led health plan to participate in the FAI, which will have a representation of Black or Hispanic staff members that is 50% or greater and create new jobs and spur economic activity in marginalized minority communities.⁴³



Theme 5: Person-centered planning can advance equity by addressing barriers at the individual consumer level

To the extent that equity can be addressed at an individual consumer level, person-centered planning, when done well, provides a framework for identifying and addressing MLTSS consumers' individual needs and self-identified goals and ensuring services are provided in a culturally- and linguistically-reflective manner. As defined by the National Quality Forum's (NQF) Committee on Person-Centered Planning and Practice,

“Person-centered planning is a facilitated, individual-directed, positive approach to the planning and coordination of a person's services and supports based on individual aspirations, needs, preferences, and values.”⁴⁴

Consistent with the 2014 HCBS Final Rule, all Medicaid-funded waiver services, inclusive of services delivered through managed care, are documented in a written person-centered service plan based on a person-centered approach, which “reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.”⁴⁵

Considerations for the Planning Process

NQF's Core Competencies for Person-Centered Planning Facilitation include having knowledge of cultural perspective, ableism and ageism, and community assets and resources.⁴⁶ Similarly, NCAPPS' Five Competency Domains for Staff Who Facilitate Person-Centered Planning includes a domain on “Strengths-Based, Culturally Informed, Whole Person-Focused.” The domain's description emphasizes the importance of learning about a consumer's cultural and linguistic preferences and experiences of trauma (personal or historical) as part of the person-centered approach. Additionally, facilitators are expected to demonstrate self-awareness and cultural humility, including being cognizant of one's own privilege and cultural assumptions.⁴⁷

States often include numerous contractual requirements for MLTSS health plans regarding how person-centered planning should be administered, including required skills and trainings for care managers. MLTSS plans have made significant investments in person-centered planning training programs and certifications, such as through The Learning Community for Person-Centered Practices. Additionally, MLTSS plans offer training to care management teams on cultural competency and humility. One state shared that they are working to enhance cultural competency training for care coordination staff to include all disability types (mental health, etc.) and highlight the barriers consumers may face based not just on their disability but also based on their race, ethnicity, language, sexual orientation and/or gender identity.



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Considerations for Service Delivery

As MLTSS plans provide person-centered care coordination (either directly or through partner organizations), it is an opportunity to ensure that members understand the options of settings in which they can choose to live and the available services in each setting. The service plan should address preferences for how people would like to receive their services, including specifications such as receiving services from a personal attendant who speaks their native language and/or respects their sexual orientation or receiving home-delivered meals that reflect their ethnic background. It's important to note that workforce shortages and geographic barriers can limit service options. For example, three states noted how the lack of assisted living facilities in particular counties significantly limits access to that service for some racial and ethnic groups. MLTSS plans can potentially partner with providers to expand their service areas or offerings. In addition, MLTSS plans have the flexibility to offer value-added services that could help create more options to meet individual needs and preferences.

Recommendations

- **Create processes to identify common needs.** Although person-centered planning is a highly individualized process, patterns in individual barriers, when combined with population-level data, can help to address broader issues. For example, if multiple consumers from the same ethnic group are having trouble finding service providers, a broader solution may be needed.
- **Administer consumer experience surveys** to ensure that person-centered processes and services are meeting consumer needs and preferences.
- **Continually assess capacity of provider network.** States and plans have noted that lack of culturally diverse providers can limit their ability to deliver person-centered services.

Conclusion

Our interviews with state and MLTSS plan leaders substantiated that equity is a top priority, and that significant work remains in the years ahead. MLTSS plans can support states in achieving their equity goals by bringing flexibility, expertise, resources, and lessons learned from other products and states. Focused efforts on data, partnerships, program structure, consumer engagement, and person-centered planning are helping to move in the right direction. Additionally, states and MLTSS health plans are working internally to infuse diversity, equity, and inclusion in the way their organizations operate and administer consumer-facing programs.

More research and specificity is needed to leverage solutions that are moving the needle in the broader Medicaid population and adapt them to support the diversity of individuals who need LTSS. Additional investments, such as those made through state HCBS ARPA spending plans and the Administration on Community Living's recent grant awards,⁴⁸ will fuel continued progress.



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Notes



Notes





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