

October 2, 2026

RE: Health Coverage That Works For Everyone: Request for Information (RFI)

Dear Senator Ron Wyden, Ranking Member Senate Finance Committee,

The National MLTSS Health Plan Association (MLTSS Association) appreciates the opportunity to respond to the Request for Information (RFI) released by the Senate Finance Committee Democratic members on Health Coverage That Works For Everyone.

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and assume risk for long-term services and supports (LTSS) provided under Medicaid.¹ Our member plans assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service (FFS) system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible.

MLTSS Association members are also leaders in integrated care — a system that aligns the delivery, payment, and administration of Medicare and Medicaid benefits for individuals who are dually eligible for both programs. There is significant overlap between MLTSS and people who are dually eligible — over 60% of individuals who use Medicaid-funded LTSS are dually eligible, and this proportion grows to 95% of Medicaid-funded LTSS users over age 65.²

We welcome the opportunity to work with members of Congress to improve our healthcare system, especially for Americans who utilize LTSS. We have provided answers to specific questions from the RFI below.

Section 1

Modernizing eligibility verification and enrollment processes

The MLTSS Association is proud to represent health plans that are leaders in providing essential LTSS to millions of Americans nationwide. Many of our members also serve these individuals through Dual Eligible Special Needs Plans (D-SNPs). D-SNPs provide enhanced care coordination, comprehensive supplemental benefits, and wraparound services, including LTSS and Behavioral Health. To enroll in a D-SNP, an individual must be eligible for Medicare as well as eligible to receive Medicaid benefits in their state.

As part of the Working Families Tax Cut Act of 2025, there was a 10-year implementation moratorium placed on significant parts of the Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment Final Rule³ and the Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and

¹ Members include Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Highmark, Humana, Lakeland Care, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, UPMC Community Health Choices.

² [Who Uses Medicaid Long-Term Services and Supports? | KFF](#)

³ [Federal Register: Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment](#)

Renewal Processes Final Rule⁴ - known together as the Eligibility and Enrollment Final Rule. These rules were intended to reduce complexity in Medicaid eligibility and determination processes, especially for individuals with disabilities and older adults.⁵

Many of the provisions in these two rules align with the Administration's focus on reducing fraud, waste, and abuse within Federal programs. For example, these rules would have required states to use existing data to determine an individual's eligibility for Medicare Savings Programs (MSPs). This is accomplished through mechanisms such as automatically enrolling most Supplemental Security Income (SSI) recipients into the Qualified Medicare Beneficiary (QMB) program, the most comprehensive MSP, and using Medicare Part D low-income subsidy (LIS) program data to enroll people with LIS into MSPs. CMS estimated that these two provisions would have increased dually eligible individuals' enrollment in the Medicare Savings Programs by nearly 1 million person-years.⁶

The Enrollment and Eligibility rule also aligned the application and renewal policies for people who qualify for Medicaid on the basis of age or disability with those for people who qualify for Medicaid based on their income. Without this rule, people with disabilities and older adults face significant barriers to Medicaid enrollment that are not imposed on other populations. For example, currently, states are permitted to require individuals who qualify for Medicaid on the basis of age or disability to apply for and renew their Medicaid coverage in-person – an unnecessary and disproportionate requirement that places barriers to care onto an already vulnerable population. Reducing the red tape associated with the Medicaid and MSP enrollment and eligibility processes would have allowed state and Federal programs to be better stewards of taxpayer dollars while also ensuring that dually eligible individuals have access to these vital programs.

According to the Congressional Budget Office (CBO), rescinding the Eligibility and Enrollment rule will cause 2.3 million Americans to lose their Medicaid coverage, 60% of whom are dually eligible individuals.⁷ These individuals will remain eligible for Medicaid, but will lose coverage due to complex and outdated enrollment and eligibility processes.

For dually eligible individuals, losing Medicaid coverage will be particularly devastating. Without Medicaid, dually eligible individuals will lose access to Home and Community-Based Services (HCBS), ultimately leading to poorer health outcomes, higher medical costs, and increased admissions to hospitals and nursing homes.⁸ As the primary payer in the United States for home-based care, Medicaid enables Medicare enrollees to age in their homes and remain in their communities. Medicaid is also the primary payer for over 60% of nursing home residents, and in some states — including Alaska, Georgia, Louisiana, Mississippi, and West Virginia — more than 70% of nursing home residents rely on Medicaid.⁹ For dually eligible individuals, Medicaid covers essential services that Medicare may not – including

⁴ [Federal Register: Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes](#)

⁵ [Rescinding the Eligibility and Enrollment Rule Would Thwart Efforts to Improve Efficiency in Medicaid and Efforts to Reduce Improper Payments | Georgetown University Center for Children and Families](#)

⁶ [What Does the Medicaid Eligibility Rule Mean for Low-Income Medicare Beneficiaries and the Medicare Savings Programs \(MSPs\)? | KFF](#)

⁷ [Estimates for Medicaid Policy Options and State Responses | Congressional Budget Office](#)

⁸ [Impact of HCBS on Nursing Home use and Impact of HCBS | LeadingAge LTSS Center UMass Boston](#)

⁹ [A Cut to Medicaid is a Cut to Medicare | Justice in Aging](#)

transportation to medical appointments, medical equipment, and dental, vision, and hearing coverage - as well as helping to pay for Medicare premiums, coinsurance, and copays.¹⁰ Medicaid also provides coverage for behavioral health services, which are incredibly important - as 64% of full benefit dually eligible individuals have a behavioral health diagnosis, compared to 40% of individuals who are only eligible for Medicare.¹¹ Overall, Medicaid saves Medicare dollars by filling in gaps in coverage and affordability for dually eligible individuals, helping to prevent hospitalizations and poor health outcomes for these individuals.

We urge Congressional leadership to lift the moratorium on implementation of these two Enrollment and Eligibility rules to reduce administrative complexity and ensure that eligible Americans are able to maintain their Medicaid coverage.

Section 2

Ensuring access to broad networks of high-quality providers for all consumers

In 2021, the MLTSS Association released our [Framework for Enhancing Access and Advancing Quality in HCBS Provision in MLTSS](#) which outlines our vision for network adequacy in LTSS that is based on quality. Getting network adequacy right in managed HCBS requires a lot more than simply counting the number of providers by service type in an area. Placing a combined focus on quality metrics and access to supports is imperative to building a first-class, high quality HCBS provider network. Focusing solely on the number of providers by service type in a geographic area drives the need to grow the number of providers but does not necessarily lead to a network of highly-qualified providers.

Focusing just on how many providers plans have in their network can ultimately lead to a fragmented, and fragile, network fighting over the same resources without a clear vision of what the priority in service delivery and outcomes should be. Additional providers do not necessarily increase the adequacy rate for direct care workers (DCWs). If the goal is to develop as many high-performing agencies with skilled and competent DCWs as possible, then evaluating, building, and improving the capacity of provider agencies and tying capacity building efforts to quality in the delivery of services in alignment with the best available evidence and desired outcomes of each HCBS recipient outlined through person-centered planning is imperative. We believe that Congress should ensure that network adequacy standards account for the distinctive characteristics of LTSS and HCBS, including provider capacity, workforce availability, quality, member choice, continuity, geography and the availability of alternative service models.

We also understand that network adequacy in LTSS is different than for traditional Medicaid providers as we are experiencing a prolonged and growing shortage of DSPs and DCWs nationwide. In order to provide LTSS recipients with robust networks of available providers, there must be DCWs to meet that need.

¹⁰ [A Cut to Medicaid is a Cut to Medicare | Justice in Aging](#)

¹¹ [A Profile of Medicare Medicaid Dual Beneficiaries | ATI Advisory](#)

In 2023, the MLTSS Association released our report on [Strengthening the Direct Care Workforce: A Framework for Leveraging the Role of MLTSS MCOs to Address the Workforce Crisis](#). This report outlines our recommendations for stakeholders, including CMS and Federal policymakers, to support and grow this critical workforce. Some of our recommendations include:

- Congress should require or incentivize states to develop bidirectional data repositories on workforce that is used by the state, MCOs, and providers to input, process, report on, and monitor trends related to the workforce.
- Congress should direct MACPAC to conduct a study to compile definitions of DCWs across states to inform future revisions to federal SOC codes.
- Congress should enact federal legislation similar in scope to the *Workforce Innovation and Opportunities Act*, directing States to build a cross-agency Unified State Plans to advance Technology, with technical and support provided by the appropriate Federal agencies.
- Congress should direct CMS to distribute guidance that includes a list of high value Appendix K flexibilities, by category, that states can adopt permanently.
- Congress should direct CMS to encourage the development of flexible HCBS network adequacy requirements that allow for the use of technology.

We urge Congressional leadership to consider these recommendations as a path towards a more sustainable LTSS and HCBS workforce.

The MLTSS Association values the role that technology serves in supporting the delivery of LTSS. In 2026, we released a report on [Unlocking the Value of Enabling Technology in Managed LTSS](#), outlining our recommendations for the use of Enabling Technology within MLTSS. We believe that when incorporated thoughtfully into MLTSS programs, enabling technologies can alleviate the impact of direct care workforce shortages, facilitate members' independence and engagement in their communities, and improve health and quality of life outcomes. We urge Congress to consider the use of technology to support individuals with LTSS needs when considering reforms to expand individuals' access to care and services.

Quantifying administrative burden

MLTSS health plans coordinate and manage the full continuum of HCBS for their members, bringing private sector innovation and accountability to the care and support of Medicaid beneficiaries. Unlike fee-for-service (FFS) systems, MLTSS health plans maintain an ongoing, holistic relationship with each member, creating the foundation for improved engagement and quality care. Our members perform key roles to ensure that members receive the right care at the right time, including:

- Care Assessment & Person-Centered Planning
- Provider Network Management
- Collaborative Partnerships
- Ongoing Care Coordination
- Utilization Management

Within MLTSS, utilization management is done to review HCBS service requests against clinical criteria and individual need assessments, ensuring that only appropriate, medically necessary services are approved and that service plans reflect each member's specific needs. This service ensures that individuals are receiving care that aligns with their person-centered care plan and supports their needs and goals. Because HCBS are delivered in homes and communities, Medicaid MCO care managers play a critical front-line integrity role by comparing assessed need, authorized hours, and actual service delivery. Routine member outreach, reassessments, and reviews of person-centered service plans can help identify red flags such as services that do not match functional need, duplicate supports, or claims for care that members or caregivers report did not occur.

These utilization management activities are an important component of program integrity. MLTSS plans invest substantially in fraud, waste, and abuse (FWA) detection and prevention through both upstream controls and layered detection models – including credentialing and provider enrollment validation, person-centered planning processes, and authorization guardrails, which work to prevent FWA before it occurs. These efforts are further reinforced by layered FWA detection models that incorporate real-time monitoring, pre-payment review, and post-payment analytics, including Electronic Visit Verification (EVV).

We recognize the importance of ensuring that program integrity requirements do not complicate service delivery or create barriers to access and support efforts to streamline unnecessary administrative requirements while preserving appropriate oversight, accountability, and program-integrity protections. The MLTSS Association has put forth [recommendations we believe will support program integrity within Medicaid HCBS](#) as well as [brief highlighting the critical work Medicaid MCOs and MLTSS health plans play in safeguarding HCBS](#).

Conclusion

The National MLTSS Health Plan Association appreciates the Committee's consideration of our recommendations and welcomes the opportunity to work with Congress to advance policies to promote access to high-quality, person-centered LTSS, while reducing unnecessary administrative burden for millions of Americans who receive LTSS. If you have any questions, please contact me at mkaschak@mltss.org.

Sincerely,



Mary Kaschak
Chief Executive Officer