PARTNERSHIP FOR MEDICAID HOME-BASED CARE

September 21, 2022

The Honorable Cathy McMorris Rodgers
Republican Leader
Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Leader Rodgers:

The Partnership for Medicaid Home-Based Care (PMHC) appreciates the opportunity to comment on the request for information (RFI) for "Disability Policies in the 21st Century: Building Opportunities for Work and Inclusion." We are tremendously grateful for the advancements that you have made to home and community-based services (HCBS) and your astute personal knowledge of the services that has propelled significant policy for the program.

The COVID-19 pandemic has illustrated the benefit of Medicaid home-based care, which supports an individual with activities of daily living (ADLs) such as bathing and dressing to enable a person to live independently and safely at home and not in institutional care. Congress must keep in mind the lessons that have been learned to inform the longer-term vision for how care is delivered to Medicaid beneficiaries in a quality-focused and fiscally responsible manner. In particular, the pandemic has shown the value of enabling individuals to remain in their home with the support of home care rather than in institutional settings, at a cost per person of less than half of nursing facility care and a setting safer from infection risk. Providing supports to people to enable them to remain in their homes is the overwhelming preference of individuals and their families and is the most beneficial publicly-funded option.

PMHC was established in 2015 to advance the delivery of high quality, cost-effective Medicaid home-based care and services. Our membership is comprised of providers, associations, managed care organizations, and technology solutions companies dedicated to improving the quality and integrity of cost-effective Medicaid HCBS. Home care workers, also known as direct support professionals or caregivers, provide essential care and supports to the most vulnerable populations, including seniors, individuals with disabilities, and medically complex children, to help them with activities of daily living so they can remain in their homes. PMHC member companies employ approximately 300,000 direct care workers throughout the country.

PMHC's comments focus on a bold vision for transformative change in the long-term services and supports (LTSS) delivery system. To truly reform LTSS in Medicaid to ensure enrollee access and program sustainability, policymakers must make significant changes to current law and invest in Medicaid HCBS. Our recommendations would achieve improved quality outcomes, deliver a return on investment, and elevate the position and services provided by the homecare workforce. PMHC offers the following recommendations to improve Medicaid HCBS:

- Establish HCBS as a mandatory Medicaid benefit and provide sufficient funding to ensure enrollees have access to HCBS;

- Incentivize presumptive eligibility for HCBS;
- Better align Medicare and Medicaid for dual eligible beneficiaries who receive long-term services and supports (LTSS) to generate savings to Medicare;
- Address disincentives for home care providers to offer services through other federal programs, such as veterans' medical benefits;
- Require the Centers for Medicare and Medicaid Services (CMS) to create a uniform methodology for states to establish their HCBS waiting lists;
- Require states to regularly update their waiting list data and report the data to CMS;
- Modernize functional eligibility assessments;
- Encourage CMS to finalize its proposal to modify medically needy regulations;
- Establish a federal standard for HCBS private duty nursing (PDN) and address the lack of portability of benefits for medically complex children;
- Avoid overreliance on unpaid family caregivers to build capacity for provision of HCBS;
- Provide incentives and supports for training and other efforts designed to provide a career path for personal care attendants; and
- Issue guidance on consistent application of State Nurse Practice Acts around delegation of tasks and training requirements.

I. Medicaid's Institutional Bias (RFI Section 1.1)

As the report describes, the institutional bias in Medicaid is the direct result of Congress entitling eligible enrollees to nursing home care at the program's inception. Not until decades later did Congress give states the option of covering LTSS in a community-setting rather than in an institution. This model made sense in 1965, when "rest homes" were often the only option for people as they aged. Today, however, numerous community-based options offering high quality and low-cost care are readily available. PMHC recommends that Medicaid rules be modernized to encourage utilization of HCBS. Such reform would reduce reliance on costlier settings of care, decrease health care expenditures, and satisfy consumers' strong preference to remain in their own homes.

To eliminate the institutional bias, Congress must establish HCBS as a mandatory Medicaid benefit and provide sufficient funding to ensure enrollees have access to HCBS. If policymakers seek to simply reduce bias and not eliminate it, Congress should incentivize presumptive eligibility for HCBS. PMHC recognizes that policymakers have expressed concerns about the cost of making HCBS a mandatory benefit and incentivizing presumptive eligibility. Congress should better align Medicare and Medicaid for dual eligible beneficiaries who require LTSS to generate savings to Medicare, which could partially offset the cost of funding HCBS as a mandatory benefit and presumptive eligibility. While these changes are unlikely to be budget neutral, Congress could expect a healthy return on investment.

A. Incentivizing Presumptive Eligibility for HCBS

PMHC urges the adoption of Medicaid placement rules that allow new applicants for HCBS LTSS be screened to determine their suitability for home-based care first, rather than institutional placement. Subject to consumer choice, this policy would enable all Medicaid consumers to be offered home-based care if they qualify for and desire such placement. Specifically, **PMHC recommends that Congress authorize the Centers for Medicare and Medicaid Services (CMS) to provide states with additional flexibility and appropriate matching funds to enable wider use among states of presumptive eligibility, so that states bear less of the risk.**

Determining individuals' eligibility for Medicaid home and community based services (HCBS) can be lengthy and complex. As a result, individuals who could be effectively served in their own home at a much lower cost may instead have to wait for weeks to months before being able to obtain home-based care. This leads to poor outcomes, including: institutional placement due to immediate need for services; higher Medicaid costs due to emergency room visits and hospitalizations; a heightened risk of clinical complications; and a greater burden to family caregivers.

To simplify and streamline the process to support people with disabilities and others in need of HCBS, several states have adopted presumptive eligibility determination programs, which have resulted in: shorter waiting periods for the initiation of home-based care; a reduction in institutional patient populations; and lower costs for states and the federal government; and earlier provision of support for family caregivers. Due to these significant benefits, presumptive eligibility has earned the support of a wide range of stakeholders including AARP.[1]

Currently, states bear all the financial risk if someone presumptively determined eligible does not ultimately enroll in Medicaid. Use of presumptive eligibility is more common in institutional placement like nursing homes and skilled nursing facilities (SNF) than in HCBS, which results in more individuals electing institutional long-term care than HCBS simply due to a lack of options. The Connecticut Association of Area Agencies on Aging estimated in 2013 that the state could save $6,033 per month for every client deemed presumptively eligible for HCBS rather than paying for institutional care. The Connecticut Home Care Program explores Medicaid eligibility for approximately 2,157 clients annually. The estimate also showed preventing premature institutional care for one month and for 25 percent of the 2,157 applicants could save the state $3,251,787.[2] Similar results have been achieved in Washington, Colorado, Kansas, and Ohio. These examples demonstrate that presumptive eligibility could offer states tremendous cost savings, and is the right thing to do for Medicaid clients.

PMHC recommends that CMS provide states with the additional flexibility of matching funds to promote the use of presumptive eligibility for HCBS applicants, so that states are not required to bear the entirety of the financial risk. Given the success of current programs, such policy action would inevitably promote efficiency and savings in the Medicaid program. To incentivize states to initiate presumptive eligibility for HCBS, states should initially be provided funding up to the

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[1] AARP Public Policy Institute, Presumptive Eligibility for Medicaid Home and Community-Based Services Can Expand Consumer Options, April 2021.

[2] Connecticut Association of Area Agencies on Aging, Legislative Testimony, Aging Committee, February 26, 2013, https://www.cga.ct.gov/2013/AGEdata/Tmy/2013HB-06396-R000226-Marie%20Allen%20CT%20Association%20of%20Area%20Agencies%20on%20Aging-TMY.PDF.

full cost of services for someone who ends up not meeting eligibility. After an initial implementation period, the Medicaid program could scale the federal share based on a state's presumed eligibility success rate. States could, for example, receive 100 percent federal funding for their presumptive eligibility services if states maintain a 0-2 percent ineligible rate, lower share if the rate is 2-4 percent and so on. Presumptive eligibility is a more efficient and streamlined policy to advance Medicaid HCBS. However, if states feel overburdened by this undertaking, they may lean on the more expensive option of institutional offerings and then rely on Medicaid funding to transition the individual to community supports once eligibility is determined.

PMHC's recommendation for presumptive eligibility for HCBS is different than how presumptive eligibility works for beneficiaries receiving other Medicaid services. Many more states offer presumptive eligibility to beneficiaries for long term care institutional placement compared to home and community based long term care largely due to states' ability to shift some or all their financial risk to the provider if an individual is deemed ineligible for Medicaid after the presumption of eligibility is made. Due to the congregate nature of institutional long term care, those providers can more easily afford the associated financial risks as an empty bed draws no revenue. Home and community-based care providers generally serve clients on a one-to-one basis and, therefore, cannot afford to assume the financial risks of presumptive eligibility. Given the differences between HCBS services and institutional care, the federal government should support states to equalize the presumption of Medicaid eligibility.

B. Aligning Medicaid and Medicare Programs for Dual Eligible Populations

Long-term care services provided in the home and community have afforded significant savings to state general funds and the Medicaid and Medicare programs for decades through diversion from institutional-based long-term care supports and services. What is less frequently studied, but is widely accepted, is that HCBS plays an integral role in reducing emergency room utilization, hospitalizations, hospital length of stay, and other profound positive impacts on the health and well-being of individuals receiving HCBS.

For the dually eligible population enrolled in both Medicare and Medicaid, HCBS services provided under Medicaid generate savings to the Medicare program. However, the vast majority of state HCBS programs as currently structured provide no incentives to state Medicaid agencies to make investments in HCBS that drive better health outcomes to achieve savings within the Medicare program because the states do not derive any benefit from the savings. In one state, Washington, the Financial Alignment Incentive demonstration program reduced Medicare expenditures by $293 million.[3]

Creating alignment between the Medicaid and Medicare programs for health and social model care for the dual eligible population would achieve the following benefits: (1) provide greater incentive to states to defer HCBS recipients from institutional settings; (2) eliminate state funding barriers to HCBS reimbursement rates to support increasing wages and benefits attract more individuals to

[3] Center for Medicare and Medicaid Innovation, Report for Washington Managed Fee-for-Service (MFFS) Final Demonstration Year 5 and Preliminary Demonstration Year 6 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative, Fall 2021, https://innovation.cms.gov/data-and-reports/2021/fai-wash-dy6-actuarialreport.

the home care industry; (3) allow the federal government to create uniform national standards for HCBS; and (4) allow the federal government to develop value-based initiatives to incentivize and require improved integration of HCBS LTSS into the health care delivery system. Medicare program savings would be achieved through reduced utilization of emergency department visits and hospital admissions and improved health outcomes among poly-chronic beneficiaries receiving long-term care.

The home care workforce is integral to helping individuals receiving HCBS retain their independence in their own homes. Home care aides and other personal care professionals deserve compensation that reflects the tremendous human, clinical, and fiscal value of the care they provide every day. At present, however, inadequate Medicaid rates prevent these professionals from receiving compensation commensurate with the value they produce for our nation. The occupation's 2020 median wage reimbursement set by states is currently $13.02 per hour, reflecting an annual salary of $27,080 according to the latest figures from the Bureau of Labor Statistics.[4]

Research has demonstrated that in addition to low wages and no benefits, a lack of recognition and inclusion in overall patient care is as much a barrier for individuals entering the home care field, and a leading cause of turnover among the existing workforce. The lack of alignment and integration of care between Medicaid and Medicare services is a main contributor to this result. Paul Osterman's extensive research[5] concludes that by expanding the participation and role of the direct care professionals in the integration of services and coordinated care to dual eligible individuals receiving HCBS will result in reduced utilization of acute care services. This in turn will reduce Medicare program expenditures. The Medicare program savings can then be redirected into improving HCBS workforce wages, benefits, and training, which results in beneficiary health improvements and savings to the Medicare program.

Without an alignment between the Medicaid and Medicare payment siloes for HCBS recipients, progress will be challenging, if not impossible. **PMHC recommends that Congress require the Center for Medicare and Medicaid Innovation (CMMI) to undertake a demonstration to test an enhanced 100 percent FMAP for HCBS and expanded role of HCBS direct care workers for the dual eligible population to evaluate the reductions in Medicare expenditures.** This 100 percent FMAP for HCBS should be used to support a wage for the HCBS workforce that is competitive in the market – never less than 2x the Federal minimum wage – and includes annual cost of living adjustments, to ensure an adequate direct care workforce.

C. Ensuring Access to HCBS Benefits Offered in Other Federal Programs

Waiting lists should not be prioritized for certain classes of beneficiaries. However, Congress should work to ensure that other federal programs, including benefits administered through the Department of Veterans Affairs (VA), have a sufficient capacity to provide access to these services. The VA reimburses home care providers wildly different rates based on the state where

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[4] U.S. Bureau of Labor Statistics, Occupational Outlook Handbook, Home Health and Personal Care Aides Summary, https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm.

[5] Osterman, P. (2017). Who Will Care For Us? Long-Term Care and the Long-Term Workforce: Long-Term Care and the Long-Term Workforce. New York: Russell Sage Foundation. doi:10.7758/9781610448673

the service is provided, maintains different standards for home care providers based on whether the provider is contracting with a third-party or directly with a VA medical center or a Veterans Integrated Services Network (VISN), and fails to ensure third parties reimburse providers in a timely manner. **These challenges create a disincentive for home care providers to offer services to veterans and should be addressed to ensure those who served our nation have access to the HCBS they need.**

D. Establishing a Waiting List Methodology and Reporting Requirement

The Medicaid and CHIP Payment and Access Commission (MACPAC) and Kaiser Family Foundation have documented that HCBS waiver waiting lists do not provide a complete picture regarding the need among Medicaid enrollees for services nor can data be compared across states because each state manages and reports data about its waiting list differently.[6] In the experience of PMHC's membership, waiting list data are generally generated by self-reported surveys conducted by states. However, some states do not respond to these surveys and data are not usually current. Individuals on waiting lists may have obtained care in institutions or are no longer eligible for LTSS. Ultimately, waiting lists that are referenced frequently at the federal level, have not actually provided fully accurate portrayals of the entire need for HCBS in states, but only a glimpse that there are beneficiaries who are not receiving services.

One area that needs to be looked at more for waiting lists involved dual eligible. The majority of HCBS recipients are dual eligible. Very little recent research exists that documents the increased cost of physical health needs resulting from individuals that are on waiting lists but clearly have LTC needs that impact their physical health. CMS should commission a study of these costs among a waitlisted population.

In order for waiting lists to be an effective measure of HCBS at the federal level where it is funded, Congress should require CMS to create a uniform methodology for states to establish their HCBS waiting lists. Congress should also require states to regularly update their waiting list data and report the data to CMS. Establishing criteria for states' waiting lists will ensure that policymakers can make comparisons across states and use the waiting list data to inform potential policy changes.

II. Ensuring Medicaid Beneficiaries Better Utilize Existing Eligibility Pathways (RFI Section 1.3)

Existing Medicaid eligibility and enrollment pathways for HCBS can be improved to ensure access to cost-effective LTSS. **Policymakers should modernize functional eligibility assessments, encourage CMS to finalize its proposal to modify medically needy regulations, and establish**

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[6] Medicaid and CHIP Access and Payment Commission, Issue Brief: State Management of Home- and Community-Based Services Waiver Waiting Lists, August 2020, https://www.macpac.gov/wp-content/uploads/2020/08/State-Management-of-Home-and-Community-Based-Services-Waiver-Waiting-Lists.pdf and Musumeci, MaryBeth, Key Questions About Medicaid Home and Community-Based Services Waiver Waiting Lists, April 4, 2019, https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-home-and-community-based-services-waiver-waiting-lists/.

a federal standard for HCBS private duty nursing (PDN) and address the lack of portability of benefits for medically complex children.

A. Modernizing Functional Eligibility Assessments

An increasing number of seniors have dementia and other cognitive disabilities but are able to manage functional tasks with supervision and cueing to stay safe at home. Current Medicaid eligibility rules, however, place greater focus on whether individuals require assistance to meet their functional needs than on their cognitive needs. As a result, many individuals with dementia and other cognitive disabilities to be found ineligible for Medicaid services. **Functional eligibility assessments should be modernized to account for cognitive disabilities such as dementia.**

B. Encouraging CMS to Finalize Proposal to Modify Medically Needy Regulations

Current rules regarding income eligibility for medically needy allow individuals receiving institutional care to deduct projected medical care expenses from their income, but do not provide the same deduction from an individuals' income for the care the person receives care in the community. CMS issued a proposed rule[7] on August 31, 2022, aimed at eliminating the institutional bias in the medically needy regulations. **PMHC supports the Agency's proposal to allow states to project additional services, such as home care, in an individual's eligibility determination. Spenddown rules should be the same regardless of where care is delivered.** CMS acknowledges that this policy would reduce administrative costs associated with enrolling and disenrolling individuals and improve health outcomes for individuals due to continuity of care.

C. Establishing a Federal Standard for HCBS Private Duty Nursing

Additionally, widespread misperceptions and lack of understanding of HCBS PDN services exist, which have resulted in a burdensome maze of programs for families to navigate in order to obtain the benefits their children are entitled to receive. HCBS PDN is often thought of, and confused with, privately paid services, services provided by personal care aides, or custodial non-medical care. The lack of a clear federal definition for PDN services does not reflect the enhanced level of care delivery provided in home and community-based settings. Further, the lack of a clear federal definition for Medicaid HCBS PDN services has resulted in limitations in access to care. **PMHC strongly supports a federal standard for the delivery of HCBS skilled nursing services to individuals with complex medical conditions and urges Congress to grant HHS the administrative authority to develop, with the input of key stakeholder groups, a national core set of quality measures specific to this population to ensure provider accountability. Policymakers should also consider the lack of portability of benefits, especially among individuals receiving PDN care. Children and their families should not be forced to move to another state simply to receive home and community-based medically complex nursing care.**

III. Building Upon Existing Infrastructure to Support Caregivers (RFI Section 1.5)

[7] 87 FR 54760

Access to Medicaid HCBS can only be ensured through a robust direct care workforce. Medicaid reimbursement rates constrain wages and the ability of home care agencies to provide training that could establish a clear career path for workers as well as lead to improved outcomes among clients. Congress must make a sustained, increased investment in Medicaid HCBS.

A. Avoiding an Overreliance on Unpaid Family Caregivers

Policymakers should avoid overreliance on unpaid family caregivers to build capacity for provision of HCBS. Although respite care is important, especially to unpaid family caregivers, this short-term relief does not address the underlying challenges of access to Medicaid HCBS benefits and the direct care workforce shortage.

In many states respite care is inappropriately utilized and authorized. It is not uncommon for states to authorize a care plan that for example includes 2 hours of personal care and 1 hour of respite care. In almost all cases respite care has a lower rate of reimbursement than personal care and in some cases an egregiously lower rate. In these instances, it is being used to lower the overall cost of the care plan by shifting personal care services to a lower reimbursed service type. Not only is this an improper use of respite care but it confuses beneficiaries and even case managers on the proper definition of respite care. Respite care should never be authorized if there is not an unpaid caregiver providing most of the care for any older adult or person with a disability and should also never be authorized in conjunction with personal care services to be delivered within the same daily appointment for care.

At a time when the entire health care industry is facing a workforce shortage unlike ever before, an adequate investment must be made in HCBS to ensure a sustainable workforce into the future. **An incremental step is to require the CMMI demonstration described earlier to test an enhanced 100 percent FMAP for HCBS for the dual eligible population in which the additional federal funding is used to increase the wages of direct care workers.**

PMHC applauds the spirit of legislative efforts, such as the Latonya Reeves Freedom Act of 2022 (H.R. 6860 / S. 3417), to protect the rights of individuals with disabilities to receive home- or community-based LTSS; however, access to HCBS will remain a challenge without a sustained federal investment to expand and support the direct care workforce.

B. Providing Additional Resources for Caregiver Training

The quality and stability of the direct care workforce is critical to the stability of the Medicaid long term services and supports program, as well as the cost effectiveness of home-based care. **CMS could provide incentives and supports for training and other efforts designed to provide a career path for personal care attendants.** Currently, Medicaid does not provide reimbursement for training direct care workers that improves their ability to recognize changes in the health of their clients. These skills could generate savings and improve health outcomes. Instead, direct care workers are subject to training mandates that have little value to them or the individuals they serve. It should be noted as well that with high turnover in the direct workforce, providers must

continuously train and retrain as they fill positions and so it is essential that the training requirements are thoughtfully applicable and necessary to the service being rendered.

CMS should provide guidance on consistent application of State Nurse Practice Acts around delegation of tasks and training requirements. Specifically, some states allow while others do not the delegation of medication administration. Many states that allow this do not allow it for all provider types and states are inconsistent in their training requirements. There should be a consistent and level playing field.

IV. Conclusion

On behalf of the Partnership for Medicaid Home-Based Care, please accept our thanks for this opportunity to provide a response to the RFI. And again, please accept our deep appreciation for the leadership you have shown for HCBS. If we can be of any additional assistance, please feel free to contact PMHC's Public Policy Committee Chair, Darby Anderson, at danderson@addus.com.

Sincerely,

Esmé Grewal
Chairman of the Board

Darby Anderson
Chairman of the Policy Committee