PMHC URGES CONGRESS TO STRENGTHEN MEDICAID HOME AND COMMUNITY-BASED SERVICES

Established in 2015, the Partnership for Medicaid Home-Based Care (PMHC) is a coalition of leading home care providers, state associations, Medicaid managed care organizations, technology companies, and other adjacent businesses committed to advancing the delivery of high quality, cost-effective Medicaid home-based care and services. PMHC is focused on the following policy priorities, all with the goal of enhancing the role of home-based care for beneficiaries served as well as those employed as direct care professionals, maximizing the cost-effectiveness of home-based care to the benefit of both Medicaid and Medicare, whose fiscal sustainability depend on home-based care.

Invest in Medicaid Home and Community-Based Services (HCBS)

As our population grows increasingly older, it is more important than ever to invest and expand the commitment to home-based care – the preferred setting of care. Making an enhanced Federal Medical Assistance Percentage (FMAP) for Medicaid HCBS permanent is necessary to ensure people receive the care they need, reduce waiting lists under state HCBS waiver programs, strengthen supports provided to personal care aides, and improve quality of care overall. Medicaid HCBS funding can produce significant savings to Medicaid and Medicare by enabling individuals to remain in their homes with the support of home care rather than in an institutional setting.

Align Medicaid and Medicare Programs for Dual Eligible Populations to Improve Care

Medicaid-funded HCBS plays a key role in enhancing care for dually eligible individuals and has been proven to generate significant savings to Medicaid relative to costlier institutional-based services. PMHC supports efforts that bring focus to the need to support and simplify care for this critical population by exploring alternatives to facilitate the integration and coordination of care under Medicare and Medicaid. The current siloed approach presents challenges in terms of the ability to measure savings that the provision of HCBS achieve in terms of reducing Medicare-funded medical costs, such as emergency room (ER) utilization, hospitalizations and prolonged hospital stays. It also serves as a deterrent to growth of state Medicaid HCBS programs relative to traditional institutional care as Medicare savings don't accrue on the Medicaid side. As an initial step, 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 comprehensively and improvements in care for beneficiaries.

Advocate for Effective Use of Electronic Visit Verification (EVV)

EVV technology is used to support HCBS recipients and caregivers. All PMHC provider members currently utilize EVV systems and many of our members have used EVV with GPS capabilities for over a decade, long before the enactment of the 21st Century Cures Act, which mandated that states implement EVV for all Medicaid personal care services (PCS) and home health services. Federal law allows for state flexibility when designing and implementing its specific EVV system and requires extensive stakeholder input during the process. The determination to use GPS-enabled EVV systems has already been contemplated by Congress, the Centers for Medicare & Medicaid Services (CMS), the states and HCBS stakeholders. PMHC stresses the importance of the use of GPS functions at the point of data collection as this is a key lever in verifying that care is being provided as indicated. PMHC home care agencies are working to educate Congress and care professionals on the privacy protections associated with the EVV technology and making sure that they are aware of privacy settings and alternative data collection alternatives. PMHC also supports efforts to clarify agencies' collection of GPS and biometrics data from the EVV application to no more than what is necessary to provide services or communications about services.

Incentivize Presumptive Eligibility for Medicaid HCBS

Presumptive eligibility provides for a simplified and streamlined eligibility determination process so that individuals may initiate home-based care while detailed paperwork is completed, a process that can take weeks or months. As states have demonstrated, presumptive eligibility generates Medicaid savings because the provision of home and community-based services enables individuals to defer institutional care. To incentivize states to initiate presumptive eligibility for HCBS, the federal government should initially provide states with funding up to the full cost of services for someone who ends up not meeting eligibility, reducing risk for the states. After an initial implementation period, a lower federal share could be provided if a state does not achieve a certain presumed eligibility success rate.

Establish a Federal Definition of Private Duty Nursing (PDN)

The lack of a clear federal definition for Medicaid HCBS private duty nursing has resulted in limitations in access to care. PMHC has drafted a revised federal definition of HCBS private duty nursing services and strongly urges Congress to engage stakeholders to make the appropriate updates to the federal definition reflecting the enhanced level of care being provided in the home to individuals with complex medical needs. PMHC strongly supports a federal standard for the delivery of HCBS skilled nursing services to individuals with complex medical conditions.