PARTNERSHIP FOR MEDICAID HOME-BASED CARE

August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Administrator Brooks-LaSure:

The Partnership for Medicaid Home-Based Care (PMHC) appreciates the opportunity to submit comments in response to the Centers for Medicare and Medicaid Services' (CMS) Request for Information on Medicare (CMS–4203–NC). 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 solution companies dedicated to improving the quality and integrity of cost-effective Medicaid home and community-based services (HCBS). Home care workers, also known as direct care workers 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 expanding access to coverage and care along with driving innovation centered care.

I. Expand Access: Coverage and Care

Medicare Advantage (MA) plans have offered supplemental benefits of different types for the last several years as a result of Congress expanding the types of benefits that can be provided to chronically ill enrollees[1] As CMS communicated to MA organizations, the intended purpose of the law is to enable plans to tailor benefit offerings, address gaps in care, and improve health outcomes for the chronically ill population.[2] Among the benefits frequently offered are personal care services supporting the activities of daily living (ADLs) and instrumental activities of daily living (IADLs) needs of MA beneficiaries. It is unclear what MA plans consider when determining which supplemental benefits to offer. In 2020, only 16 percent of MA plans offered in-home supports.[3] A more recent analysis of contract year 2022 MA supplement benefit offerings shows a significant increase in the number of plans offering in-home support services.[4] Personal care

[1] P. L. 115-123
[2] Centers for Medicare and Medicaid Services, Memorandum to Medicare Advantage Organizations, April 24, 2019, https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.
[3] The Commonwealth Fund, Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment, February 10, 2021, https://www.commonwealthfund.org/publications/issue-briefs/2021/feb/medicare-advantage-plans-supplemental-benefits.
[4] Milliman Brief, Review of Contract Year 2022 Medicare Advantage Supplemental Healthcare Benefit Offerings, https://bettermedicarealliance.org/wp-content/uploads/2021/11/Milliman-Issue-Brief-CY-2022-MA-Supplemental-Benefits_20211115112.pdf.

services are generally offered in a very limited scope and breadth. Very few hours of care are authorized to beneficiaries, and PMHC's provider members report that the authorized hours are frequently used to provide respite care for a permanent caregiver rather than to meet long term care needs of the beneficiary. The rates of reimbursement offered are typically below Medicaid reimbursement rates, which can vary significantly from state to state based on costs associated with delivering care. PMHC encourages MA plans to expand their offerings of personal care services with the objective of achieving early intervention and improved health outcomes and offsetting care in more expensive settings through reduced use of emergency departments or hospital admissions.

Incorporating more information related to physical health and health-related social needs within a personal care service plan is critical in engaging providers in greater whole person care and achieving the objective of improving health and financial outcomes for MA beneficiaries. In-home care direct support professionals spend more time with poly chronic beneficiaries than anyone in the larger health care delivery system but frequently do not have information regarding the nature, acuity, and past treatment history of the beneficiary. HCBS providers currently identify real-time changes in the condition of this high-risk and high-cost population; however, there is little incentive provided within the supplemental benefit offering to utilize this real-time information for interventions that would significantly improve physical health care and reduce costs.

CMS should support MA plans in better coordinating supplemental benefits into their care management structure and align incentives for providers to adopt integration and coordination efforts as described above.

The personal care workforce has been undervalued and underappreciated for too long. Research shows that in addition to low wages and benefits, a lack of respect and inclusion in overall patient care is another significant barrier to individuals entering the home care field and a leading cause of turnover among the existing workforce. The existing siloes between Medicaid and Medicare health care services are the main contributor to this result; however, the lack of integration and coordination of MA supplemental benefits is similarly a challenge.

II. Drive Innovation Centered Care

According to the Better Medicare Alliance, a greater proportion of MA beneficiaries (23 percent) are dually eligible for Medicaid compared to Medicare fee-for-service beneficiaries (17 percent).[5] PMHC urges CMS to better align Medicare and Medicaid, especially for HCBS recipients. Specifically, the Center for Medicare and Medicaid Innovation (CMMI) should establish a demonstration to test an enhanced 100 percent Federal Medical Assistance Percentage (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 minimum wage of two times the federal minimum wage including annual cost of living adjustments to ensure an adequate direct care workforce.

[5] Better Medicare Alliance, State of Medicare Advantage, July 2022, https://bettermedicarealliance.org/wp-content/uploads/2022/07/BMA-State-of-MA-2022-FIN.pdf.

Research shows 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.[6] 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 further beneficiary health improvements and savings to the Medicare program.

On behalf of the Partnership for Medicaid Home-Based Care, please accept our thanks for this opportunity to share our comments. If we can be of any further assistance, please feel free to contact Darby Anderson at danderson@addus.com.

Sincerely,

Esmé Grewal
Chairman of the Board

Darby Anderson
Chairman, Policy Committee

[6] 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