May 3, 2022

The Honorable Brett Guthrie
Co-Chair
Healthy Future Task Force
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Vern Buchanan
Co-Chair
Healthy Future Task Force
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kevin McCarthy
Republican Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Guthrie, Chairman Buchanan, and Leader McCarthy:

The Partnership for Medicaid Home-Based Care (PMHC)[1] appreciates the initiative of the Healthy Future Task Force (HFTF) to identify challenges facing Americans and pragmatic policy solutions to improve, modernize, and personalize care. The COVID-19 pandemic has illustrated the benefit of Medicaid home-based care, which supports an individual with activities of daily living (ADLs) like bathing and dressing to enable the person to live independently and safely at home. Congress must keep in mind the lessons that have been learned in the last two years to inform the longer-term vision for how care is delivered to Medicaid beneficiaries in a 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. Providing supports to people to enable them to remain in their homes is beneficial to the individuals and their families is what they want and is the most affordable 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 united in 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.

[1] Members of PMHC include: Addus Homecare, AlayaCare, Aveanna Healthcare, Axxess, BAYADA Home Health Care, BrightSpring Health Services, CareBridge, CareCentrix, Caring Home Care Inc., CellTrak Technologies, Centene Corporation, Council of State Home Care and Hospice Associations, Help at Home, HHAeXchange, Home Assist Health, LHC Group, Sandata Technologies, Simplura Health Group, TEAM Public Choices, Tendercare Home Health Services, and Thrive Skilled Pediatric Care.

PMHC's comments focus on a bold vision for transformative change in the long-term services and supports (LTSS), delivery system. Our recommendations would achieve improved quality outcomes and fiscal savings and would elevate the position and services provided by the home care workforce. **PMHC offers the following recommendations to improve Medicaid HCBS:**

- Align Medicaid and Medicare program incentives to improve care coordination for dual eligible populations and expand the role of Medicaid direct care workers to generate savings for the Medicare program.
- Modernize Medicaid presumptive eligibility rules to encourage utilization of HCBS to defer individuals from more costly institutional care.
- Establish a federal standard for the delivery of HCBS skilled nursing services, commonly referred to as private duty nursing (PDN), to individuals with complex medical conditions and grant the Department of Health and Human Services (HHS) the administrative authority to develop, with the input of key stakeholder groups, a national core set of quality measures specific to this population.
- Refrain from advancing Section 409 of H.R. 6000, which would prohibit the use of GPS in electronic visit verification (EVV) systems for personal care services and home health; instead, Congress should enable states to adopt open EVV systems that allow providers to select the EVV system that is appropriate for their workforce and clients.

I. Align Medicaid and Medicare Programs for Dual Eligible Populations

Long-term care services provided in the home and community have been affording 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.[2]

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

[2] 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-actuarial-report.

HCBS reimbursement rates to support increasing wages and benefits attract more individuals to 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. Given the excellent return on investment delivered by HCBS, we will continue to advocate that the HCBS workforce needs to be valued for its contribution. Since the inception of HCBS services, however, this workforce has actually been undervalued and under-appreciated, according to compensation data. PMHC strongly supports policy reforms that honor and protect these dedicated professionals that deliver high quality, cost-effective services to a large and growing population of seniors and individuals with disabilities. These services enable individuals to remain in their homes and communities while providing relief to taxpayers from the much higher cost of institutionalized care. Critically, 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.

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.[3]

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.

The following excerpts from Dr. Paul Osterman's[4] books, Who Will Care For Us? Long-Term Care and the Long-Term Care Workforce, most aptly describe a system of fundamental change in long-term care that can achieve improved compensation and the expansion of the role of HCBS direct care professionals.[5]

> Contrary to much discussion, home care aides are broadly committed to their occupation. High turnover rates reflect not lack of commitment but low compensation: people move between agencies to find slightly better-paying work. But home care aides are generally

[3] 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.

[4] Paul Osterman is Nanyang Technological University (NTU) Professor of Human Resources and Management at the M.I.T. Sloan School of Management.

[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

> committed to the occupation. There is some *evidence that improvement in compensation reduces turnover, both between employers and in and out of the occupation itself* [emphasis added]. (Osterman, 2017, p. 52).
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> Three recent trends in the delivery of health care point directly to an expanded role for home care aides. First is the growing focus on the creation of health care teams, as opposed to the traditional top-down, doctor-focused practices. Second is the increased attention to the management of chronic conditions. The third is new interest in managing transitions from hospitals after acute incidents. *The importance of all three trends is supported by research-based evidence, and each creates new opportunities for home care aides to play an expanded role* [emphasis added]. (Osterman, 2017, pp. 77-78).
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> Given this complex market, how can we move forward to improve opportunities for home care aides? Any strategy must...be based in large part on enlarging their scope of practice so that enhanced productivity can justify improved compensation. (Osterman, 2017, p. 52).
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> ... we can move forward and take up the challenge of improving long-term care systems in this country. *In rethinking how care is delivered, the health care system must recognize that direct care workers, both paid and unpaid, spend more time with clients than anyone else* [emphasis added]...the reality is that better training, better compensation, and an expanded role will add up to both better care and reduced costs...[which] that not only improves the circumstances of consumers and workers but goes a long way toward paying for itself. (Osterman, 2017, p. 153).
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> The coming explosion of demand, driven by demographics, will put these issues on the political map. The worst response would be to continue to muddle through, relying on a patchwork system composed of a poorly designed welfare system, expensive private insurance, burdensome out-of-pocket expenditures, and unpaid family labor. We certainly can do better. And we can also recognize that *without an army of paid direct care workers who are empowered and trained and compensated decently, no system of long-term care can work well* [emphasis added]. (Osterman, 2017, p. 154).

Paul Osterman's extensive research 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 further 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 minimum wage of two times the federal

minimum wage including annual cost of living adjustments to ensure an adequate direct care workforce.

There is considerable discussion and proposals at both the federal and state levels specific to additional training of home care aides. While not uniform across the states, most home care aides receive a considerable amount of pre-service and in-service training. While all training is beneficial, additional training to improve the quality of the primary role home care aides have in supporting a consumer's ADLs is difficult to evaluate in terms of return on the investment and to correlate to higher compensation for the home care aide, particularly when HCBS reimbursement rates are fixed regardless of how much training the aide has received.

PMHC proposes that new home care workforce training investments be focused on expanding the role of home care aides. Training focused on general health education and awareness related to the chronic conditions seen in the population receiving HCBS will equip home care aides with the tools to recognize changes in condition of the recipients they serve and observe and report these changes to other disciplines on the health care team, thus facilitating early interventions that drive better outcomes. Additionally, training focused beyond ADL delivery will help establish a career advancement ladder to positions such as health navigators, certified home health aides, nurses and other clinical-based roles within health care.

II. Establish Requirements to Ensure Home-Based Care Rather than Institutional Placement

Since the Medicaid program's establishment in 1965, its operations and eligibility rules have traditionally favored nursing home placement rather than home-based care. 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.

As a result, PMHC recommends that Medicaid rules be modernized to encourage utilization of HCBS. Such reform would reduce reliance on more costly settings of care, decrease health care expenditures, and satisfy consumers' strong preference to remain in their own homes. This reform would also help maintain compliance with the U.S. Supreme Court's Olmstead decision,[6] which established that people with disabilities have the right to community-based services in the most integrated setting.

In light of the above factors and the many clinical and technological advances that have been achieved since 1965, 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 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.** Currently, states bear all the financial

[6] Olmstead v. L.C., 527 U.S. 581 (1999).

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.[7] 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.

Premature institutional placement also increases pressure on programs like Money Follows the Person to return individuals to their home and community after institutional placement versus HCBS placement from the onset. Congress authorized the Money Follows the Person demonstration program in the Deficit Reduction Act of 2005 (P.L. 109-171). Since the start of the program in 2008 through the end of 2020, states have transitioned more than 107,000 individuals from institutions to home and community settings.[8] However, this represents an extraordinarily small subset of Medicaid enrollees who are or could be served by HCBS. Medicaid HCBS state plan services collectively serve 2,562,500 individuals, and waivers serve 3,042,200 individuals.[9]

HCBS providers could assist with making presumptive eligibility more common. States should be held to a target percentage of successful Medicaid enrollment following presumptive eligibility determinations and could be responsible for the cost of care for individuals not Medicaid enrolled above the target percentage. One way to reduce the burden on states bearing the risk of presumptive eligibility is for the federal government to provide an enhanced Federal Medical Assistance Percentage (FMAP). As states have demonstrated, presumptive eligibility generates Medicaid savings because the provision of home- and community-based services enables individuals to defer institutional care.

III. Create a Federal Standard for HCBS Skilled Nursing Services

Under federal law, states participating in Medicaid are required to cover certain mandatory services, which include the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit providing comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. Under the EPSDT benefit, private duty nursing (PDN) is a service

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[7] 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.

[8] Centers for Medicare and Medicaid Services, Money Follows the Person, https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html.

[9] Kaiser Family Foundation, Medicaid Home & Community-Based Services: People Served and Spending During COVID-19, March 4, 2022, https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief/.

category available to provide ongoing medical care and interventions that are necessary to correct or ameliorate the individuals' status.[10]

CMS noted in a 1987 Final Rule[11] that "[i]n the original Medicaid legislation...Congress listed private duty nursing services among the services that could be covered under the program, without defining them. By not defining the term "private duty nursing services" in the legislation or accompanying committee reports, Congress left the responsibility to [HHS] for developing a reasonable interpretation of this term...[t]he private duty nursing benefit is an optional one, and States generally have considerable latitude in defining the scope of optional services. *This flexibility serves as an incentive ...to tailor optional services to the specific needs of their populations* [emphasis added]." However, states typically use the flexibility granted to them under the federal definition to meet the specific needs of a state's population not to expand the scope of services they offer to an individual with complex medical needs, but rather to restrict services. This is likely due to the high-cost nature of the PDN benefit and state decision-makers' desire to reduce spending in their Medicaid programs.

Private duty nursing is currently defined as "nursing services for...[individuals] who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility...[and provided by]...a registered nurse or a licensed practical nurse [u]nder the direction of the...[individual's] physician." Private duty nursing services can be provided in the home, hospital, or skilled nursing facility.[12] An individual is able to use his or her private duty nursing hours when normal activities take them outside of the home to participate in activities outside the home.[13] Documents explaining the rationale for the definition were lost or destroyed in 1977, when records of the newly-created Health Care Financing Administration were moved from Washington to Baltimore. Only existing document that discusses §440.80 is a memorandum prepared in 1981 by the HCFA Task Force for Regulatory Reform. The authors of that memorandum could find "no files available which indicated the source or rationale for this definition..."[14]

Since passage of the Social Security Amendments of 1965 (P. L. 89-97), the ability to care for individuals with complex medical conditions that may require skilled interventions or be dependent on medical technology in the home has vastly improved. However, 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-

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[10] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)(5)
[11] 52 FR 47934
[12] 42 U.S.C. §1396d(a)(8); 42 C.F.R. 440.80
[13] Detsel v. Sullivan, 895 F.2d 58 (2d Cir. 1990)
[14] Id

based settings. Further, the lack of a clear federal definition for Medicaid HCBS PDN services has resulted in limitations in access to care.

Updating the Definition of HCBS Skilled Nursing Services

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. The revised definition should, at a minimum, reflect the following:

- Skilled nursing services provided in the home and community to an eligible individual who requires daily ongoing medical care, including skillful observations and monitoring, clinical judgments, interventions to sustain, correct or improve the individual's status.
- Services provided by a registered nurse, licensed practical nurse, or licensed vocational nurse under the direction of the individual's physician and defined by the highest scope of nursing licensure with regard to safety, medical necessity, and level of care.
- Beyond what is authorized under the traditional home health care benefit.
- Provide the ability for the individual to remain in his or her home rather than a hospital or a skilled nursing facility (SNF).

National Standard and Quality Measures

As noted in the 1987 Congressionally-mandated *Fostering Home and Community-based Care for Technology-dependent Children, Report of the Task Force on Technology-Dependent Children,*[15] barriers existed related to a "lack of nationally recognized and implemented minimal safety and performance standards for care at home" and a "lack of accountability for quality provided in the home." The Task Force recommended that national standards as well as a mechanism for measuring quality should be developed and implemented. However, no federal standards exist for HCBS private duty nursing services or standardized national quality measures. **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.**

IV. Preserve States' Ability to Adopt Technologies

All PMHC provider members currently utilize EVV systems, and many of our members have used EVV with GPS capabilities for more than a decade, long before the enactment of the 21st Century Cures Act, Section 12006, which mandated states implement EVV for all Medicaid personal care services (PCS) and home health services (HHCS).[16] Home care agency and financial management

[15] Fostering Home and Community-based Care for Technology-dependent Children: Report of the Task Force on Technology-Dependent Children. (1988). United States: Department of Health and Human Services, Health Care Financing Administration.

[16] P. L. 114-255

services (FMS) providers rely on mobile GPS verification to document time and attendance, in addition to many other uses to support HCBS recipients and employee caregivers. Generally, this GPS technology facilitates the capture of the location at the start and stop of care delivery; it does not track caregivers or beneficiaries on an ongoing basis and that is not the intent of the technology.

We are very concerned that H.R. 6000, the Cures 2.0 Act, includes a provision that would prohibit the use of geographic features (GPS) within EVV systems.[17] Restricting the use of GPS and biometrics would be highly detrimental to the implementation and use of EVV in HCBS. By legislating the restriction of the use of GPS, yet keeping the federal mandate for EVV to be utilized by Medicaid HCBS providers would be like establishing a goal of supplying internet access to all Americans but not allowing the use of Wi-Fi technology.

After considerable time, cost, and effort to implement a compliant EVV system, restricting the use of GPS would immediately put many states out of compliance with federal law. A majority of states have chosen to deploy GPS mobile solutions for EVV after receiving extensive input from state stakeholders into their system design.

The restriction on GPS is being proposed five years after enactment of the federal EVV mandate and years after states have initiated efforts to design and implement an EVV system that complies with federal law. If adopted, the restriction of the use of GPS would immediately subject states to financial penalties for non-compliance with the federal EVV mandate. Kentucky offers providers an option to use Kentucky's state-sponsored EVV system, which uses GPS,[18] or to select an EVV system of their choice.[19] Similarly, Florida contracted with a vendor to operate an EVV program with GPS capabilities and allows providers to continue using their own systems.[20]

Privacy concerns regarding the use of GPS do not reflect actual use of geographic data points. Using GPS to comply with the federal requirement of establishing location at the start and end of a visit is not the equivalent to an electronic tracking system. HCBS providers have addressed this concern from caregivers from time to time. Direct care workers' concerns about continuous tracking are alleviated by simply shutting down the EVV application on their mobile device or disabling the location services on their phone. Additionally, there is no reason to spend administrative or supervisory time tracking caregivers when they are not providing direct care or generally outside of the start and end time of the visit with a HCBS recipient.

Landline telephones are rapidly disappearing from the homes of all Americans, including Medicaid HCBS recipients. In 2004, more than 90 percent of U.S. adults lived in households that had an

[17] H.R. 6000, Section 409.
[18] Kentucky Cabinet for Health and Family Services, Electronic Visit Verification Frequently Asked Questions for Medicaid 1915(c) Home and Community Based Services Waivers, Last Updated 07/08/21, https://chfs.ky.gov/agencies/dms/dca/Documents/kyevvfaq.pdf.
[19] Kentucky Department for Medicaid Services Division of Community Alternatives, Electronic Visit Verification, https://chfs.ky.gov/agencies/dms/dca/Pages/evv.aspx.
[20] Agency for Health Care Administration, Home Health Services Electronic Visit Verification, https://ahca.myflorida.com/Medicaid/home_health/dmv.shtml.

operational landline phone; today less than 40 percent of Americans have a landline.[21] Therefore, states simply cannot fully comply with the federal EVV mandate relying solely on interactive voice response (IVR) or telephone-based systems. The use of a fixed device, such as a fob, is the only alternative and represents a clumsy and difficult technology to use for caregivers and clients alike. Additionally, a fob requires the placement of hardware in the recipient's home, which is prone to loss, damage, and subsequent replacement. Also, services that need to be confirmed without GPS typically have to be confirmed from an at-home landline, thus restricting services from being delivered in the community or other location that is not within the home.

The use of biometrics in EVV is a convenience to both clients and caregivers. Current biometrics consist primarily of voice verification as a substitute for a written client signature that is required by state and federal regulations to attest to the hours and delivery of care. Some clients have difficulty or are uncomfortable signing electronically, so voice verification is an option to alleviate this concern. Prohibiting the use of biometrics will limit how individuals can use the system according to their needs and stifle additional technology innovation for simpler and more convenient means of providing client attestations.

GPS-enabled EVV systems provide other capabilities and conveniences that will be unachievable if GPS is restricted. Caregivers receive compensation for time spent travelling between clients, mileage between clients, and mileage running errands or transporting clients. GPS provides an efficient and accurate method to capture these costs incurred by caregivers and to compensate them fairly.

Mobile technology allows for simple and real-time documentation of client visits. Mobile GPS does not require a landline or cellular coverage. GPS-enabled EVV systems are a straightforward application that efficiently guides caregivers through a visit documentation that would otherwise need to be completed and submitted on paper forms. Although IVR can capture some of this documentation, it is not as simple or efficient and increases costs considerably.

The use of GPS-enabled EVV systems improve caregiver safety. With mobile GPS applications, an agency administrator or supervisor can assist caregivers when they have issues during their workday. The EVV system verifies the caregiver arrives safely and on time to their scheduled visit, and allows easier communication with agency staff in the event of an emergency.

Eliminating the use of mobile GPS would have a downstream negative impact. Alternative methods are limited in their capability, which means more administrative burden on caregivers and less information collected on each visit. If caregivers need to spend additional time documenting care, they will spend less time with each client. As a result, more caregivers will be needed at a time when HCBS providers are having significant challenges in workforce recruitment and retention.

The current federal EVV mandate does not require the use of GPS. Federal law allows for state flexibility when designing and implementing its specific EVV system and requires extensive

[21] Richter, Felix, Landline Phones Are a Dying Breed, Mar 17, 2021, https://www.statista.com/chart/2072/landline-phones-in-the-united-states/.

stakeholder input during the process. Therefore, the determination to use GPS enabled EVV systems has already been contemplated by Congress, CMS, the states, and HCBS stakeholders. The decision of which EVV technology should continue to be left to the states, the stakeholders, and the HCBS provider community who are experts in care delivery.

These proposed restrictions would establish an undesirable precedent for the adoption and use of technology to ensure individuals are receiving services and care, hold providers accountable, and take steps toward measuring quality.

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