PARTNERSHIP FOR MEDICAID HOME-BASED CARE

October 25, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20407

Re: Proposed Rule *Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes* (CMS-2421-P)

Dear Administrator Brooks-LaSure:

The Partnership for Medicaid Home-Based Care (PMHC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (CMS-2421-P). 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 home and community-based services (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 are focused on expanding access to care by eliminating regulatory and administrative barriers, including some key issues not referenced in the proposed rule.

I. Proposal to Facilitate Enrollment Through Medicare Part D Low-Income Subsidy "Leads" Data (II.A.1.)

A. Promote presumptive eligibility for Medicaid HCBS

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 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,

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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.

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. Modernize Functional Eligibility Assessments

Although the proposed rule acknowledges that dually eligible beneficiaries – some of the most vulnerable among us – lost Medicaid coverage most often for reasons including changes in functional status, the proposed rule does not address ways CMS can improve administrative requirements related to those situations. 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. **CMS should modernize functional eligibility assessments to account for cognitive disabilities such as dementia.**

II. Proposal to Allow Medically Needy Individuals to Deduct Prospective Medical Expenses (Section II.A.5.)

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. As you acknowledge in the proposed rule, this policy would reduce administrative costs associated with enrolling and disenrolling individuals and improve health outcomes for individuals due to continuity of care. **PMHC supports your 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, and we urge you to finalize this proposal.**

III. Promoting Enrollment and Retention of Eligible Individuals (Section II.B)

A. 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.[3] In the experience

[3] 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,

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 long-term support services (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 eligibiles. 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 long-term care 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, CMS should create a uniform methodology for states to establish their HCBS waiting lists. CMS should seek authority to 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.

B. Private Duty Nursing

Existing Medicaid eligibility and enrollment pathways for HCBS can be improved to ensure access to cost-effective LTSS. **CMS should establish a federal standard for HCBS private duty nursing (PDN) and address the lack of portability of benefits for medically complex children.**

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.**

IV. Conclusion

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https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-home-and-community-based-services-waiver-waiting-lists/.

On behalf of the Partnership for Medicaid Home-Based Care, please accept our thanks for this opportunity to provide a response to the proposed rule. 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