January 9, 2017

Attn: Melissa Harris
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-2404-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-2404-NC. Medicaid Program; Request for Information (RFI): Federal Government Interventions to Ensure the Provision of Timely and Quality Home and Community Based Services

Dear Ms. Harris:

The Partnership for Medicaid Home-Based Care (Medicaid Partnership) appreciates the opportunity to comment on this important RFI. The Medicaid Partnership was established in 2015 to advance the delivery of high-quality, cost-effective Medicaid home-based care and is comprised of organizations representing providers, associations, payers and business affiliates who came together to work with decision makers to improve the quality and integrity of home-based services.

It is in that spirit and with gratitude for this opportunity that we offer the following feedback for CMS' consideration:

I. **<u>Access to HCBS</u>** - *What are the Additional Reforms that CMS can take to accelerate the Progress of Access to HCBS and Achieve an Appropriate Balance of HCBS and Institutional services in the Medicaid LTSS system to meet the needs and preferences of beneficiaries?*

A. <u>Adopting "Home First" for Medicaid Applicants</u>

Medicaid law and eligibility rules have traditionally favored nursing home placements rather than home-based care. In 1965, "rest homes" were often the only option for people as they aged. Today, there are many community-based options for senior care – homebased care, assisted living, and adult day centers, which are generally preferred by individuals.

The U.S. Supreme Court's *Olmstead* decision requires that everyone has the right to be cared for in the most integrated setting. However, nursing home care is still the default Medicaid long term care benefit. Indeed, Medicaid funded home-based care is generally provided through a Medicaid "waiver" program. In many states, waivers are also capped at a certain number of consumers. In addition, State Medicaid eligibility rules continue to favor institutional care by permitting presumptive eligibility and allowing spend down for individuals going into a nursing home, but generally restricting these flexibilities for home based care.

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In light of this history and the many clinical and technological advances that have been achieved since 1965, we respectfully submit that Medicaid law and regulations should be updated to (1) adopt a "Home First" approach to placement, and (2) extend presumptive financial eligibility and spend-down to home-based care. The Medicaid Partnership recognizes that this shift would require Congressional action, but submits that CMS has some discretion to further a home-first approach.

For example, a Home First policy could require that individuals be screened for home-based benefits prior to being considered for nursing home benefits. Subject to consumer choice, this policy would enable all Medicaid consumers eligible to enter a nursing home to be offered home-based benefits if they qualify for and desire such benefits.

We believe that this update would enable Medicaid policy to better fit with today's legal and practical realities. Importantly, we also recognize that this policy has the potential to generate significant savings, which can be utilized to preserve the fiscal sustainability of the Medicaid program for federal and state taxpayers alike while also making resources available for further updates to the program, such as those described below.

B. <u>Updating the HCBS Benefit Package</u>

1. *Housing support* - A key to avoiding unnecessary nursing home placement is adequate, accessible, and affordable housing that allows individuals to stay in their homes and communities to receive care. Apart from home modification services, which are critical despite being generally underfunded, the current HCBS benefit package does not offer beneficiaries any assistance with securing and maintaining a home.
    - The Medicaid Partnership supports benefit redesign that would redirect a portion of Medicaid savings generated by placing more individuals in the home setting rather than nursing facilities into initiatives such as housing tax credits and vouchers that would allow even more individuals to be able to remain, and receive needed care, at home.
    - The Medicaid Partnership proposes a demonstration program that examines the amount of savings generated by this rebalancing and in turn re-invests an appropriate portion of such savings into housing credits and other programs that empower individuals with disabilities and seniors to be able to remain in the home setting rather than more costly institutional facilities.

2. *Medicare-Medicaid Coordination* - With more and more states transitioning to managed long term services and supports, it is incumbent on government to ensure that both Medicaid and Medicare services are coordinated.
    - The Medicaid Partnership supports efforts to coordinate Medicare and Medicaid services in a variety of delivery systems, including through the Medicare Advantage Dual Eligible Special Needs Plans and the Financial Alignment Demonstrations.

- The Medicaid Partnership views Medicare/Medicaid coordination of home-based care to be important to beneficiary access to care.

3. *Meeting the Needs of Individuals with Cognitive Needs* - Medicaid eligibility rules place low importance on an applicant's cognitive needs and focus more on whether individuals require assistance to meet functional needs. It is easy to imagine a scenario in which a senior with dementia is fully capable of performing activities of daily living on their own, yet they still require supervision and cueing to stay safe at home. Based on commonly used assessment items for Medicaid functional eligibility, which examine individuals' abilities to use the bathroom, dress and eat on their own, she would not score low enough to trigger Medicaid services unless her cognitive impairment is given adequate weight.
    - This flaw in the functional assessment leads many individuals with dementia to be found ineligible for Medicaid services.
    - CMS should consider a benefit redesign, in concert with a functional assessment redesign that allows more functionally capable individuals with dementia to qualify for services. Without Medicaid coverage, these individuals are often cared for by family members who may be ill equipped to meet their cognitive needs or they go without care.
    - While this may result in an increase in Medicaid enrollees in the short term, it would prevent these patients from declining rapidly and later requiring more expensive care in institutional facility settings. Simple redirection and supervision from a homecare aide, for example, could allow an individual to stay at home longer and prevent further decline.

C. <u>Protecting Access to HCBS: Paying Adequate Rates</u>

CMS would make great strides in protecting access to HCBS by ensuring state Medicaid programs provide provider rates that are commensurate with the value of service and the cost of providing such service. State Medicaid agencies are not required by CMS to periodically update rates or undertake a study to ensure rates are still adequate. As years pass, the cost of care increases as does any other cost, yet HCBS rates have remained stagnant.

1. The Medicaid Partnership recommends CMS mandate bi-annual rate studies by state Medicaid agencies that include a comprehensive examination of current costs, current and anticipated enrollment numbers and general capacity to fulfill patient needs based on the number of enrolled Medicaid providers in each category of HCBS covered benefits. Rate studies should also include a review and list of rates paid for like services within the state through sources including but not limited to; Veteran's Administration, Older American Act services through Area Agencies on Aging, Centers for Independent Living, State funded programs, commercial and long-term care insurers and private paying consumers.

2. The Medicaid Partnership supports CMS' role in protecting HCBS access by requiring MCO network adequacy for long term services and supports such as home health, homecare, hospice and other HCBS provider types. While typical measures of

network adequacy, such as driving distances and appointment wait times, do not apply to these provider types as easily as they do to physicians or specialists, this care is too critical to managed care members to leave no standards at all. The recently published regulation, *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule*, requires states to develop network adequacy standards and provides an opportunity for MCOs and stakeholders to provide input.

II. <u>Ensuring Quality of HCBS</u>

A. *What is the appropriate role for the state vs. CMS in ensuring the quality of care for Medicaid beneficiaries receiving HCBS services?*

We strongly believe that CMS' focus on ensuring the quality of care is of utmost importance and therefore wish to recommend the following policy modifications to best enable the Agency to meet this goal:

1. CMS should set the performance framework for states to provide oversight of the quality of care, as it has done for Medicaid MCOs, including offering technical support regarding selection of measures, related data sets and collection, as well as reporting.

2. CMS should incentivize states that:
   - Utilize the quality framework set for MCOs and FFS;
   - Reward high performing providers per established measures, moving toward STAR ratings that could support narrow networks;
   - Remove barriers to rebalancing, such as bed hold policies; and,
   - Utilize a common assessment instrument that ensures data on key elements is reported consistently across states.

B. *How can CMS and the States best monitor quality and beneficiary safety? What is the role of CMS in standardized measurement for HCBS? What data, reporting and system resources are needed?*

The Medicaid Partnership believes the program has made important technological strides during its history, which we recommend be strengthened via the following updates:

1. CMS should select a core set of measures relevant to the HCBS populations served and services provided, and require a common assessment tool to capture data sets.

2. CMS should establish a minimum HCBS data set that supports measurement in the following domains across States – beneficiary health, welfare, quality of life and

satisfaction, financial accountability, and service provision and delivery. This would set a foundation for CMS accountability for federal dollars spent, as well as insight into efficiency and outcomes that could be shared across States. Such core measures would offer efficiency to CMS and states in initial data collection and reporting, while enabling States to add unique measures.

3. CMS should also fully utilize the performance data resources that have already been developed for use. For example:
   - Data regarding the quality of the delivery of skilled care to Medicaid recipients by home health agencies has been collected through the OASIS data set for 15+ years. To date, the data has not been sufficiently utilized even though it offers great insight into the types of services provided and the profile of these Medicaid recipients (most of whom are not dual eligible) about diagnoses as well as physical and mental status.
   - Under the IMPACT Act of 2014, CMS is charged with developing quality measures for post-acute settings. The Medicaid Partnership is particularly interested in measures around cognitive and functional status. Since these measures will be used in SNF/LTCs as well as home health agencies offering skilled nursing to Medicaid beneficiaries, the functional and cognitive status and related care spending for recipients in Medicaid long term facility care versus home and community based care could be used in measuring the relative efficacy of HCBS services as compared with SNF and other institutional settings.
   - The utilization of open-system electronic visit verification (EVV) in Medicaid delivery offers a ready source of data collection and reporting. The 21st Century Cures Act mandates EVV by 2019. This can be a ready system for measuring performance and incentivized for state use. For example, EVV data can measure timely care, authorized or planned duration of services, as well adherence to the beneficiary plan of care.
   - Finally, advanced telehealth and care management tools are in use by MCOs which have proven to be of significant value in managing utilization and helping consumers avoid institutionalization and remain in the home. CMS should explore the utility of these advanced tools for a broader spectrum of the Medicaid home-based care population.

C. *What should CMS do if the services provided are found not to meet federal requirements?*

CMS should offer technical assistance and resources to the States. CMS should also oversee state compliance through audits and, as necessary, require State remediation.

D. *Should there be an oversight structure such as the Conditions of Participation in Medicare? If so, should there be on-site surveys for compliance?*

The Partnership recommends consideration of the following proposed improvements:

1. Minimum standards should be put in place for HCBS.

2. Just as minimal standards are articulated in the Medicaid managed care rules, minimum provider standards related to organization, business status, staff qualifications, disability access, and quality of care and service delivery should exist. In states without related licensure for these services, the application to be a Medicaid provider is all that is required. Should the provider not be required to be Medicare certified, no organization has oversight over the provider of HCBS services other than the appropriateness of billing.
   - We also wish to note that, in states which require Medicare certification of a home care provider to deliver Medicaid services, the oversight and on-site survey is often not relevant to HCBS services. The state surveyors use Medicare conditions of participation that are not relevant to the providers of personal care or to care provided for children with disabilities, dependent adults that use a ventilator, and those with traumatic brain injury, or a developmental disability. Therefore, the care delivered to these individuals in their home is not assessed with regard to the unique needs of the population served.

3. Once the delivery of care and services leaves the confines of an institution, there is responsibility that oversight includes some frequency of on-site, in-home or community review by a qualified individual using relevant standards to ensure beneficiary safety as well as quality of care. This does not exist and cannot exist solely with the use of current state surveyors. We recommend the use of voluntary accreditation that leverages CMS and State approved standards to take the burden off the State.

III. Program Integrity Safeguards - *What program integrity safeguards should states have in place to ensure beneficiary safety and reduce fraud, waste and abuse in HCBS?*

The Medicaid Partnership condemns fraud, abuse and neglect, and supports targeted and enforceable measures to address abuse in any form and improve patient care. The Medicaid Partnership is committed to a proactive stance on program integrity and development of policy solutions in order to protect Medicaid beneficiaries, State and Federal Taxpayers, and compliant and ethical providers by instituting measures to prevent fraud and abuse before it occurs.

The Medicaid Partnership cautions that efforts targeted at fraud, abuse and neglect should not be misconstrued to include routine compliance monitoring to specific state program regulations, rules and policies. In some cases, states, under the banner of program integrity efforts, have taken actions that result in recoupment of funds for minor or routine compliance errors by otherwise non-fraudulent providers. Such items as errors in documentation, isolated errors in background check policies or care plan adherence have resulted in excessive recoupment of claims for services legitimately rendered.

A. Electronic Visit Verification

As an over-arching step to contribute to Program Integrity efforts, the Medicaid Partnership endorses legislation contained in the 21st Century Cures Act which mandates the use of Electronic Visit Verification (EVV) systems. EVV should be deployed throughout the entire system to ensure program integrity. States should however be encouraged to develop mechanisms for stakeholder input that include beneficiaries who self-direct to ensure implementation of EVV systems in self-directed models do not result in unintended consequences such as of limiting personal choice and decreasing community integration. While we recognize that there is some objection to the use of EVV by stakeholders due to concerns of limiting personal choice, we feel that modifications to EVV systems can be made to accommodate personal choice for places in which care/services are rendered.

EVV is a technology solution that, among other benefits, helps to ensure that Medicaid funded home-based care is actually provided at the right place and right time. These systems utilize the consumers own telephone or other mobile technology (smart phones) to verify that care taxpayers are paying for is actually being provided. EVV provides real-time visibility and accountability to ensure the integrity of Medicaid personal care and home care benefits.

Although the Medicaid Partnership supports the use of EVV, many state implementations have had serious delays and have been unnecessarily disruptive to patient care based on the manner in which the EVV system is developed. Based on these experiences Medicaid Partnership encourages federal guidelines on EVV implementation and encourages use of "open" systems which allow providers to use any system meeting EVV standards to capture time in, time out and other information commonly referred to as the "point of care". Medicaid Partnership supports the creation of an ad-hoc or formal working group that includes consumers to set minimum standards for any open system, and offers itself and its members as a resource for any such group.

We believe it is in the best interest of all personal care stakeholders including states, to provide additional guidance and direction to educate states on the benefits of an open solution and the interfaces necessary to accept electronic service data from multiple EVV systems that are incorporated into a single data warehouse for review, claims management and accountability by states. An open solution will provide flexibility to the provider to use the best EVV solution available now and in the future to most effectively and efficiently serve consumers. It would also provide future flexibility to states to make enhancements or change the internal system as technology develops, without having to go through a painful reimplementation across the entire provider spectrum.

Although technology, such as EVV, is an effective tool in improving Program Integrity on its' own it is not a panacea. Therefore, we offer the following additional input into Federal actions and guidelines that can be adopted to further enhance the integrity of Medicaid Personal Care Services.

B. Care Providers

Self-directed care - The Medicaid Partnership supports the concept of self-directed care. We believe that all recipients of in-home services should be empowered to tell aides how, when and where services should be completed. The Medicaid Partnership believes in offering Medicaid beneficiaries as much input and control over their care as the beneficiary desires. That said, the Medicaid Partnership believes regardless of whether care is self-directed or involves an agency, any care provided to beneficiaries must be adequately overseen, and the individual who provides that care should be subject to oversight.

Care provider qualifications - The Medicaid Partnership supports establishing minimum Federal qualification standards applicable to all personal care aides reimbursed by Medicaid. Such program should:

1. Take into consideration the best practices identified from state programs implemented under previous CMS program integrity efforts, including those established under Section 6201 of the Affordable Care Act.

2. Ensure that criminal background checks are conducted and processed for all agency and self-directed personnel who have direct patient contact or access to patient records and for all local owners and operators of a home care agency.

3. Ensures that contractors are also required to obtain background checks for the same personnel.

4. Provide a basic level of training to all personal care workers.

5. Ensure that all personal care workers are over the age of 18.

6. Create a mechanism that ensures a State level review when legal guardians also work as personal care aides for the same beneficiary.

7. Ensure that all direct care workers should be provided the same benefits, rights and protections afforded all employees under the law.

C. Payment Integrity Reforms to Ensure Accuracy, Efficiency and Value

The Medicaid Partnership supports reforms that further standardize payment rules to assure the integrity of care provided. Specifically, the Medicaid Partnership recommends measures that would:

1. Require the Secretary to establish uniform regulations regarding the allocation of hours of care, including standard weekly allocation versus monthly allocation, applicable to home care agencies and self-directed care providers, to ensure the hours billed are fully authorized, match the care plan, account for any

hospitalizations, and prevent any banking of hours. Accommodations or exceptions to this requirement may be made in programs that utilize a consumer budget model.

2. Require the Secretary to establish the following conditions for home care agency and self-directed care provider eligibility for Medicaid reimbursement:
    - Home care agencies must file its Employer Identification Number (EIN) for all employees;
    - All self-directed care providers must file their EIN or a unique identifier provided by the State Medicaid agency; and,
    - All claims for personal care services must include the specific date or dates on which services were performed and the identity of the home care agency employee or self-directed care provider rendering such services.

3. Provide guidance to States regarding adequate prepayment controls. For example, CMS should identify a list of needed controls, including the necessary claims edits to prevent inappropriate PCS payments during periods when beneficiaries are receiving institutional care, including but not limited to nursing facility and hospital care. CMS should also offer design instructions to better ensure the operability of prepayment controls.

4. Develop a data sharing system designed to:
    - Improve pre-payment review of claims to eliminate payment of incomplete or questionable claims.
    - Prevent inappropriate PCS payments during periods when a patient is institutionalized for treatment.
    - Make data compatible with States' systems so that States may crosswalk Medicare and Medicaid data to identify potential instances of fraud, waste, and abuse.
    - Enable States to store the data needed to identify improper Medicaid payments and payments eligible for federal match.
    - Reduce significant variation in States' PCS laws and regulations by creating or expanding Federal requirements and issuing operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants.
        - Requires the Secretary to establish minimum standards to validate the competency of agency owners and managing employees and of similar relevant assurances in self-directed care programs as a condition of Medicaid reimbursement for personal care services.
            - The standards shall include evaluation of the agency owner or agency manager's knowledge of Medicaid requirements, benefit coverage standards, and reimbursement policies and competency in claims

documentation, beneficiary assessment, attendant supervision, and plan of care administration.

  - The standards shall include a mechanism of stakeholder input, that includes beneficiaries who self-direct, to develop a system to properly assess competency of Medicaid reimbursement for self-directed programs.
  - Requires agencies with new provider numbers initiating service on or after a date certain to demonstrate access to capital sufficient to operate for not less than six months, exclusive of actual or projected accounts receivable from Medicaid or other sources. This capital requirement does not apply to self-directed care and may be waived if the agency or provider is primarily located in a frontier county or as the Secretary may waive to ensure patient access to care.

- Requires the Secretary, working jointly with the HHS Inspector General, to promulgate rules not later than one year after the date of enactment that require home care agencies and self-directed care programs to have in operation a compliance and ethics program designed to prevent and detect criminal, civil, and administrative violations. Each agency and program shall have such compliance plan in operation not later than 90 days after the regulations are final. The program shall be developed to be effective in preventing and detecting violations and shall include written standards and procedures.
  - In the case of home care agencies, each program shall have a compliance officer or other body to oversee such policies and procedures and shall include effective communications, training and steps to achieve compliance, including monitoring and auditing, as well as a reporting system. The program must require that reasonable steps are taken after an offense has been detected.
  - In the case of self-directed care, each provider, and consumer, must read and sign a statement attesting to their understanding that false reporting of care delivery constitutes Medicaid fraud and spelling out the penalties for such fraudulent acts.

<u>Responses to RFI Questions</u>

1. *What role could state-administered home care worker registries play in facilitating access to HCBS? What issues should be addressed in the creation of home care worker registries?*

   In our view registries are appropriate for programs utilizing independent providers in a self-directed model and can facilitate the recruiting of replacement or back-up personnel to serve the recipient. However, registries do little to facilitate access to HCBS in an agency mode and we do not support their use in this mode of service delivery. Prior to utilization of registries in self-directed programs, states must be required to regulate registries and provide some level of consistent oversight.

Consideration must also be given to the cost to develop and maintain public registries and provisions to safeguard privacy, safety and security of the personal care workforce and caregivers. Our comments regarding the use of registries in agency provided care are not proposing any change to the use of "Registries" in the State of Florida, which licenses agencies as "Registries" in the delivery Personal Care Services under Medicaid.

2. *Should states be required to enroll or register all PCS attendants and assign them unique numbers for purposes of tracking claims?*

   This is largely addressed by Electronic Visit Verification (EVV) implementation; however, for self-directed PCS attendants such a system typically exists. It is less necessary under Agency-provided care as the agency is responsible for the delivery of care and accurate claims provided by their employees.

3. *What is the feasibility for state Medicaid programs of including home care worker identity on claims submitted for Medicaid reimbursement?*

   This is simpler under EVV, but it is important to include MLTSS claims.

IV. <u>HCBS Workforce</u> - *What are specific steps CMS could take to strengthen the HCBS home care workforce, including establishing requirements, standards or procedures to ensure rates paid to home care providers are sufficient to attract enough providers to meet service needs of beneficiaries and that wages supported by those rates are sufficient to attract enough qualified home care workers.*

As America ages, we will continue to demand a growing personal care and home health aide workforce. There are currently 1.8 million personal care aides and 900k home health aides.[1] The forecasted demand / growth for these jobs over the next 10 years is 25.9% and 38.1% respectively[2], far out pacing other occupations.

In order to prepare for the pending "age-wave" of boomers and the caregiver shortage that will go along with it, we need to begin now to prepare for an alternate reimbursement system that will help increase capacity while focusing on outcomes. An episodic model for personal care service would bring these services into the trend of shifting from volume to value. Such a transition will be a paradigm shift for consumers, payers, and providers; consequently, planning and piloting new models needs to be a priority.

1. Technology will play a key component in allowing providers and caregivers to be more efficient with care delivery and communication/coordination with other members of the inter-disciplinary team. Technology will also be a key component to providing support for quality oversight for caregivers and payers.

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[1] See http://www.bls.gov/ooh/personal-care-and-service/home.htm, http://www.bls.gov/ooh/healthcare/home-health-aides.htm

[2] *Id.*

2. Visit vs. hourly fee for service reimbursement will put the emphasis on the services and tasks needed; and allow a caregiver to move to the next visit rather than stay for an arbitrary time. The increased flexibility will allow employers to be more competitive with wages and benefits which will help address the caregiver shortage and low wages.

In the short term, before a new model is developed work needs begin immediately to address caregiver shortages and emerging access challenges today. The elimination of the companionship exemption, new regulatory requirements on benefits and minimum wage, stagnant reimbursement increases on Medicaid and regulatory inconsistencies are impacting agencies ability to meet the needs of today's consumers. Actions that can be taken in the short term are the following:

1. CMS could work with states to look at the issue of rate setting to make sure it includes the reasonable cost of doing business.

2. 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.

3. CMS could also provide further incentives and supports for training and other efforts designed to provide a career path for personal care attendants.

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In closing, we would like to thank you again for this opportunity to offer our perspective on solutions that can improve the quality, efficiency and integrity of Medicaid home-based care. We look forward to a continued and productive dialogue with CMS and are available as a resource to CMS as it considers the real world impact of these policies.

Sincerely,

David J. Totaro, Chair

Partnership for Medicaid Home-Based Care Members
AccentCare, Inc., Addus HomeCare, Inc., All Metro Health Care, BAYADA Home Health Care, CareCentrix, Caring Associates, Inc., CellTrak Technologies, Inc., Centene, Consumer Direct Care Network, Council of State Home Care Associations, HHAeXchange, Home Care Association of America, Home Care by Blackstone, Interim HealthCare Inc., LHC Group, Inc., Molina Healthcare, Inc., ResCare Home Care, Sandata, Sutter Care at Home, VNA Health Group, WellCare Health Plans