PARTNERSHIP FOR MEDICAID HOME-BASED CARE

June 26, 2019

The Honorable Susan Collins
Chair
Special Committee on Aging
United States Senate
Washington, DC 20510

The Honorable Bob Casey
Ranking Member
Special Committee on Aging
United States Senate
Washington, DC 20510

Dear Senator Collins and Senator Casey:

On behalf of the Partnership for Medicaid Home-Based Care (PMHC), I would like to thank you for this opportunity to comment on how falls and fall-related injuries can be prevented and managed. We applaud the Special Committee on Aging for bringing heightened focus to this critically important issue, and we are enthusiastic about the improvement that can be achieved thanks to the valuable time and attention you are devoting to it.

By way of brief background, PMHC was established in 2015 to advance the delivery of high-quality, cost-effective Medicaid home-based care and services. Our members bring to this important quest their experience as home care providers, associations, managed care organizations, and technology providers. While such a diverse membership is somewhat unique, our members have come together due to a shared commitment to support legislative and regulatory efforts that improve the quality, accessibility, and integrity of home and community-based care and services in Medicaid.

It is precisely because the Special Committee's work contributes so greatly to these outcomes that we are grateful to contribute our comments to the forthcoming annual report on falls and fall-related injuries. As you know, the Medicaid program enables the delivery of clinically effective, patient-centered, and fiscally efficient Home and Community-Based Services (HCBS). As a result, millions of older Americans and individuals with disabilities are able to remain in their homes where they most want to be, and billions of dollars have been saved for federal and state taxpayers by reducing the need for high-cost institutional care.

In addition, advanced clinical training, care delivery systems, and care management technologies have made it possible for substantial progress to be made in combatting the two crises on which the Special Committee is focusing: falls and fall-related injuries. However, we believe even more can – and must – be done. The tragic reality is that falls continue to occur every day across the U.S., and the injuries that result from them are deeply impacting older Americans and taxpayers alike.

300 New Jersey Avenue, NW ▪ Suite 900 ▪ Washington, DC 20001
Phone: 202.742.5274 ▪ Fax 202-315-3490 ▪ www.medicaidpartners.org

As a result, we would like to offer the following recommendations for your consideration. Organized in alignment with the topics articulated in your May 15, 2019 letter, we hope these comments will be of value as you seek to foster further progress in preventing and managing falls and fall-related injuries among older Americans and individuals with disabilities.

Overview:

In our collective view, in-home care services delivered by Home Care Aides (also referred to as Personal Care Aides, Personal Attendants and other titles in some states) are the best yet most underutilized resource available to mitigate the risk and result of falls and fall-related injuries among older adults. These Home Care Aides spend more time with their elderly consumers, and their many responsibilities include assistance with ambulation, bathing and dressing, and general housekeeping tasks. Each of these activities provides Home Care Aides with first-hand knowledge that can and, we believe, should be leveraged to significantly reduce the occurrence and implications of falls among older Americans. Given their close and frequent contact with consumers, Home Care Aides are also an unrivalled resource in assessing and reporting on any changes in conditions that may impact elderly individuals' ability to ambulate safely.

Despite these unique characteristics, Home Care Aides are often not included as part of the health care team. Borne of the historical silos that define the Medicare and Medicaid programs, this problem is exacerbated by the lack of coordination that often exists between payers and providers of physical health services (i.e., Medicare) and the payers and providers of Long-Term Services and Supports (LTSS) (i.e., Medicaid).

As a result, our consensus view is that a key element of the solution to falls and fall-related injuries is improved use of America's home care resources. To be sure, efforts to better coordinate care for older adults are emerging, but development remains slow and positive outcomes have yet to be disseminated. Movement of LTSS services to managed care (MLTSS), Dual Demonstration projects, and greater flexibility in supplemental benefits under Medicare Advantage are steps in the right direction but they have not yet applied focused attention on fall reduction or moved the needle dramatically on better care coordination. It is in the interest of addressing this gap that we offer for your consideration the following comments and recommendations.

Reporting and Follow-Up:

Today, fall reporting is generally reported by home care providers but the processes and requirements to do so are highly variable between state programs. Aggregation of data is equally inconsistent at the state level and no reporting of statistics on falls among the elderly is reported by states to CMS. Although fall risks and prevention are routine components addressed in initial functional assessments, there is little coordination on an on-going basis to mitigate risks or modulate care plans to address changes in consumer status and mobility. Many home-based providers take action to mitigate falls given their familiarity with the home setting and with measures routinely implemented to eliminate any conditions within the home

that can lead to falls. However, in most cases these actions are not requirements of state Medicaid waiver programs, and at present providers are not taking such action universally. These safeguards are further weakened by gaps in the current system. For example, mechanisms are more often not in place within the continuum of self-directed care, nor are auditable systems in place to measure and mitigate falls. Similarly, falls that result in emergency department care do not consistently benefit from caregiver notification and coordination of follow-up care. As a result, both of these circumstances mean that many falls and injuries which could be prevented are not, with significant physical and fiscal consequences.

PMHC Recommendation:

- To address the lack of uniformity and other weaknesses, PMHC recommends that Congress direct or encourage the Secretary of Health and Human Services (HHS) to improve processes for the assessment, education, reporting, and post-event coordination of falls on a uniform basis within Medicaid and Medicaid Waiver home-based services, inclusive of both modes of care, agency-provided and self-directed.

Tools and Resources:

A combination of enhanced staff training and advanced assistive technologies has contributed to improvement in fall prevention and reporting. Within the home setting alone, the tools and resources available to older Americans today are dramatically better than what was the norm just a decade ago. In addition, there is now a much broader understanding of the risks that may be posed by such common home conditions as uneven floor services, small pets, physically demanding bathrooms, and the like.

Mitigating these risks depends on assessment, education, and preventive activities which, as noted above, can and should be delivered on a much more uniform basis. For many older Americans, however, access to other resources – including home modifications and assistive technologies – are not financially feasible because these expenses are generally not covered. In addition, many older Americans are unable to bear the out-of-pocket expense of these tools and resources, leaving them vulnerable to falls and the healthcare system exposed to the resulting costs.

PMHC Recommendation:

- PMHC recommends that Congress direct or encourage the Secretary of HHS to undertake a comprehensive demonstration project, via the Center for Medicare and Medicaid Innovation (CMMI) or other auspices, to fund and measure the impact of enhanced home care assessments, home modifications, and assistive technologies.

Medicare:

Despite its myriad contributions to senior health, the Medicare program has frequently (and not unjustly) come under criticism for addressing healthcare needs after they have arisen

rather than placing equal or greater focus on proactive prevention. Unfortunately, falls are a relevant illustration of this weakness, as Medicare provides substantial coverage for the treatment of injuries sustained in falls but offers less support than would be optimal to prevent those falls from occurring.

The expansion of supplemental benefits under Medicare Advantage by CMS is a positive step toward better coordination of home and community-based services for Medicare beneficiaries, including coordination to mitigate fall risk. Recognizing that CMS changes to these benefits is relatively new, the benefit designs to date have not focused on use of these services for better coordination.

PMHC Recommendation:

- The Medicare program has begun implementing payment and documentation changes that have the effect of restricting access to Medicare Home Health services, especially among homebound individuals. PMHC recommends that Congress direct or encourage the Secretary of HHS to provide coverage of preventative therapy, medication management, and wellness services designed to prevent or reduce risk of falls. Further, PMHC recommends that the Secretary of HHS encourage Medicare Advantage plans to make better use of the supplemental benefit flexibility provided to improve health outcomes and reduce costs associated with falls and fall related injuries.

Evidence-Based Practices:

PMHC members are among the nation's leaders in long-term services and supports. However, the lack of sufficiently coordinated care management system-wide has prevented the production of evidence-based best practices in falls prevention. In their place, our members have pioneered a variety of solutions to reduce the risk of institutionalization for older adults and believe that any efforts to improve outcomes related to falls should engage Home Care Aides. Some recommended best practices include:

- Use of required in-home supervisory visits to assess and document changes in the home environment or in consumer condition that may result in increased fall risk and communicate assessment results to consumer/family and Case Manager.
- Enhance training of Home Care Aides to improve recognition of increased fall risk from changes in home environment or client condition and require Home Care Aides to report such observations to Agency supervisory staff.

PMHC Recommendation:

- Due to the breadth of experience that exists across the home care community, PMHC recommends that the Special Committee utilize the annual report as the kick-off for an extended process with stakeholders to identify best practices and formulate uniform policy changes that can expand the use of best practices across the delivery system.

Polypharmacy:

Thanks to the tremendous strides achieved in pharmaceutical research and coverage, life-saving and -extending therapies are not commonly available to older Americans. Indeed, it is not uncommon for today's seniors to rely on multiple medications for their health improvement and management. The flip side of this progress, however, is that many elderly individuals are experiencing complications from the poorly coordinated use of a variety of products.

In many cases, this lack of coordination is due to the role played by multiple physicians and caregivers – often without knowledge of each other's participation in a consumer's care – as well as the use of more than one pharmacy to fill medication orders. The result is a veritable stew of powerful agents, raising the risk of adverse events and impacting the patient's ability to ambulate safely and engage in routine activities of daily living (ADLs).

Here too, fortunately, in-home care can play a very important role. If clinicians review medications on a regular basis, enabling polypharmacy risks to be identified, education to be provided about risk monitoring and proper self-administration, it provides the opportunity for alerts to be delivered to the various members of the consumer's care team, including the Home Care Aide to ensure that care is coordinated. This is also an example where the importance of coordination of in-home care is not being fully utilized, since the input of the in-home care team is not yet sufficiently valued to be fully integrated by the full care team into holistic and effective care planning.

PMHC Recommendation:

- In light of the growing reliance of older Americans on pharmaceuticals and, thus, the growing risk of falls and other polypharmacy complications, PMHC recommends that Congress direct or encourage the Secretary of HHS to require the uniform production of medication and risk assessment reports by in-home caregivers as well as their full dissemination and use by all members of a consumer's care team.

Transitions of Care and Post-Fracture Care (combined):

The days following discharge are crucial to the recovery and sustained health of many older Americans. And yet, this period is also fraught with tremendous gaps which often cause discharged individuals to languish at home for an extended period of time before post-acute, post-fracture care can be initiated. In an era when communications technology enables information of all kinds to be shared all over the world on an instantaneous basis, our nation's inability to provide for seamless, skilled transitions of care is not only a serious problem – it is positively baffling.

Fortunately, the solution to this problem is readily available. If the in-home care team were included in the discharge planning process, they would know when the consumer is being discharged so that they can be there when the consumer returns home. As a result, steps could be immediately taken to prepare the home environment for safe ambulation and other ADLs,

coordinate and support the delivery of needed therapeutic and rehabilitative services, and prevent complications and recurrence of falls. Just as important, fully-engaged home care teams would be able to ensure consistent coordination with all members of the patient's care team, enabling meaningfully improved outcomes and significantly lower cost.

PMHC Recommendation:

- PMHC recommends that Congress direct or encourage the Secretary of HHS to undertake a comprehensive demonstration project, via CMMI or other auspices, to fund and measure the impact of improved discharge planning processes in which the in-home care team is included, on-site, and engaged in ongoing communications and coordination.

In closing, we would like to thank you again for considering our perspectives on this important issue. We are proud to applaud your efforts and hope our comments will meaningfully contribute to your annual report on falls and fall-related injuries. We are confident both crises can be significantly mitigated, and we thank you for all that you, your colleagues, and your staff are doing to achieve this worthy goal.

Sincerely,

David J. Totaro, Chairman