May 23, 2017

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Chairman Hatch:

As members of the Partnership for Medicaid Home-Based Care[1] (PMHC), we would like to take this opportunity to offer our views and recommendations on healthcare reform. Dedicated to advancing the delivery of high-quality, cost-effective Medicaid home-based care and services, PMHC is comprised of organizations representing providers, associations, payers and business affiliates who have come together to support legislative and regulatory efforts to improve the quality, accessibility, and integrity of home-based services.

As Congress considers modifications to the Medicaid program, we wish to underscore the importance of expanding individuals' access to home-based care and services. Home-based care is well-documented as a high-touch, low-cost, and consumer-preferred solution that delivers clinically-advanced, cost-effective, and self-determined services to Americans every day. It is for these reasons that lawmakers and government officials strongly support Home and Community-Based Services (HCBS) and recognize them as an important way for the Medicaid program to be fiscally responsible and provide services that people need and want.

It is our sincere hope that these ideas are useful to your important work, and we stand ready to answer any questions you may have or provide any information or feedback that may be helpful to you.

To modernize the program and expand access to home-based care and services, we recommend that the following solutions be considered:

1. Adopting "Home First" Model for Medicaid Applicants:

Established in 1965 and updated only occasionally in the years since, the Medicaid program includes elements that are vestiges of a time long past. Nowhere is this as evident as the bias that still exists within the program for institutionalization of individuals who can be served equally well and at much lower cost in their homes and communities. For example, an analysis by the Texas Legislative Budget Board recently determined that the state saved an estimated $2.6

[1] Members of the Partnership for Medicaid Home-Based Care include: Addus HomeCare, All Metro Health Care, Anthem, BAYADA Home Health Care, CareCentrix, Caring Associates, CellTrak Technologies, Centene, Consumer Direct Care Network, Council of State Home Care Associations, HHAeXchange, Home Care Association of America, Interim HealthCare, LHC Group, Molina Healthcare, ResCare Home Care, Sandata, Sutter Care at Home, VNA Health Group, and WellCare Health Plans.

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billion by utilizing home and community-based services rather than nursing home care.[2] And yet, placement of individuals in nursing homes remains a default mandate within the Medicaid program.

As a result, we believe Medicaid rules should be modernized to encourage utilization of HCBS. Such reform would enable individuals to remain out of more costly settings, decrease health care expenditures, and satisfy consumers' strong preference to remain in their own homes. This reform would also achieve compliance with the U.S. Supreme Court's Olmstead decision (Olmstead v. L.C., 527 U.S. 581, 1999), 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 respectfully urges the development of a **"Home First" model for Medicaid placement**, in which new applicants for long-term services and supports would 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.
- We further encourage **States and MCOs be given sufficient flexibility** in defining benefit packages to ensure that costly nursing home placement is not used as the "default" or "catch all" due to programmatic, funding or benefit gaps. Addressing significant HCBS wait lists would expand access to long-term services and supports (LTSS). Allowing shared cost savings between Medicare and Medicaid would also address incremental cost increases in Medicaid as a result of wait list reductions.

2. Strengthening Medicaid Program Integrity:

PMHC supports reforms applicable to agencies and self-directed providers to ensure the integrity of care/services provided. These recommendations are not intended to increase overall regulation but to streamline operations for providers and states by establishing uniform standards and regulations. Specifically, we recommend:

- Standardized rules, to ensure hours billed are authorized, match the care/service plan, account for hospitalization days, and prevent banking of hours.
- Establishment of conditions specific to eligibility for Medicaid reimbursement for Personal Care Services (PCS) that at a minimum include:
  - Home Care Agencies must file its Employer Identification Number (EIN) for work performed by all employees of the home care agency;
  - Filing an EIN or a unique identifier provided by the State Medicaid agency by each self-directed provider;

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[2] Texas Legislative Budget Board Staff; "Expenditure and Caseload Trends for Long-Term Care in the Texas Medicaid Program"; pp. 223–228 in "Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations"; January 2009.

  - Requiring all claims for personal care services include the specific date on which each service is performed and the identity of the home care agency or self-directed care provider rendering each service;
  - Requiring, prior to award of a new provider number, that the applicant demonstrate access to capital sufficient to operate for at least six months, exclusive of actual or projected accounts receivable from Medicaid or other sources (exempting self-directed care and agencies or providers in frontier or underserved areas.); and,
  - Conducting an on-site review within the first year of operation and triennially thereafter to review adherence with minimum business practices; ensure qualifications of staff per state regulation as well as supervision of same staff per waiver requirements; consumer assessment per waiver requirements and any state minimums; and provision of services per plan and respect of consumer rights.
- Guidance to States regarding adequate prepayment controls, including:
  - Claims edits to prevent PCS payments during periods when consumers are receiving institutional care, except in cases where PCS services may be required for instrumental activities of daily living (e.g. money management and meal preparation);
  - Electronic Visit Verification (EVV) enabled claims verification;
  - Crosswalk of Medicare and Medicaid data to identify potential instances of fraud, waste, and abuse; and full, timely, and free access to data sources such as Medicare Coordination of Benefits Agreement (COBA); and,
  - Establish minimum federal requirements and guidance for PCS care/service plans, claims documentation, consumer assessments, and attendant supervision appropriate to the scope of the site's authorized services.
- Payment Accuracy
  - Bi-annual analysis of network adequacy and access to care including: rate studies and a comprehensive review of current costs, current and anticipated enrollment numbers, impact of rate structure on institutionalization, and general capacity to fulfill consumer needs based on the number of enrolled providers in each category of HCBS.
- EVV Implementation
  - Use of an open model that allows providers to use any system meeting EVV standards and 508 regulations to capture time in, time out and other "point of care" information and that also allows for dignity of risk by self-directed consumers.
- Standardized Quality Standards
  - A minimum LTSS data set (that includes long-term care and HCBS) that utilizes a core set of measures including: consumer health, welfare, quality of life and satisfaction, financial accountability, and service provision and delivery;
  - Use of the LTSS data set to achieve: CMS accountability for funds spent, insight into efficiency and outcomes, efficiency for CMS and the States in initial data collection and reporting, and flexibility enabling States to add unique measures;

- State requirement that LTSS managed care plans serving their clients consider these quality measures when contracting and credentialing providers; and,
- CMS use of performance data resources that have already been developed, including: OASIS data on the quality of the delivery of skilled care to Medicaid consumers by home care agencies, post-acute care quality measures, as required by the IMPACT Act of 2014 (with particular reference to measures related to the cognitive and functional status of and the level of spending on LTSS recipients in HCBS settings as compared other institutional settings), and EVV measures, as required by the 21st Century Cures Act (with particular reference to measures of timely care, quality care, and efficiency of care).

By strengthening Medicaid recipients' access to high-quality, cost-effective, consumer-preferred home and community-based services, we are confident that these reforms can improve outcomes, increase quality of life and satisfaction, and significantly reduce program costs. We hope these recommendations are of value to you and would be honored to serve as a resource to you at any time needed.

Sincerely,

David J. Totaro
Chairman

cc: The Honorable Ron Wyden, Ranking Member
Committee on Finance
United States Senate
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The Honorable Patrick J. Toomey, Chairman
Subcommittee on Health
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The Honorable Debbie Stabenow, Ranking Member
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