PARTNERSHIP
FOR
MEDICAID HOME-BASED CARE

www.medicaidpartners.org

Home-Based Care: Value Options for Medicaid Policymakers

Established in 2015, the Partnership for Medicaid Home-Based Care (PMHC) is an alliance of leading home-based care providers, associations, MCOs and other payers, and business affiliates committed to building a higher quality, more sustainable, and more secure Medicaid program. We are proud to offer the following perspectives and solutions, which have been crafted with the objective of enabling the cost-effectiveness of home-based care to be maximized for the benefit of both Medicaid and the Medicare program, whose fiscal sustainability similarly depends on home-based care.

We hope these proposals are of value to Congress and the Administration and would welcome the opportunity to provide experienced input during the ongoing Medicaid policy discussions.

Home-Based Care is a Value Driver with Broad Support:

- AARP's Spotlight report, "State Studies Find Home and Community-Based Services to Be Cost-Effective" (March 2013), examined 38 HCBS studies from states across the U.S. and concluded "The studies consistently provide evidence of cost containment and a slower rate of spending growth as states have expanded HCBS."
    - For example, a study conducted by the University of North Florida found that "Nursing home cost savings associated with HCBS use ranged from $1,000 to $1,500 per member per month compared with non-HCBS applicant utilization".
    - Similarly, an analysis by the Texas Legislative Budget Board Staff concluded that "the state would have exceeded historical expenditures by $2.6 billion" if care had been provided in institutional sites rather than in HCBS settings.
- Home-based care also enjoys broad support among citizens and advocates alike.
    - For example, AARP surveys document that 9-in-10 American seniors prefer to remain in their home rather than live and receive care in an institutional setting. As AARP states in their Aging in Place survey, "The great majority of older adults have a strong desire to live in their own homes and communities."

Home-Based Care Proposals for Consideration:

- In order to assist decision-makers as they work to improve the Medicaid program's effectiveness and efficiency in a manner preferred by consumers and advocates alike, PMHC recommends consideration of the following proposals:
    1. Preserve Cost-Effective Care Delivery Systems
    2. Adopt "Home First" for Medicaid Applicants
    3. Improve Value Delivery in Home-Based Care
    4. Strengthen Medicaid Program Integrity Safeguards
    5. Modernize Consumer and Provider Supports
- Through these approaches, we believe a higher quality, more sustainable, and more secure Medicaid program can be achieved.

1. Preserve Cost-Effective Care Delivery Systems:

An estimated 10 million Americans – known as dual eligibles – are enrolled in both Medicaid and Medicare. Comprising seniors and younger individuals with disabilities, this population is entitled to Medicare as well as some level of assistance from their state's Medicaid program. In general, Medicare acts as the primary payer for a range of services, while Medicaid provides cost-sharing assistance and may pay for services excluded from or limited under Medicare, such as long-term services and supports (LTSS) delivered in home and community-based settings.

In this manner, Medicaid LTSS services provide important fiscal relief for the Medicare program. In 2011, for example, the Medicaid program covered $91.8 billion in LTSS costs for dual eligibles. Absent this support, many dual eligibles would have been institutionalized, resulting in the shift of billions of dollars in costs to Medicare.

- As Washington and the states consider fiscal adjustments to Medicaid, we therefore urge that care be taken to **preserve and expand access to long-term services and supports (LTSS) for people who are dually eligible for Medicaid and Medicare** by allowing shared cost savings between Medicare and Medicaid so that their needs can be met in cost-effective HCBS settings.

2. Adopt "Home First" Model for Medicaid Applicants:

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, 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.

3. Improve Value Delivery in Home-Based Care:

The nation's healthcare delivery system has embarked on a fundamental transformation to emphasize and reward value over volume. Home-based care plays a critical role in achieving this change, due to the high quality, low cost, and cost-avoidance power of its services. To further improve the delivery of value in home-based care, PMHC believes HCBS providers should be held accountable to and rewarded for providing high-value care.

Standardized Quality Measures:

To most effectively support the delivery of value in home-based care, PMHC recommends **adoption of a strong, national set of quality measures** that are standardized, industry accepted, and efficacious. Essential elements of such a quality measurement system include:

- 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).

New Payment Model:

PMHC also recommends consideration **of a new payment model, in lieu of the current fee for service basis per unit** (where units are measured in 15 minute or 1 hour increments) in order to address the system's current incentives for volume rather than value. A new system that promotes efficiency will also help the delivery system address its serious workforce shortage. Key principles and benefits of a new payment model that incentivize value and reward quality include:

- Reimbursement for the task rather than the time increment; and
- Reimbursement tied to meeting threshold quality measures with rewards for improving health outcomes.

4. Strengthen Medicaid Program Integrity:

PMHC supports reforms ensuring the integrity of Medicaid home-based care, wherever it is provided. We believe any diversion of Medicaid resources away from the delivery of needed care – whether due to fraud, waste, or abuse –must be combatted. Strengthening Medicaid program integrity is therefore integral to the overarching principles of preserving access to care, improving quality and outcomes, and ensuring the dignity of those who depend on Medicaid services.

Towards that end, we are pleased to offer the following recommendations that we believe would achieve significant improvement in program integrity. In preparing this proposal, we were mindful of the need to avoid increasing regulatory burdens and therefore designed these recommendations in a manner streamlining provider and state operations by utilizing uniform standards and regulations. Our recommendations are as follows:

- Standardized rules, to ensure hours billed are authorized, match a detailed care/service plan, account for hospitalization days, and the banking of hours.
- Establishment of conditions specific to eligibility for Medicaid reimbursement that at a minimum include:
  - A national provider identifier, of a type and modality to be determined in collaboration with law enforcement and stakeholders;
  - Demonstration, prior to award of a new provider number, that the applicant has sufficient access to capital 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 (which may be waived in case of accreditation) 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 payments during periods when consumers are receiving care in institutions or other settings, except in cases where services may be required for instrumental activities of daily living (e.g. money management and meal preparation);
  - 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 additional minimum federal requirements and guidance for care/service plans, claims documentation, consumer assessments, and aide/attendant supervision appropriate to the scope of the provider's authorized services.
- EVV Implementation
  - Use of an open model that allows providers to use any system meeting EVV standards to capture time in, time out and other "point of care" information and that also supports the principles of self-direction.

www.medicaidpartners.org

- Data Transparency and Oversight
    - A minimum LTSS data set to be developed in collaboration with stakeholders (that includes long-term care and HCBS) and enhances transparency and oversight by utilizing 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, including in the future efforts of CMS to enhance the State Medicaid Scorecards, 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).

- Documentation of the following (which may be waived in case of proof of current accreditation or certification by an appropriate national organization):
    - The legal structure under which the provider is organized to do business;
    - A list of the provider's directors, officers or owners, as applicable to the legal structure of the provider;
    - The address, phone and fax number, and website address associated with a physical office location with sufficient square footage for administrative personnel and office equipment and the capacity to serve all contiguous geography. The office location must be in a properly zoned area for business and not operated from a private residence. The location must also have adequate space for designated, locked storage of client records that are accessible to program staff;
    - Verification of experience in providing service for which certification is requested;
    - A minimum of 3 years of experience in business operations providing like services;
    - Past business practices of the provider and its affiliates, including the managers, directors or owners, relevant to the service applied for, involving, but not limited to, the following circumstances: denial, suspension, revocation or termination for cause of a license or Provider Agreement, or any other enforcement action, such as civil court or criminal action; termination of a Provider Agreement or surrender of a license before expiration or allowing a contract or a license to expire in lieu of enforcement action; any federal or state Medicaid or Medicare sanctions or penalties relating to the operation of the agency, including, but not limited to, Medicaid abuse or fraud; any federal or state civil or criminal felony convictions; operation of an agency that has been decertified in any state under Medicare or Medicaid; or citations for client abuse, neglect, injury, financial exploitation or inadequate care in any state;

www.medicaidpartners.org

- The provider's written policies and procedures, including but not limited to: confidentiality of client records, authorized-only access to client records, maintenance of current and archived files in a secure and confidential manner; and assurance that the type and amount of service provided is in accordance with the governing client agreement or care plan;
- The provider's ability to comply with all applicable responsibilities imposed on like providers, including proof of required insurance coverages;
- Compliance with all applicable federal, State and local laws, regulations, rules, service standards and policies or procedures pertaining to the provider in its business operations and services provided;
- Job descriptions, personnel policies, and personal records for all employees;
- Compliance with U.S. Department of Labor, Occupational Safety and Health Administration (OSHA); U.S. Department of Homeland Security, U.S. Citizenship and Immigration Services; Drug Free Workplace Act; and Patient Self-Determination Act requirements;
- Administrative and client records, including observance of confidentiality in the maintenance and transmission of records, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- All-hazards disaster operations plan to respond to emergency situations, including, but not limited to, medical emergencies, home or site-related emergencies, client-related emergencies, weather-related emergencies and vehicle/transportation emergencies;
- Adequate supervision of all persons, both staff and volunteers, having direct contact with applicants/clients; and,
- Reporting processes for all conditions or circumstances that place the applicant/client, or the applicant's/client's household, in imminent danger (e.g., situations of abuse or neglect).

5. Modernize Consumer and Payment Supports:

Last but by no means least, we believe updates to four other areas of Medicaid policy – pertaining to housing, individuals with cognitive impairment, provider network adequacy, and use of smart home technology – have the power to further reduce Medicaid spending while expanding access to consumer-preferred, cost-effective home-based care.

Improving Access to Community-Based Housing:

A key to avoiding unnecessary nursing home placement is access to adequate, affordable, integrated housing that allows individuals to stay in their homes and communities to receive care. At present, however, the Medicaid program is forced to bear billions of dollars in nursing home costs due to the inadequate supply of affordable, accessible, integrated housing for Medicaid participants.

Contributing to this problem are current regulations that prohibit home and community-based programs from providing financial support for housing. Specifically, the current HCBS benefit

package does not offer consumers any assistance with securing and maintaining a home, and vital home modification services are generally underfunded.

- As a result, PMHC urges consideration of **regulatory reform that corrects unnecessarily restrictive housing policies** in order to allow states and MCOs the flexibility to design benefit packages that are cost effective and serve consumers where they prefer, at home and in the community.
- PMHC also 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 mechanisms such as **housing tax credits and vouchers** to allow more individuals to be able to remain, and receive needed care, at home.

Meeting the Needs of Individuals with Cognitive Disabilities:

America is experiencing significant expansion of its population of seniors who have dementia and other cognitive disabilities but who 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, this flaw leads many individuals with dementia and other cognitive disabilities to be found ineligible for Medicaid services.

Unless functional eligibility assessments are modernized to account for cognitive disabilities leading to access to HCBS tailored to the needs of people with cognitive disabilities, individuals with cognitive disabilities will continue to decline rapidly and face the risk of requiring more expensive care in institutional facility settings.

- As a result, PMHC urges consideration of Medicaid benefit design modifications that improve placement and reduce program costs by ensuring **functional eligibility assessments that adequately account for cognitive disabilities** such as dementia.

Strengthening Provider Network Adequacy:

One of the foundations of a strong and sustainable delivery system for home-based care is a viable provider network. Without workforce and network stability, home-based care is at risk of fragmenting, which can lead to placement of individuals in more costly institutional settings and a worsening of their clinical outcomes.

At present, however, State Medicaid agencies are not required to perform periodic reviews to ensure the accuracy or adequacy of their HCBS reimbursement rates. Optimally, these studies should include a review and list of rates paid for like services within the state and like states through sources including but not limited to: Veteran's Administration, Older American Act services through Area Agencies on Aging, Centers for Independent Living, State programs, commercial and long-term care insurers and private pay consumers.

Additionally, the quality and stability of the direct care workforce is critical to the stability of the Medicaid long term services and supports program, as well as the cost effectiveness of home-based care. Any comprehensive review of costs should therefore incorporate the additional

www.medicaidpartners.org

training needs and improved wage scales of direct care workers to meet the demands of the aging and disability populations.

- In light of these factors, PMHC urges the design and implementation of a 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.

Use of Smart Home Technology:

Emerging evidence regarding smart home technology – including but not limited to advanced monitors, scales, communications tools, and other means to report key metrics and changes in condition – indicates improvement or the potential to improve consumer wellbeing and the efficiency of the health care delivery system in a way that serves as an important complement to services delivered by Medicaid home-based care providers and as a vital facilitator to information gathering for quality measurement.

- As a result, PMHC urges consideration of incentives for **expanded use of smart home technology in demonstration projects,** subject to consumer choice, that monitors individuals' clinical status, enables care teams to avoid costly institutionalization, and measures consumer outcomes.