C. MEDICAID

REQUIRE TRANSPARENCY IN THE STATE PLAN AMENDMENT PROCESS

ISSUE: In order to make changes to the Medicaid benefits that a state can offer, the state must file a State Plan Amendment (SPA) with CMS. When the SPAs are filed the details and rationale of the SPA are typically unknown to stakeholders. Once a state receives an approval, providers are notified of the changes and are required to comply, often with little notice and little knowledge of the reasoning behind the change. Unfortunately these SPAs can often be damaging to the provider and the patient, requiring more limited services or reduction in payment rates both of which hinder access to care.

RECOMMENDATION: CMS should require states to conduct a transparent State Plan Amendment Process. The SPA should be announced, made public, and offer a comment period prior to submission to CMS. States should also be required to maintain a SPA repository so that stakeholders can review the SPAs in their entirety at any time, including the SPA as approved by CMS. The repository should include the language of each SPA as well as any data that the SPA has been based on so that stakeholders can get a full view of the rationale behind the SPA. In addition, CMS should provide a formal comment process prior to any SPA determination.

RATIONALE: When states make a decision to modify the Medicaid program, it is essential to allow input from the stakeholders who will ultimately be responsible for implementing the changes. Currently, the SPA process is a mystery for most stakeholders and they are left scrambling to find ways to implement the amendments and often discover that the amendments will be damaging to patients and providers after the amendment has already been approved by CMS. Stakeholders are also in the best position to offer insight to the practicality of a particular SPA but can only do so when presented with the information and offered an opportunity to comment. In many cases stakeholders may be able to offer a different solution that does not require the state to submit a SPA. Creating a more transparent SPA process benefits stakeholders, the states and CMS by allowing the involved parties to participate in the process and avoid unnecessary work on ineffective amendments.
REQUIRE MEDICAID HOME CARE PROGRAMS TO MEET QUALITY OF CARE STANDARDS AND OFFER A FULL RANGE OF DELIVERY MODELS

ISSUE: Some states contract directly with individuals to provide paraprofessional services ranging from social support to “hands-on” personal care rather than using home care organizations for the provision of such services. In some cases, the services provided by these individual providers require highly-trained health care workers, such as in cases where insulin injections, catheter care, nasogastric tube insertion and feeding, and other services are needed. These services are financed through a variety of programs at the federal, state and county levels. Many states have determined these workers to be employees of the client, thereby delegating the traditional duties of the employer (such as hiring, educating, supervising, firing, securing backup workers when the primary care provider is not available, performing background checks, and, in some cases, transmitting payment for services and making employer tax contributions) to the client.

Advocates for people with disabilities are strongly supportive of consumer direction of personal care and have worked diligently to make the option more widely available. Clearly, it provides recipients more choice and greater independence. However, states’ decisions to use this model may be driven by financial considerations rather than patient needs.

The National Association for Home Care & Hospice (NAHC) recognizes and fully supports the rights of individuals to direct their own care. However, NAHC has serious concerns about state or federal imposition of the consumer-directed model of care upon individuals who are incapable of directing their own care, fearful of assuming the responsibilities of an employer, or unaware of the responsibilities associated with consumer-directed care. NAHC is also concerned that, in the absence of minimum quality standards, it is possible that neither clients nor workers may be protected by important Occupational Safety and Health Administration (OSHA) safeguards, such as the blood borne pathogen standard, because the workers are not considered to be employees of organizations which are bound to follow OSHA rules.

In 2012, the Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding the Community First Choice optional benefit. In this rule, CMS suggested that states offer a self-directed care model and an agency model for the delivery of services. However, the rule is not sufficiently clear that states must offer full freedom of choice to Medicaid beneficiaries on the model of care delivery. It is possible that different levels of care may be available under the different models.

RECOMMENDATION: Congress should require all states contracting with individuals to provide paraprofessional home care services through federally-funded programs to provide adequate assurances that consumers receiving care from such individuals are assessed to be capable (for example, a person receiving highly skilled services such as catheter care must be capable of directing the caregiver in the performance of that task) and willing to assume the required employer responsibilities. Consumers should also be given the full option to choose among service models (consumer-directed, home care agency, etc.) to ensure individual freedom of choice, and should have access to the same frequency and type of care regardless
of the chosen delivery model. States should also provide a mechanism for resolving any problems that arise between a consumer and providers, and should devise a method for ensuring that backup workers are available. Consumers directing their own care and their caregivers should be afforded the same important protections that are required when care is provided through an agency. The same needs should be met under each model for the same level of care. Caregivers should be trained, tested, and competent to provide services.

**RATIONALE:** A goal of home care is to foster independence in the least restrictive environment while safely meeting the consumer’s needs. Consumers have the right to choose the model of care that best suits those needs. Individuals who are capable and choose to should be permitted to self-direct care. However, those who are unwilling or unable to assume the many responsibilities associated with this model should be able to select other options. For the safety of consumers and caregivers, the education, testing, and quality standards to which agencies are held should apply to all models of care. All models of care should require compliance with applicable state and federal labor laws and health and safety regulations.
ENSURE ACCESS TO HOME CARE IN MEDICAID MANAGED LONG TERM SERVICES AND SUPPORTS

ISSUE: In the early stages of Medicaid care delivery reforms, most states that tested the use of managed care in Medicaid excluded long term services and supports (LTSS) from the program and continued coverage of those services under traditional Medicaid fee-for-service. In response to Olmstead and the increasing financial pressures of the cost of institutional care, states have begun efforts to rebalance long term services and supports expenditures in favor of home care. At the same time, with the growth of long term care spending, states have begun implementing managed care for LTSS services as well. It is expected that many states will partly or fully move to mandatory managed care enrollment in the next few years.

While states are provided great flexibility in Medicaid, it is crucial that any transition to managed LTSS not lose the valuable benefits of community-based care that have been achieved in Medicaid over the last several years. Foremost is the effort to avoid institutionalization of the elderly and disabled spurred on by the landmark Supreme Court decision in Olmstead v. L.C. A key element of Olmstead compliance is the extensive use of home and community-based care waiver programs. These programs, often targeted to specific disabled groups, provide essential access to care at home. A Medicaid LTSS managed program is at high risk of losing these options as the business of managed care may shift patients to institutional care believing it is less expensive.

Because of the high level of flexibility afforded by the federal government to states in the Medicaid program, managed care plans receive in the management of Medicaid benefits. On the clinical side of care, care that managed care plans have vast experience in providing, many Medicaid beneficiaries have had positive experiences. There is a high risk, though, that due to the states’ flexibility in Medicaid, managed care plans’ inexperience, and lack of federal oversight, the long term services and supports now being managed by managed care plans will suffer. Payment rates, network adequacy, continuity of care and patient access to care can all be easily jeopardized by a lack of guidance and oversight.

In addition, managed LTSS should conform with the quality of care standards applicable to fee-for-service home care under Medicaid. Finally, managed LTSS home care under Medicaid should afford enrollees with reasonable choices among providers in order to encourage quality and efficiency. Limiting Medicaid eligible patients to a single provider is not effective choice.

State Medicaid programs, with the support of CMS, are rapidly moving to managed LTSS delivery models. In 2014, nearly two dozen states had proposed to adopt some form of managed LTSS, either partially or as the complete delivery model. It is apparent that this trend will continue to expand. Early indications are that Medicaid beneficiaries face limited choices of home care providers and enrollment standards that steer individuals away from the traditional program into a managed care provider model. In addition, access to care appears to be restricted through a combination of payment rate reductions and restrictive care authorizations.

RECOMMENDATION: Congress should require that any LTSS Medicaid managed care program develop an Olmstead compliance plan, establish parity or a "maintenance of effort"
requirement for any home care benefits provided by the state in an existing fee-for-service program, comply with the fee-for-service quality of care standards, and ensure enrollees choice among home care providers. These requirements should apply to both skilled and personal care services. Additionally, CMS should create a program of federal oversight to monitor the compliance of managed long term services and supports programs with respect to payment, network and care adequacy as currently done for Medicare Advantage plans.

RATIONALE: A transition to managed care should not result in a change in the scope of the Medicaid home care benefits or any jeopardy to home care providers or patients. Likewise, the goals of Olmstead and managed care are common: access to community-based care in a clinically and economically appropriate direction for health care.
ESTABLISH FEDERAL STANDARDS FOR MEDICAID PERSONAL CARE SERVICES

ISSUE: In the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), Congress established a Medicaid optional benefit for personal care services that modified existing regulatory standards for such care. Under OBRA 1993, care can be planned at a state’s discretion by non-physicians and provided by any caregiver considered qualified by the state Medicaid program. There are no federal quality of care standards for the services. Some states have implemented personal care programs that require no training or testing of the competency of the caregiver and no quality of care oversight. The result can be poor quality of care and a system that leaves the client open to fraudulent billing and abuse by caregivers.

In the Patient Protection and Affordable Care Act of 2010 (PPACA), Congress added nearly $13 billion in support for Medicaid home care services. It is expected that Medicaid personal care services will correspondingly grow in future years. However, the legislation did not include a requirement for mandatory minimum quality of care standards or benefit accountability.

RECOMMENDATION: In any Medicaid reform efforts, Congress should establish minimum federal standards for delivery of personal care services, including standards for quality of care and competencies, education, and supervision of caregivers.

RATIONALE: Personal care and support services are significantly growing in home care. Within Medicaid, both the population served and the caregivers providing the service vary widely from state to state and location to location. Strict standards of quality are established for Medicaid and Medicare home health agencies, yet it is left to the states’ discretion to establish any quality of care standards for Medicaid personal care services. With that discretion, some states have allowed personal care workers without education or competency testing to provide invasive and complex services such as catheter insertion and tracheal suctioning of ventilator-dependent patients. Some states have allowed untrained individuals who are not home care workers, such as community health workers and paramedics to provide care to patients even though those workers are not subject to quality of care standards equal or comparable to regulated home care agency such as nurse supervisors. For the protection of consumers and caregivers, the same quality standards that apply to agencies should apply to personal care workers, and individuals performing some of the tasks of personal care workers, who are not employed by agencies.
REFORM MEDICAID HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENT

ISSUE: Section 6407 of the Patient Protection and Affordable Care Act of 2010 (PPACA) establishes as a condition of payment for home health services coverage under Medicare that a patient have a face-to-face encounter with the physician who certifies the need for home health services. Subpart (d) of section 6407 applies the face-to-face requirement to Medicaid home health services but does not provide any guidance on how the requirement is to be managed by the individual Medicaid programs. Absent standards from CMS as to how the face-to-face requirement should function and how the requirement will be monitored, states cannot effectively implement the PPACA provision.

Even without guidance from CMS, some states have moved forward with the face-to-face requirement. While the intention behind section 6407 was to gain greater physician involvement in ordering home health services, early indications are that the lack of standards or guidance are causing new problems. Providers and physicians alike are unclear as to what is required of them and states are unclear as to how to make the Medicaid face-to-face requirement any different from the Medicare face-to-face requirement. This lack of clarity is resulting in duplicative work for home care providers and physicians as well as frustrating access to care.

CMS has yet to implement a formal regulation on the Medicaid face-to-face encounter requirements. However, federal Medicaid has permitted states to implement the requirement on their own, creating confusion because of standards that vary from the Medicare requirements. As a result, the requirement is, in some cases, creating a barrier to access to care and in other cases being completely ignored.

The experiences with the Medicare face-to-face physician encounter requirements demonstrate that little or no positive program integrity outcomes occur. Instead, the requirements simply block access to care.

RECOMMENDATION:

1. Congress should repeal the Medicaid face-to-face physician encounter requirements. If such does not occur, the following should be mandated by Congress:
2. CMS should establish standards for the Medicaid face-to-face encounter requirement. Those standards should be specific to the Medicaid home health benefit and not merely an extension of the requirements for Medicare patients.
3. Any future standards from CMS for the Medicaid face-to-face encounter should include the use of a uniform certification statement and not physician narratives. The standards should make no reference to a homebound requirement.
4. Congress should monitor the impact of the face-to-face encounter requirements and, if necessary, repeal the provision and devise more constructive ways to secure physician involvement in home health care.
5. Revise PPACA section 6407 to remove the reference to section 1834(m) of the Social Security Act and substitute a definition of telehealth services that allows an individual to meet the face-to-face encounter requirements through modern technologies available in their home. These technologies should include two-way audio and video communications.
6. Establish exceptions to the requirements for patients who have been recently discharged from an inpatient setting, individuals in frontier areas where access to a physician or non-physician practitioner is limited, and individuals where a physician attests to the inability of the patient to leave the home for a physician encounter and is unable to have a physician perform a home visit.

7. Provide financial protection to a home health agency that admits a patient in good faith with the reasonable expectation that a qualified face-to-face encounter has or will occur on a timely basis with appropriate documentation that is compliant with Medicare standards in the event that compliance is not met without the fault of the home health agency.

8. Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.

**RATIONALE:** The purpose of the face to face requirement was to enhance physician involvement in home health care, not to discourage physicians referring patients to care in their own homes. There is no evidence that pre-existing methods of physician involvement and communication negatively impacted the quality of patient care. Further, any evidence of overutilization of Medicaid coverage cannot be tied to a lack of physician involvement or the nature of physician/patient/home health agency communications. The benefits of the face-to-face requirement serving as a measure of program integrity are far outweighed by the harm the requirement causes relative to patient access to care.
ESTABLISH MEDICAID HOME CARE AS A MANDATORY BENEFIT AND SUPPORT REBALANCING OF LONG TERM SERVICES AND SUPPORTS EXPENDITURES IN STATE MEDICAID PROGRAMS IN FAVOR OF HOME CARE

ISSUE: In 1999, the United States Supreme Court held, in Olmstead v. L.C., that state Medicaid programs were required under the Americans with Disabilities Act (ADA) to undertake steps to support access to community-based health care options as an alternative to institutional care. Subsequently, the Bush Administration established its New Freedom Initiative, which has provided guidance to the states in developing Olmstead/ADA compliance plans. In addition, both the Bush and Obama administrations have voiced support for increased federal payments to assist states in transitioning Medicaid nursing facility patients into home care services. In some states, Medicaid has moved with reasonable and deliberate speed. In others, action seems nonexistent. One problem is the limits on valuable federal support for the administrative actions needed. Another problem is the pressure from institutional care providers to slow any progress towards home care alternatives.

The Deficit Reduction Act of 2005 (DRA), (Public Law 109-171) contains several provisions that rebalance Medicaid long term services and supports coverage toward home care. These initiatives include a "Money Follows the Person Rebalancing Demonstration" through which individuals who are residing in institutions can be provided an opportunity to receive alternative home and community-based care. The provision makes grants and enhanced federal Medicaid payments available to incentivize states to compete for an award of the demonstration program. The enhanced federal payments can range as high as 100 percent of the cost of the home care for the first 12 months. The bill provided $1.75 billion in new federal payments to support the project.

DRA also included an optional benefit for Home and Community-Based Services for the Elderly and Disabled that allowed states to bypass the "waiver" process that includes requirements for proving the cost effectiveness of services. This benefit required that states establish more stringent standards for Medicaid payment of institutional care as one means of shifting patients to home care settings.

The DRA provisions, while evidencing the federal preference for rebalancing Medicaid long term care expenditures in favor of home care, also highlight support for self-directed care. Both provisions allow for, and even encourage, the availability of services through consumer-directed care models. However, these models are designed with quality assurance requirements, a patient need assessment requirement, and authority for the use of multiple delivery model types. The degree to which states are establishing and enforcing effective quality standards is less clear.

The Patient Protection and Affordable Care Act of 2010 (PPACA) incorporated several provisions that encourage greater utilization of home and community-based services under Medicare, including, under sections 2401-2406:

- Establishment of the Community First Choice Option, which allows for enhanced federal matching for community-based attendant supports and services to disabled individuals up to 150 percent of federal poverty level who require an institutional level of care;
• Extension of the Money follows the Person Rebalancing Demonstration program;
• Protections against spousal impoverishment in Medicaid home and community-based services;
• Enhanced federal matching through the State Balancing Incentive Program for select states to increase the proportion of non-institutionally-based long-term services and supports; and
• New options for states to offer home and community-based services through the state plan for individuals with incomes up to 300 percent of the maximum supplemental security income payment who have a higher level of need and to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.

In recent years, as financial strains have beset federal and state governments alike, providers of home care services have raised concerns that while rebalancing efforts continue, payment levels fall far short of the cost of providing services. In addition, these financial strains have led a number of states to shift Medicaid beneficiaries into managed care plans for acute care services as well as long term care supports. The experiences with long term managed care create concern that the rebalancing of care away from an institutional setting and towards home and community-based care will be set back.

RECOMMENDATION: Congress should ensure that CMS properly implements the Medicaid home care expansion in PPACA and encourage states to embrace broader coverage of home and community-based services under Medicaid.

Congress should establish firm deadlines for Olmstead/ADA compliance with the penalty of lost federal financial matching payments for failure to meet the deadlines. Further, Congress should authorize an increase in the federal matching payment for expanded Olmstead/ADA-compliant home and community-based services, and 100 percent federal reimbursement for state Medicaid compliance costs in transitioning to improve home care alternatives. The rebalancing of long term care expenditures in favor of home care should be accomplished consistent with principles that: 1) establish Medicaid home care as a mandatory benefit in state Medicaid programs; 2) authorize care based on need; 3) assure quality of care through enforcement of comprehensive delivery standards; 4) provide the Medicaid client with a choice of care delivery models; and 5) ensure adequate reimbursement levels.

Congress should monitor carefully any shift of Medicaid beneficiaries into long term managed care and ensure that the patients’ rights to home care under the ADA and the Olmstead decision are fully secured.

RATIONALE: After several years, it is necessary for the Congress to intervene and secure the systemic reforms guaranteed by the ADA. However, states need financial support in these efforts since the transition will have start-up costs. The rebalancing must be accomplished with federal minimum standards of care and access whether the state maintains a traditional fee-for-service care model or a managed care approach.
SUPPORT AN INCREASE IN THE FEDERAL MEDICAID MATCH (FMAP) AND OPPOSE CAPS ON FEDERAL PAYMENTS

ISSUE: The National Governors Association reports that the states are suffering severe shortfalls in their budgets and have begun, or are planning, to cutback their Medicaid programs. This will likely result in cuts in home and community based care and impede efforts to implement the Olmstead decision, which requires states to offer home care as an alternative to institutionalization.

As part of his FY 2004 budget, President Bush proposed sweeping financing and programmatic changes for Medicaid. Under the proposal, states would have two options: they could continue to run Medicaid under existing rules and receive the normal federal Medicaid matching payments, or they could opt to turn their Medicaid program into a block grant with broad flexibility to change program rules. The capped federal payments would be front-loaded over the 10-year life of the block grant to provide states some additional funds in the first few years, but these funds would be offset through reductions in federal payments to states in the later years. The National Governors Association did not endorse the proposal.

In 2003 Congress rejected President Bush’s approach and instead provided a $10 billion increase in Medicaid payments to the states for the period April 1, 2003 – June 30, 2004. Each state received a 2.95 percentage point increase in its federal Medicaid matching rate for this period. An additional $10 billion was allocated to state governments for health care and other social services.

Instead of proposing a cap on federal Medicaid spending, in 2006 the President proposed to cut Medicaid spending by $25 billion over five years through certain “reforms,” including restricting the ability of states to enhance federal matching payments and tightening restrictions on individuals transferring away assets to qualify for Medicaid.

In 2008 Medicaid advocates and governors campaigned for a temporary increase in the Federal Medicaid matching rate as part of a stimulus package to revive the economy. Congress took up a stimulus package early in 2009 that included a substantial increase in the Federal contribution to Medicaid over two years. Congress has extended the enhanced FMAP several times. However, with the expiration of the enhancement in 2011, Medicaid programs across the country are in financial jeopardy. The resulting actions include elimination or restrictions of home care programs, restricted eligibility criteria for home care programs, payment rate reductions, and a shift of fee-for-service program models to managed care where experiences indicate that home care will be difficult to secure for Medicaid patients. Congress should support further federal matching payment assistance to the states as the country’s economic difficulties have taken a great toll on state Medicaid budgets.

During deficit reduction discussions in 2011 and 2012, proposals surfaced to establish per beneficiary caps on Medicaid spending or, alternatively, to block grant all Medicaid spending to control the federal share of Medicaid costs.

RECOMMENDATION: Congress should reject any consideration of placing caps on Medicaid spending and increase the federal match for state Medicaid programs, thereby bolstering efforts to bring states into compliance with the Olmstead decision. Proposals for
per beneficiary caps or full program federal spending caps such as block grants should be rejected by Congress.

RATIONALE: Many states have begun efforts to expand home and community-based alternatives to institutionalization in their Medicaid programs. The federal government, through such programs as the New Freedom Initiative, has sought to facilitate this development. Medicaid is one of the biggest items in state budgets, so it will certainly be a focus of state efforts to save money. States are required to balance their budgets, so federal assistance is essential to preserve and expand home and community-based care within the Medicaid program.
ENSURE APPROPRIATE MEDICAID RATES FOR HOME CARE AND HOSPICE

ISSUE: Medicaid has taken on an increasing role in providing coverage of home care and hospice services to children, the disabled, and the elderly. In addition, the Patient Protection and Affordable Care Act of 2010 (PPACA) expands Medicaid funding for home care services by nearly $13 billion through 2019. Data already indicates that Medicaid expenditures for home care and hospice services now exceed Medicare expenditures. A significant part of the reason behind the Medicaid growth is the flexibility allowed states in the structuring of Medicaid coverage and the recognition that home care is a viable, cost-effective alternative to institutional care. However, as Medicaid expenditures for home care and hospice have increased along with general strains on state Medicaid budgets, reimbursement rates have failed to keep pace with increasing costs of care and, in some cases, they have been subject to reduction for purely budgetary savings purposes.

Federal Medicaid law establishes a broad and somewhat ambiguous standard for rate setting that merely requires the states to set rates at a level sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The “sufficient access” standard for rate setting operates in a manner that requires a demonstration that individuals in need of care cannot find it solely because of inadequate rates. This method fails to prevent the loss of services and only reacts when inaccessibility to services reaches a high enough level to gain political attention. In 2011, the Centers for Medicare and Medicaid Services proposed a new federal regulation that would establish rate setting standards. The proposed standards are not perfect, but go a long way to setting out a sensible framework that state must follow in rate setting. However, the proposed standards did not progress to a Final Rule. With the passage of more than 3 years, the proposed standards are now considered abandoned under the Administrative Procedures Act.

With the initiation of the Medicaid Access and Payment Advisory Council (MAPAC) it was expected that Congress will be better advised on the shortcomings of existing Medicaid payment rates throughout the states. However, MAPAC has not addressed rate setting concerns in Medicaid generally nor has it addressed rate concerns in Medicaid home care.

Inadequate reimbursement for home care and hospice services has affected all populations served in the home and in all of the various home care programs available under Medicaid. Technology intensive home care services, personal care services, private duty nursing services, and basic home health services are often reimbursed at levels of payment equal to 60 to 75 percent of the cost of the provision of care. Transportation and mileage costs, along with staff travel time, are often not a reimbursable expense even though travel to and between patient’s homes is a necessary piece of providing home care and often hospice. The result is a very fragile Medicaid home care benefit structure that relies on payment subsidization by non-Medicaid sources, thereby jeopardizing continued access to care.

RECOMMENDATION: Congress should enact legislation that requires that states continually assess Medicaid home care and hospice rates of payment and the methodology utilized for establishing rates. The legislation should further require that rates be reasonable
and adequate so as to:

- Assure access to care comparable to the non-Medicaid patient population;
- Ensure reimbursement sufficient for providers to conform with quality and safety standards; and
- Guarantee payments sufficiently adequate to incentivize providers of care to operate efficiently while meeting the cost of care provision.

**RATIONALE:** Virtually all Medicaid home care reimbursement systems pay insufficient attention to the effect of payment rates on patients’ access to care or the cost of efficiently delivering services. Inadequate rates also severely impact the ability of the provider to meet quality and safety standards. Requiring states to engage in an annual analysis of the rate setting methodology and the adequacy of payment rates combined with federally mandated goals for a rate setting process will ensure that Medicaid recipients receive high quality care.
REQUIRE MEDICAID MANAGED CARE ORGANIZATIONS TO RECEIVE STATE APPROVAL BEFORE LOWERING PAYMENT RATES FOR HOME CARE SERVICES

ISSUE: Medicaid managed care has been growing in popularity over the last decade. More than half of Medicaid beneficiaries are enrolled in a managed care organization. Traditionally, home care services have been carved out of managed care and instead services are managed through a fee-for-service approach with providers of care. In recent years, however, states have begun moving home care services into managed care. This move into managed care has presented challenges for providers as managed care plans have unilaterally cut payment rates, negatively impacting a provider’s ability to stay in business and continue to provide much needed care.

RECOMMENDATION: CMS should require states to require a payment rate review process and state approval before Medicaid managed care organizations are permitted to cut rates paid to providers. As part of the process, managed care organizations would submit the proposed payment rate to the state, along with a rationale for the cut. The state would then allow at least 30 days for public comment before allowing any new rate to be implemented.

RATIONALE: Medicaid managed care organizations’ unfettered ability to reduce payment rates is creating an unstable home care industry. Providers are finding themselves unable to operate with rates that are often less than the cost of care. Fair and reasonable payment rates are needed to maintain a viable home care delivery infrastructure to meet the needs of a growing home care-dependent population. To achieve that end, payment rate reductions by Medicaid managed care entities should be monitored and approved prior to implementation.
REJECT MEDICAID WAIVERS THAT REDUCE BENEFITS FOR CURRENT BENEFICIARIES

ISSUE: The CMS waiver policy known as the Health Insurance Flexibility and Accountability Initiative (HIFA), first instituted in the Bush Administration, was touted as a way for states to expand Medicaid and State Children's Health Insurance Program (SCHIP) coverage. However, it included no new funds and gave states new tools to pay for those expansions by curbing Medicaid spending for current low-income beneficiaries, including children and their parents, disabled people, and seniors.

The policy gives states expanded power to charge current and future low-income beneficiaries fees for health care services they cannot afford and to cut many (now mandatory) critical health services for some groups of beneficiaries and not for others. It also allows states to cap the number of people who can enroll.

Nothing in the policy ensures that all dollars raised from fees or saved from cutting services will be reinvested in Medicaid or SCHIP expansions. Alternatively, it is possible that a small expansion could be used to justify significant increases in fees charged to low-income beneficiaries and significant cuts in covered health benefits.

While those in mandatory groups would continue to be entitled to mandatory services and limited cost-sharing, states would have new discretion -- and incentive -- to cut benefits and increase cost-sharing, both for optional groups and for people eligible under any new expansions. Under this scheme, low-income seniors on Medicaid are particularly at risk because the majority of them -- 56 percent -- are optional beneficiaries. Forty-four states set Medicaid eligibility for optional beneficiaries at or below the federal poverty level.

RECOMMENDATION: Congress should closely monitor use of the HIFA option. At a minimum, state officials should be required to provide full disclosure of waiver proposals and ample opportunity for all advocates and stakeholders to have real input in the design of waivers. Unfortunately, rather than promoting public participation, the HIFA waiver policy includes an expedited federal review process that is likely to diminish public participation.

RATIONALE: Under the HIFA initiative, states that want to expand their programs are encouraged to cut services for currently eligible people. The HIFA waiver puts these states in a catch-22: To help new people, the state must hurt current enrollees.

Under the HIFA waivers, states could charge premiums, deductibles, copayments, and coinsurance to optional Medicaid seniors with no limits on the out-of-pocket costs. For low-income seniors, who generally use more health care services, the burden of meeting repeated out-of-pocket copayments and coinsurance may prevent them from receiving needed care.

States that request waivers could eliminate skilled nursing care provided in the home for optional beneficiaries. For both mandatory and optional beneficiaries, the states could eliminate home and community-based care (other than skilled nursing services), prosthetic devices and medical equipment, rehabilitative and physical therapy services, hospice, and personal care services.

By allowing states to cap enrollment, the HIFA waiver policy converts Medicaid from an entitlement program, in which all eligible applicants can enroll and receive services, to a block grant that stops enrollment when a finite expenditure is reached.
EXEMPT HOME CARE AND HOSPICE FROM COST-SHARING BY MEDICAID BENEFICIARIES

ISSUE: Expenditures for Medicaid, the $330 billion federal-state safety net program that provides health care services to 58 million Americans, have grown from about 11 percent of the average state budget in 1988 to 22 percent in 2006 (National Governors Association, 2006). According to state governments, in testimony before Congress and the Medicaid Commission on Medicaid Reform, this growth is unsustainable from both the state and the federal standpoint. To address this spending growth many states are looking for ways to increase revenues and cut program costs. Potential budget reductions in some states may lead to decrease Medicaid spending resulting in limiting benefits and imposing premiums and cost sharing for beneficiaries. This raises concerns that states may look increasingly more to the imposition of cost sharing for home care services to help fund the program. At the same time, many states are shifting Medicaid program to managed care systems. This shift creates further risks that the managed care plans will restructure Medicaid benefits to include some forms of cost sharing for enrollees.

On November 25, 2008, a new federal rule was promulgated that allows states to charge premiums and higher co-payments to Medicaid participants. On January 9, 2013, CMS issued another proposed rule that would authorize states to impose higher co-payments. However, the proposal also allows states to exempt home care from any beneficiary cost sharing on the rationale that cost sharing is prohibited under the Medicaid nursing facility benefits.

RECOMMENDATION: Congress and state legislatures should support an exemption of home care and hospice services from any Medicaid beneficiary cost sharing.

RATIONALE: Most states do not cover all individuals under the poverty line. In fact, in 1998, less than 25 percent of non-elderly, low-income Americans with incomes below 200 percent of poverty were covered by Medicaid (Kaiser Family Foundation, The Medicaid Program at a Glance, 01/01). The 1996 welfare reform bill, the Personal Responsibility & Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), made Medicaid eligibility even more problematic by eliminating automatic Medicaid coverage for individuals and families eligible for welfare.

If, in an effort to keep Medicaid payments in check, the states impose even a nominal cost-sharing requirement on Medicaid home health services, many low-income individuals would be forced to go without needed care. As a result, beneficiaries may incur unnecessary hospitalizations as they forgo needed home care because they cannot afford the copays. In addition, far from saving program costs, requiring home care agencies to collect copayments can also result in increased administrative costs that exceed the amounts collected.

Finally, federal Medicaid regulations on cost sharing prohibit providers from denying access to services based on a beneficiary’s inability to pay the cost sharing amounts. With already inadequate payment rates, providers would be forced to assume significant bad debt.
ESTABLISH MINIMUM FEDERAL STANDARDS FOR HOME
HEALTH COVERAGE UNDER MEDICAID

ISSUE: Medicaid is a joint federal and state program of health care for low-income individuals. The federal government shares the cost of the program with the states and establishes certain requirements for the operation of the program. However, each state administers its Medicaid program and establishes eligibility, coverage, and payment levels within broad federal guidelines.

Currently, Medicaid home health benefits are generally more limited in coverage and reimbursement than the Medicare home health benefit. Federal regulations allow states to limit home health benefits to intermittent nursing care, home care aide services, and medical supplies and equipment. In some states, such as California, provision of medical supplies often goes unreimbursed. Physical therapy, occupational therapy and speech pathology services are optional and are frequently not available to Medicaid recipients in the home. In addition, there are no federal standards regarding the minimum frequency and duration of any of these services.

RECOMMENDATION: Congress should expand the mandatory Medicaid home health benefit to include speech, occupational and physical therapy, and medical social work, as well as hospice care. Congress should also set minimum standards regarding the frequency and duration of care. Block grants and other proposals which would grant states full authority to determine the scope, amount, and duration of home care benefits should be rejected.

RATIONALE: The varying levels of home care coverage available under Medicaid create inequities in access to home care services for low income individuals. Institutional care should be the last resort, not one inadvertently encouraged by limitations on Medicaid coverage of home health services. State demonstration programs have shown that reasonable expansions of the Medicaid home health program can be cost-effective, while maintaining patients in their homes and keeping families intact.
REQUIRE COVERAGE OF HOME CARE, HOSPICE AND PERSONAL CARE SERVICES IN ANY MEDICAID REFORM

ISSUE: Title XIX of the Social Security Act (Medicaid) requires that, in order to receive federal matching funds, certain basic services must be offered in any state’s program. These are:

- Inpatient and outpatient hospital services;
- Prenatal care;
- Physician services;
- Skilled nursing facility services for individuals age 21 and older;
- Home health care for persons eligible for nursing facility care;
- Family planning services and supplies;
- Rural health clinic services;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioner services;
- Certain ambulatory and health center services;
- Nurse midwife services; and
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for children.

Home health services covered by Medicaid include three mandatory services: part-time nursing, home health aide, and medical supplies and equipment; and one optional service category: physical therapy, occupational therapy, or speech pathology and audiology services.

States may also receive federal funding for 32 optional services, including personal care services and hospice care.

RECOMMENDATION: Congress should require mandatory coverage of comprehensive home care, hospice, and personal care services and home care medical supplies to all populations receiving Medicaid coverage. These services should include all therapies and medical social work services. All home and community-based care services should be mandatory benefits, including those offered under current optional programs and through waiver authority.

RATIONALE: Home care and hospice services are basic to any individual’s well-being and are critical to the health of this nation’s poor. Home health is already greatly underutilized even as part of the basic Medicaid benefit package. This problem is only exacerbated as more managed care entities provide Medicaid services. Historically, managed care plans provide less home care services than traditional Medicaid.

Home care and hospice services are cost-effective and should be available to all those in need. The Medicaid program could realize substantial cost savings by caring for people in their homes.

In addition, the US Supreme Court held in *L.C. v. Olmstead* that the Americans with Disabilities Act (ADA) requires state Medicaid programs to meet health care needs in the least restrictive environment. However, so long as home care services are optional benefits the promise of the ADA will not be realized.
EXTEND SPOUSAL IMPOVERISHMENT PROTECTIONS TO HOME CARE

ISSUE: Before 1989, when an elderly woman was forced to place her husband in a Medicaid nursing home, she was forced to live in poverty herself. The Medicaid program required that, in order for the husband to qualify for Medicaid nursing home care, nearly all of the couple’s assets and income had to be spent-down, leaving the spouse at home with, in many states, less than $400 per month to pay for housing, food, and other expenses. In 1989, Congress created the Medicaid “spousal impoverishment” protections to end this unfair treatment. In 2015, under these provisions, the spouse at home will be able to retain assets, in addition to the home, of up to $119,220 and income of up to $2,980.50 a month.

Unfortunately, the spousal impoverishment protections were only required in the case of nursing home care. States with home- and community-based waivers could elect to extend these protections to couples that are able to care for their loved ones at home, but most states had not chosen this option. In these cases, the wife who enrolls her infirm husband in the Medicaid home care waiver program to enable him to continue to live at home was still faced with having to impoverish herself. As a result, the institutional bias of the Medicaid program was stronger than ever.

The Patient Protection and Affordable Care Act (H.R. 3590; Public Law No. 111-148), extends these spousal impoverishment protections to all home and community based Medicaid services beginning January 1, 2014 and ending December 31, 2019.

RECOMMENDATION: Congress should ensure that CMS implements the PPACA spousal impoverishment provision properly and enact legislation to make the protections permanent.

RATIONALE: A spouse should not be penalized when his or her loved one becomes infirm and needs long-term care at home. Current law makes a husband or wife choose between having enough money to live on by putting his or her spouse in a nursing home, and keeping the loved one home and living in poverty. Passage of legislation to extend the spousal impoverishment protections would enable couples to remain together at home.
ESTABLISH REASONABLE STANDARDS FOR CONSOLIDATION OF MEDICARE FEE-FOR-SERVICE PAYMENTS WITH MEDICAID FOR DUAL-ELIGIBLE BENEFICIARIES

ISSUE: Nearly 30 percent of home health services patients receiving Medicare coverage are also eligible for state Medicaid benefits. In most instances, these patients do not receive Medicaid home care concurrent with Medicare coverage. However, on occasion dual-eligible beneficiaries receive both Medicare and Medicaid covered home care at the same time as these programs cover different services under different conditions.

The Centers for Medicare and Medicaid Services (CMS) has approved “demonstration programs” that combined Medicare and Medicaid benefits and financial support for dual-eligible beneficiaries. These consolidated shift control over both programs to state Medicaid programs. This consolidation will shift control of Medicare fee-for-service from the beneficiaries to Medicaid. Under Medicare, beneficiaries control the decisions as to what care best meets their needs and which provider they wish to supply that care. Under Medicaid, states are permitted to restrict patient choices involuntarily. Further, the availability of providers under Medicaid is often limited because of low reimbursement rates that can be lower than a provider’s cost of care.

The various demonstration programs that have emerged are not true “demonstrations” in that all state Medicaid beneficiaries with the project design are assigned to program. As such, there is no control group for comparison purposes to determine the actual impact on care access, quality, spending, and all the other concerns in a health care program. Further, beneficiaries are passively enrolled in a combined managed care plan requiring and affirmative action by the beneficiary to dis-enroll with regard to Medicare benefits. These plans have also restricted rights of access to qualified providers by limiting benefits to approved in-network providers. Finally, the demonstration programs are approved in the absence of sufficiently detailed structure regarding benefit administration, quality of care, adequate access to care, and provider participation.

RECOMMENDATIONS: Congress should order the suspension of CMS approval of dual-eligible demonstration programs until adequate safeguards can be devised with regard to standards for benefit administration, quality of care, adequacy of access to care, and provider participation. The standards should prohibit passive or mandatory enrollment of beneficiaries into such programs.

RATIONALE: Medicare is the primary payer over Medicaid. Medicare beneficiaries have greater freedoms to choose care and providers under Medicare than under Medicaid. These beneficiary rights should not be lost or subordinated through consolidation of Medicare and Medicaid programs for dual-eligibles. Medicaid beneficiaries also should have rights to choose their provider of care rather than to be mandatorily enrolled in a managed care plan. At a minimum, Medicaid beneficiaries should have a full and transparent understanding of their home care benefits.