January 9, 2017

The Honorable Andrew M. Slavitt via electronic submission
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244

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

Dear Administrator Slavitt:

Thank you for the opportunity to provide comment on proposed interventions to ensure the provision of timely and quality home and community-based services (HCBS). We compliment the Centers for Medicare & Medicaid Services (CMS or the Agency) for publishing this RFI and appreciate the chance to provide feedback on innovative proposals to accelerate access to HCBS, strengthen the homecare workforce and improve quality outcomes for patients.

Almost Family is the third largest provider of home health services in the country, operating 340 branches in 26 states. Our company provides Medicaid HCBS to approximately 7,500 patients at 82 locations in eight states, and manages 17 physician-led accountable care organizations (ACOs) that help coordinate care for over 120,000 beneficiaries. Our unique involvement in the development of state and federal legislation, in particular homecare access reforms and program integrity initiatives, such as electronic visit verification (EVV) and value-based purchasing (VBP), positions us well to provide informed feedback on several issues raised in the RFI. In addition, our company's participation in the CMS technical expert panel (TEP) responsible for developing quality measures for dual-eligible beneficiaries and Medicaid clients receiving HCBS lends useful background and perspective caring for this unique population.

We are strong supporters of reforms to expand access to quality HCBS and taking steps to strengthen the homecare workforce. By removing barriers and increasing the ability of patients to move to the most appropriate care setting, these reforms are an essential step toward creating a health care delivery system centered on the needs of patients, rather than providers. Taking much-needed action to strengthen the homecare workforce is an essential reform in Medicaid HCBS, as well. This is because quality homecare depends on the industry's ability to hire, train and retain quality employees who provide the services.

For the remainder of this comment letter we respond to questions posed in the RFI. Our key points are as follows:

EXECUTIVE SUMMARY

1. **We strongly support adoption of additional policies to accelerate access to HCBS as the patient-preferred, least restrictive and most cost effective setting for patients. Simplified eligibility processes and patient assessment tools can shorten wait times for service and help family caregivers.**

2. **We encourage CMS to explore ways to improve access to HCBS and require clinical attestations as to medical necessity and set provider financial incentives to reward desired behaviors. Such policies can include VBP and Medicaid ACO models.**

3. **We urge CMS to focus on restructuring the Medicaid benefit in a way that focuses on the needs of patients rather than providers. We propose managing the patient rather than the provider type with a benefit package that includes non-skilled personal care services to assist with ambulation and activities of daily living (ADLs) combined with available wrap-around skilled services for patients who might be post-surgical.**

4. **CMS should strengthen oversight of state home health and personal care rates to ensure the ability of homecare providers to hire, train and retain quality caregivers. Rate structures in some states have not changed in over ten years, resulting in constant caregiver turnover and disruption in patient care.**

5. **CMS should encourage, as legislation enacted and proposed in Congress demonstrates, proven program integrity and cost-saving strategies, such as EVV safeguards and VBP reimbursement policies.**

I. Access to HCBS: What are the additional reforms CMS can take to accelerate the progress of access to HCBS and achieve an appropriate balance of HCBS and institutional services in the Medicaid LTSS system to meet the needs and preferences of beneficiaries?

A. Adopting Policies to Accelerate Patient Access to HCBS

We strongly support adoption of policies to accelerate patient access to HCBS and achieve an appropriate balance between homecare and institutional services in the Medicaid LTSS system. When medically appropriate, homecare is the patient-preferred,[i] least restrictive[ii] and most cost effective[iii] care setting for patients. Our experience with one policy in particular, called "homecare presumptive eligibility" or the "hospital-to-home transition program," has convinced us such reforms can improve quality, drive savings, provide necessary support for family caregivers and help rebalance state Medicaid budgets.

Medicaid eligible patients often wait weeks to obtain homecare services, burdening family caregivers and resulting in expensive emergency room and hospital visits. Homecare presumptive eligibility helps family caregivers and patients obtain Medicaid homecare services faster and has been successfully implemented in several states as a means to move away from institutional care. It provides for a simplified eligibility determination process within ten days of a referral for Medicaid homecare services. Proven benefits of homecare presumptive eligibility include better care, shorter wait times for service, greater patient autonomy, stronger family caregiver support and significantly lower costs when patients are diverted from higher-cost institutional settings to lower-cost HCBS.

States such as Washington, Colorado, Kansas, Ohio and Kentucky have experienced positive results legislating and deploying homecare presumptive eligibility:

- **Washington**: Deployed an early functional and financial assessment tool to shrink the average wait time required to access Medicaid HCBS by 66%, saving the state an average of $1,964 per patient per month for every client who went home instead of to an institution.[iv]

- **Colorado**: The state's Medicaid presumptive eligibility pilot saved more than four times the program's cost as "[a]bout 60% of the Medicaid eligible people discharged from hospitals avoided nursing home placement."[v]

- **Kansas**: Researchers at KU found Kansas' hospital-to-home transition program would need to divert just 5 out of 200 patients away from institutional care and into HCBS for the program to break even. In the end this pilot diverted 11% of patients into HCBS that otherwise would have gone to the nursing home.[vi]

- **Ohio:** In 2014, for the first time ever, Ohio Medicaid devoted the majority of its LTSS budget to HCBS instead of institutional care. Through the use of homecare presumptive eligibility, Medicaid nursing home expenditures fell from 60%-48%. As a result, Ohio has been able to provide care to more Medicaid patients than ever before, at less cost than ever before.[vii]

- **Kentucky:** Our company led the effort to enact HB 144, the "Hospital-to-Home Transition Program," and presented testimony before the legislature in support of a pilot included in the FY 2016-18 Budget.[viii] The state is currently developing metrics for deployment of the policy expected to target disease states such as diabetes and COPD in spring 2017.[ix]

In our experience, success of such programs depends upon development of an accurate and reliable assessment tool to be used earlier in the process. Both Kansas and Ohio, for example, achieved significant cost savings by developing tools that assessed patients for Medicaid HCBS with more than 99% accuracy.[x]

We strongly support adoption of policies in Medicaid similar to homecare presumptive eligibility because such reforms have proven to accelerate patient access to HCBS and strike an appropriate balance between homecare and institutional services in Medicaid LTSS.

B. Adding Flexibility and Controls

In addition to adopting such policies, we encourage CMS to explore additional steps to improve access to HCBS, including requiring clinician attestations as to medical necessity and appropriateness and establishing financial incentives to reward desired behaviors.

With regard to provider actions and financial incentives, we recommend CMS:

1. Require all inpatient facilities to inform primary care physicians (PCPs) in a timely fashion regarding admission and discharge processes, which would enable PCP participation in clinical decision-making.

2. Require clinical certification as a part of all admission attestations that in the ordering clinician's judgment the patient cannot be cared for in a lower cost settings, making use of clinical "indicators" developed from empirical claims and assessment data to guide ordering clinicians toward utilization of lower cost care settings.

3. Maintain cost sharing strategies in lower cost settings with directionally higher patient-responsible portions in higher cost settings.

4. Make bonus payments to PCPs for better risk-adjusted outcomes relative to service utilization and enable PCPs and homecare providers to share in cost savings for their patient populations through ACO or ACO-like mechanisms.

5. Utilize VBP models to reward non-PCP providers demonstrating higher success rates with higher payment rates or bonus payments.

We applaud the Agency's recently announced Medicare-Medicaid ACO model.[xi] In Kentucky, our company designed a similar model and successfully encouraged the state to include parts of our proposal in its State Innovation Model (SIM) Design Grant plan. With its "Accountable Care Organization Initiative," Kentucky proposed the use under Medicaid of physician-led ACOs because that model has been studied and proven to achieve better outcomes than hospital-based ACOs.[xii] Further, Kentucky's recently-elected Governor Matt Bevin, in his comprehensive waiver proposal submitted to CMS, announced his intention to develop incentive-based payment systems including value-based purchasing.

C. Updating the HCBS Benefit Package

We strongly support updating the Medicaid HCBS benefit package to improve access to and quality of services. We urge CMS to focus on structuring the benefit in a way that focuses on the needs of HCBS patients, rather than providers. Our view is to manage the patient rather than provider type with a benefit package that includes non-skilled personal care services to assist with ambulation and activities of daily living (ADLs) combined with available wrap-around skilled services for patients who might be post-surgical.

In addition, case or care management services, using evidence-based clinical standards, must be integrated as an essential part of utilization management in Medicaid HCBS. This feature is lacking in the current system. Below is an outline of how we envision such a program might work:

1. Patients who meet the functional and financial qualifications for Medicaid HCBS would choose a care management provider following consultation with their PCP. The care management process would start with an annual PCP or nurse practitioner-performed comprehensive health assessment fully informed by historical claims data.

2. The assessment would produce a risk score, which, as it increases, would drive increased frequency of reassessments (semi-annual, quarterly and monthly). Results of the assessment would be provided to treating providers to better inform their clinical decisions.

3. State Medicaid programs would use risk-assessment scores for program integrity safeguard purposes where high utilization and low risk scores would trigger probe edits to provider payments and low utilization and high risk scores would trigger patient notifications that they should consult with their PCP more frequently.

4. Care management firms would provide patient education materials and reference sites for disease state management. Patients who complete disease-state management educational courses online or in person at their care management firm site would be eligible for selected additional benefits and/or co-pay and deductible reductions. Patients who demonstrate high compliance rates would also be eligible for such additional benefits or co-pay reductions.

5. Care management firms would be required to operate a network of community-based response resources that provide an alternative to the over-used "go to the ER" default treatment option. This

would include communication protocols with PCPs, remote patient monitoring (RPM) of patient vital signs (e.g., medication, insulin levels, blood pressure and weight) and a team of rapid response nurse practitioners and home health nurses who would have access to assessment, care plan, RPM data and claims records. When the patient does require a trip to the ER, one of these professionals armed with the records would accompany the patient to the ER, dramatically improving the ability of the ER physician to rapidly assess the situation and provide alternatives to the overused "admit through the ER" default treatment option.

6. Care management firms would be paid a "per member per month" premium and would participate in a share of savings against a benchmark similar to Medicare ACOs, but at a lower rate.

II. Quality HCBS: What actions can CMS take, independently or in partnership with states and stakeholders, to ensure quality of HCBS including beneficiary health and safety?

As the agency responsible for administering Medicaid, CMS plays a leading role in ensuring quality of HCBS and protecting beneficiary health and safety. Below are two ideas that could help.

A. Strengthening the Homecare Workforce

We explore homecare workforce improvements in greater detail in Section IV below, but in our experience the most important factor in ensuring quality HCBS is the industry's ability to hire, train and retain quality staff. We encourage CMS to explore mechanisms to incent states to offer higher rates and regular increases to providers combined with "pass through" requirements obligating providers to demonstrate funds actually pass through to employees. After a recent rate increase in Ohio, for example, our industry was able to provide adequate assurances to the state that funds were used to increase employee salaries. Such "pass through" requirements are an effective way to ensure funds from rate increases actually go to paying employee salaries. Given demonstrated savings in existing HCBS reforms, such as EVV and VBP, we urge CMS to explore ways to incent states to *reinvest* those savings in strategies to pay homecare workers more.

B. Adopting Proven Program Integrity Solutions

Another way CMS can promote quality HCBS is to adopt proven program integrity and cost-saving strategies, such as electronic visit verification (EVV) and value-based purchasing (VBP). Whether it is through a revision of Medicaid conditions of participation, increases or decreases in the Federal Medical Assistance Percentages (FMAP) or exercising its broad Innovation Center authority, CMS has various tools at its disposal to encourage states to follow best practices, ensure patient health, safety and quality in Medicaid HCBS.

As described in Section III below, EVV is a popular program integrity tool used by states and payers around the country to verify home health visits, control Medicaid expenditures, reduce fraud and improve quality of care. It functions as a remote "check in, check out" system that helps ensure scheduled visits and services are actually provided when and where they are supposed to be.

VBP describes the movement in health care away from reimbursing providers for costs and toward rewarding them for creating *value* for the Medicaid Program, by providing the highest quality care to patients at the lowest possible cost to the Program. In September, our company President Steve Guenthner was invited by House Ways & Means Chairman Kevin Brady and Ways & Means Health Subcommittee Chairman Pat Tiberi to testify before Congress on proposed Medicare VBP legislation.[xiii] In his testimony Mr. Guenthner stated:

> Value-based purchasing is the natural next step in the evolution of patient-centric Medicare policy, especially when it rewards providers for patient-focused outcomes balanced against the costs incurred to achieve those outcomes. The ideal VBP would redistribute payments to providers not only within a payment silo, but also across payment silos with the goal of getting patients to the best value care setting for their needs. We need to change the policy question from "how should we pay providers?" to "how we should care for patients?"[xiv]

In our judgment VBP is another effective way for CMS and the states to promote beneficiary health, safety and quality in HCBS. We are actively participating in CMS' Home Health Value-Based Purchasing Model in three of the nine pilot states and continue to partner with the House Ways & Means Committee to strengthen Medicare post-acute VBP legislation. We note several states are actively considering developing Medicaid VBP programs in the hospital and post-acute space. These states include Tennessee, which has already deployed VBP for nursing facilities and has provided notice of its intent to develop post-acute VBP, Ohio, New York, Connecticut and Kentucky, which announced its intention to develop post-acute VBP in its recent Medicaid waiver application to CMS.

In the consideration of any state Medicaid VBP program we suggest post-acute providers be rewarded through a system of quality measures that include not just a ranking of spend per beneficiary but also functionality measures to track patient improvement in health status. Functionality measures such as ability to complete ADLs, ambulation, restoration of previous functional status, emergency department use without hospitalization and others are a critical part of what we do as homecare providers and should be measured as part of any post-acute VBP program.

We strongly encourage CMS to continue exploring ways to incent states to implement Medicaid post-acute VBP, rewarding agencies for providing high quality care to patients at the lowest possible cost to the Program.

III. <u>Program Integrity:</u> What program integrity safeguards should states have in place to ensure beneficiary safety and reduce fraud, waste and abuse in HCBS?

A. Adopting Electronic Visit Verification (EVV) in Medicaid HCBS

Our company's dedication to senior advocacy has led us to partner with Congress, CMS and the states to develop and implement proposals to eliminate fraud and abuse across Medicare and Medicaid. Our experience working with EVV technology in three states of operation, Tennessee, Ohio and Connecticut, has convinced us it is a useful tool to verify visits, reduce fraud, improve patient care and control expenditures in Medicaid HCBS.

As deployed in several states, EVV utilizes telephone and computer-based technology to monitor important visit information, including date and time, beneficiary and caregiver identification, services rendered and patient status. Missed or late visits automatically send alerts to payers and providers that services were not rendered in accordance with the patient's plan of care. Essentially, EVV operates as a "punch in, punch out" system that helps ensure scheduled visits and services are provided when and where they are supposed to be.

States around the county have utilized EVV to verify visits, improve patient care, reduce fraud and control Medicaid expenditures. Florida Medicaid launched EVV in Miami-Dade County in 2010. In its first year the program saved $19 million.[xv] The next year, it saved an additional $3.5 million.[xvi] Texas implemented EVV in 2011, producing between 5%-7.75% of savings per year.[xvii] When the Texas Legislature voted to expand the program statewide in 2014, budget analysts projected $22 million in savings.[xviii] In Tennessee,

99.75% of all scheduled services were provided on time following the adoption of EVV for Medicaid HCBS.[xix]

Of note, on December 13, 2016, President Obama signed into law the bipartisan "21st Century Cures Act," which included language incentivizing the states to adopt EVV technology beginning in 2019 for unskilled personal care services and 2023 for skilled home health services.[xx] The new law mandates FMAP reductions for noncompliant states and includes language requiring states to interact with providers to ensure EVV is "minimally burdensome," "takes into account best practices," is conducted "in accordance with HIPAA" and incorporates a "stakeholder process" that includes input from beneficiaries, family caregivers and individuals providing the services.

Our experience with EVV informs us it can be an effective program integrity tool. We encourage CMS to expand the use of EVV in Medicaid HCBS and urge the Agency to consider reinvesting savings from the program into initiatives that will improve quality outcomes, care coordination and help pay workers in the industry a living wage.

B. Reigning in Independent Providers

Recognizing an important role for many different types and sizes of providers in the health care continuum, we encourage the Agency to consider ways to incent the states to increase oversight of independent providers (IPs).

In some states where we operate we notice that smaller agencies, often known as IPs, are not held to the same high standards of quality and safety as larger agencies. In our experience, lower standards for some agencies encourages bad behavior and increases the risk of fraud and abuse, especially when a significant number of agencies are involved.

In Ohio in 2014, for example, there were 14,500 IPs authorized to bill Medicaid directly. The state's questionable billing rate was twice as high as the national average and, according to one report, "Officials in law enforcement and Medicaid surveillance generally consider independent providers to be higher risks for fraud."[xxi] Wisconsin is another state where thousands of unregulated IPs have produced allegations of widespread fraud and abuse, caused reputational harm to the industry and forced the state to spend millions trying to stop it.[xxii]

In our view CMS should take action to incentivize states to hold all providers operating in the state accountable to the same rules and regulations, regardless of size. Lack of uniform standards and oversight for IPs opens the door to fraud and abuse and harms patient health, safety and quality of care as a result.

C. Opposing Registries

We oppose states maintaining registries of home health workers' private information for two reasons.

First, most states where we operate already require extensive background checks and fingerprinting at a cost to the provider. In our experience these background checks, together with proven program integrity reforms such as EVV, VBP and IP reform, are more effective at eliminating fraud and abuse and driving Medicaid savings than requiring registries. As a company, we always prefer adopting proven program integrity solutions to adding unnecessary administrative burdens and extra cost.

Second, and most importantly, we believe requiring states to maintain registries of employee personal information presents a significant and unjustifiable risk of breach of privacy. Placing this information in

the hands of states opens the door to endless state open records act requests, which could compromise employer, employee and, by extension, patient privacy. CMS and the states have a duty to protect patient privacy, not subject it to far-reaching open record requests that could lead to unpredictable and inconsistent results across different states.

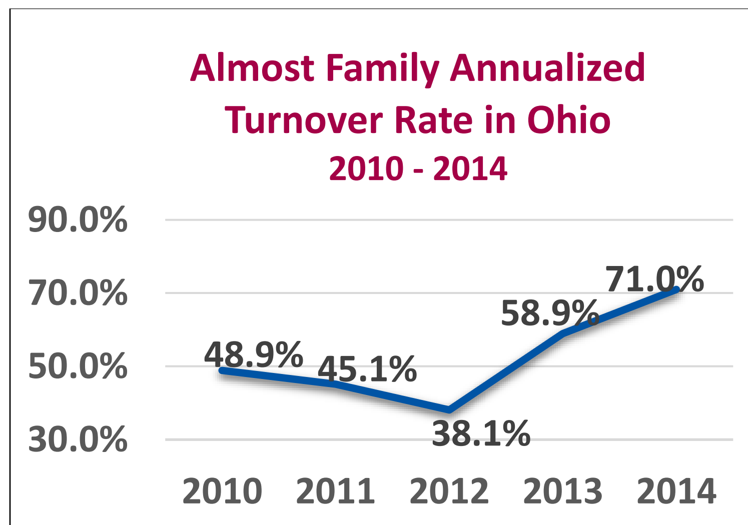
IV. Strengthening HCBS Workforce: What are specific steps CMS could take to strengthen the HCBS homecare workforce, including establishing requirements, standards or procedures to ensure rates paid to homecare providers are sufficient to attract enough providers to meet service needs of beneficiaries and that wages supported by those rates are sufficient to attract enough qualified homecare workers?

From our perspective providing Medicaid HCBS in eight states, stagnant wages for home health workers is a growing problem. All around the country low reimbursement rates, mounting regulations, regular unfunded increases in the minimum wage and strong demand for workers in jobs with comparable pay jeopardize the industry's ability to hire, train and retain quality employees. We are convinced this has a direct negative impact on quality of patient care as the inability to pay an adequate wage results in high employee turnover and disruption of services, further burdening family caregivers.

On average personal care aides make between $8-9 dollars an hour. At this pay grade, our industry competes for the same workers as large multinational corporations, such as McDonald’s and Walmart, but, unlike multinationals, our industry’s ability to pay employees is entirely a function of how much we are paid by states for the services we provide.

In Ohio, for example, the personal care aide rate remained unchanged for nearly 15 years. In 2014, the *Columbus Dispatch* ran a series of articles profiling Ohio’s “home-care crisis,” which found that home health aides in the state were earning $1 less per hour than a decade before.[xxiii] As a result, the *Dispatch* concluded, “consumers suffer[ed].”[xxiv]

That same year the *Dispatch* ran its series, our company’s annualized turnover rate in Ohio reached 71% (see graph).



Since it is impossible to run a successful business with that much turnover, we presented data to the Kasich Administration and testified before the legislature to successfully secure the first rate increase for home

health workers in Ohio in over a decade. Even the modest 5% increase we received has helped stabilize our workforce to provide better care for patients.

Similar to our experience in Ohio, Wisconsin has not increased its personal care aide rate in ten years. Among our states of operation, Wisconsin has the lowest hourly reimbursement rate for personal care aides ($16.08). This has contributed to our company's annualized turnover rate in Wisconsin rising to 53% in 2016. As mentioned before, this level of turnover makes it difficult to employ the quality workforce necessary for seniors and disabled beneficiaries.

To address this problem, we ask that CMS require states to produce assurances reimbursement rates they propose are commensurate with payment levels given local wage pressures, administrative/training costs and regulatory burdens. The Agency took a similar stance in an August 2016 letter urging states to adjust their reimbursement rates commensurate with the wider marketplace in order to "strengthen and stabilize" the Medicaid home care workforce.[xxv] We encourage CMS to make this a condition of participation in Medicaid or adjust funding levels to incentivize states to do it.

We appreciate this opportunity to share our comments and look forward to continuing to work with CMS to ensure the provision of timely and quality HCBS. As always, we welcome the opportunity to participate in further stakeholder discussions and hope the Agency will not hesitate to contact us with questions by phone at 502-693-7249 or email at denisfleming@almostfamily.com.

Sincerely,

Denis Fleming
VP of Gov't Relations
Almost Family, Inc.

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[i] AARP's "Livable Communities Baby Boomer Facts and Figures" reports "87 percent of adults age 65+ want to stay in their current home and community as they age." Retrieved from: http://www.aarp.org/livable-communities/info-2014/livable-communities-facts-and-figures.html.

[ii] The US Supreme Court's decision in *Olmstead v. L.C.* (1999) found that people with disabilities have a right to receive state funded supports and services in the community rather than institutions, i.e., in the "least restrictive environment."

[iii] Based on national long-term care statistics compiled by the Department of Health and Human Services. Retrieved from: http://longtermcare.gov/costs-how-to-pay/costs-of-care/

[iv] Robert Mollica, *Expediting Medicaid Financial Eligibility*. National Academy for State Health Policy (2004), pp. 5-6.

[v] Robert Mollica, *Expediting Medicaid Financial Eligibility*. National Academy for State Health Policy (2004), pp. 10.

[vi] Rosemary Chapin, et al. *Expedited Service Delivery Pilot Evaluation Final Report*. University of Kansas School of Social Welfare Office of Aging and Long Term Care. (1999), pp. 12, 43.

[vii] Catherine Candisky, *Columbus Dispatch*, "Ohio Reduces Spending on Nursing Homes." Sept. 11, 2014.

[viii] H.B. 303 signed into law by Governor Bevin, pp. 80-81. Retrieved from: http://www.lrc.ky.gov/record/16RS/HB303/bill.pdf.

[ix] This according to Kentucky Department of Aging and Independent Living (DAIL) Commissioner Deb Anderson.

[x] Rosemary Chapin, et al. Expedited Service Delivery Pilot Evaluation Final Report. University of Kansas School of Social Welfare Office of Aging and Long Term Care. (1999), pp. 12, 43; Robert Mollica, Expediting Medicaid Financial Eligibility. National Academy for State Health Policy (2004), pp. 8.

[xi] Centers for Medicare & Medicaid Services (CMS) Fact Sheet: Medicare-Medicaid Accountable Care Organization (ACO) Model, Dec. 15, 2016. Retrieved from: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-15-2.html.

[xii] Farzad Mostashari and Ross White, "The ACO Hypothesis: What We're Learning from the Medicare Shared Savings Program." Brookings Institution, Mar. 10 2014. Retrieved from: https://www.brookings.edu/blog/up-front/2014/03/10/the-aco-hypothesis-what-were-learning-from-the-medicare-shared-savings-program/.

[xiii] House Ways & Means Subcommittee on Health, "Hearing on the Evolution of Quality in Medicare Part A." Sept. 7, 2016. See more at: https://waysandmeans.house.gov/event/hearing-incentivizing-quality-outcomes-medicare-part/.

[xiv] House Ways & Means Subcommittee on Health, "Hearing on the Evolution of Quality in Medicare Part A." Sept. 7, 2016. Retrieved from: https://www.youtube.com/watch?v=0ElRdLTuW6g.
[xv] Alaska Department of Health and Social Services, "Sandata: Electronic Visit Verification Overview." Dec. 17, 2015. Retrieved from: http://www.akleg.gov/basis/get_documents.asp?session=29&docid=52974.
[xvi] Alaska Department of Health and Social Services, "Sandata: Electronic Visit Verification Overview." Dec. 17, 2015. Retrieved from: http://www.akleg.gov/basis/get_documents.asp?session=29&docid=52974.
[xvii] Sandata, "Electronic Visit Verification Technologies: Solutions to help reduce fraud, waste and abuse and increase visibility," Dec. 27, 2015. Retrieved from: http://www.akleg.gov/basis/get_documents.asp?session=29&docid=52973.
[xviii] Tania Colon, Medicaid/CHIP Division, Memo to Health and Human Services Commission Council, "Subject: Agenda Item 5.f.-Medicaid Electronic Visit Verification," Nov. 22, 2013. Retrieved from: http://legacyhhsc.hhsc.state.tx.us/news/meetings/past/2013/Council/112213/5f.pdf.
[xix] Sandata, "Electronic Visit Verification Technologies: Solutions to help reduce fraud, waste and abuse and increase visibility," Dec. 27, 2015. Retrieved from: http://www.akleg.gov/basis/get_documents.asp?session=29&docid=52973.
[xx] H.R. 6, "21st Century Cures Act." 114th Congress (2015-16). Retrieved from: https://www.congress.gov/bill/114th-congress/house-bill/6.
[xxi] Ben Sutherly and Rita Price, "Home-care crisis: Fraud costs taxpayers, vulnerable Ohioans." *Columbus Dispatch*. Dec. 14, 2014. Retrieved from: http://www.dispatch.com/content/stories/local/2014/12/14/home-care-crisis.html.
[xxii] David Wahlberg, "State aims to cut personal care fraud; providers say move could harm patients." *Wisconsin State Journal*, Dec. 21, 2015. Retrieved from: http://host.madison.com/wsj/news/local/health-med-fit/state-aims-to-cut-personal-care-fraud-providers-say-move/article_ff5dcbcc-fda5-5782-9399-82d22c01f08c.html.
[xxiii] Rita Price, "Home care for vulnerable Ohioans leans hard on poorly paid workers." *Columbus Dispatch*, Dec. 15, 2014. Retrieved from: http://www.dispatch.com/content/stories/local/2014/12/15/low-wage-care.html.
[xxiv] Rita Price, "Home care for vulnerable Ohioans leans hard on poorly paid workers." *Columbus Dispatch*, Dec. 15, 2014. Retrieved from: http://www.dispatch.com/content/stories/local/2014/12/15/low-wage-care.html.
[xxv] Vikki Wachino, Director, Center for Medicaid and CHIP Services, Department of Health and Human Services, Centers for Medicare & Medicaid Services, CMCS Informational Bulletin, "Subject: Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce," Aug. 3. 2016. Retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/cib080316.pdf.