



Medicaid Rates for Home Health Care Working Group

MEETING MINUTES

Monday, September 14, 2015

10:00 AM in Room 2E of the LOB

The meeting was called to order by Chairman, Rep. Abercrombie C. 083.

The following committee members were present:

Rep. Catherine Abercrombie, Sen. Marilyn Moore, Rep. Patricia Dillon, Rep. Michelle Cook, Rep. Jeff Currey, Rep. Robin Porter, Rep. Peter Tercyak, Rep. Terrie Wood, Sen. Kevin Kelly, Deborah Hoyt, Tracy Wodatch, William Sullivan, Kathy Morgan, Robert Prezioso, Martin Morrissey, Kim Nystrom, Richard Corcoran, Jeanne Silverwatch, Mag Morelli, Janine Fay

Representative Abercrombie welcomed everyone to the first meeting of the working group and explained that she feels that it is most productive to begin working on complex issues during the interim to be as prepared as possible for session with some potential proposals.

She also explained that this group was not legislatively created, but was put together by the co-chairs of the Human Services Committee as an informal way to gain understanding of issues around Medicaid rates for home health care. Members of the Human Services, Aging and Appropriations Committees were invited to join the working group, along with advocates, agencies and providers of services.

Introductions and brief comments were made around the room.

Rep. Abercrombie noted information had been distributed to everyone for background.

Deb Hoyt discussed the state's efforts to move individuals from institutionalized care such as nursing homes into a home care setting under Medicaid. This is often referred to as rebalancing, and will result in significant cost savings to the state.

She noted that the home care setting of today is far more technical than the home care setting of 10 years ago, and can, at times, be likened to intensive care in the home.

Mag Morelli referred to a status report put out in June which shows that the state is keeping up with the goals of rebalancing. One reason that the state was previously dependent on nursing homes was that Medicaid would only cover care given in this setting. Factors such as the Affordable Care Act, the creation of waiver programs and changing to an Administrative Services Organization (ASO) from Managed Care have contributed to success in efforts to move to home and community based long term supports and services.

She went on to say that the intent of the Money Follows the Person (MFP) program is not just to move people out into the community, but also to force us to build a network of community providers. The challenge has been building this network as well as making people aware that it exists and that the state can help pay for that care.

The spotlight has been on Hospital Discharge Planning which has become crucial. There is MFP funding to help people get discharged back into the community with the right set of services, instead of going to a nursing home first. According to the MFP website, to participate in the program, you must be eligible for Medicaid and living in a long-term care or hospital setting for at least three months.

The focus of nursing homes has shifted to short term rehabilitation. With new Medicaid changes and people having Accountable Care Organizations (ACOs) and bundled payments, there is incentive for nursing homes is to get people back to the community as quickly as possible.

The effects Department of Public Health regulations on rebalancing must also be examined. Easy, legal transitions from hospitals and nursing homes into the community must be ensured.

Mag Morelli said there is now a higher acuity in both nursing homes and in the community as compared to before the rebalancing efforts.

Rep. Abercrombie stated that when we were a managed care state, Blue Cross had some leverage when negotiating rates with providers. Now we are an ASO, which means that the state has taken on the liability of Medicaid, and we have it administered by Administrative Services Organizations.

Tracy Wodatch explained that DSS has four contracts with administrative services organizations. CHN administers our medical and some non-skilled services in the home. Value Options is our behavioral health ASO. There is a Dental ASO and a Transportation ASO, called Logisticare.

For clients whose claims show a greater frequency with which they seek emergency services or have a more intensive care need, Intensive Care Management is available to manage their care with greater scrutiny of care and utilization management.

The long-term goal is to move 75%, or 5200 people into the community by 2025. With this goal in mind, MFP is working well to a degree. There are dollars, primarily federally funded and offered as part of an RFP process, for different providers to get grants. These were initially only offered to the nursing homes to come up with creative solutions for transition care.

In the home setting, it's not going as smoothly. Some issues are transportation and housing. Housing is a very significant issue and some creative solutions are being offered. Families are offering to have people live in their home at a stipend. Some have clients living in multiple rooms of a house.

When someone comes out of a nursing home on MFP, they only receive MFP funding for 1 year, and then revert to regular Medicaid. Some have extensive medical needs in addition to home health and personal care needs. Appropriate care coordination within the cost cap can be very complex.

Self-directed care is for the client served in the community, who directs his or her own care within the dollars allocated for that care. They have to manage their own staff, including hiring caregivers and a fiscal intermediary (Allied).

Bill Sullivan stated that it was important to keep in mind the change in acuity of patients now being cared for at home as opposed to 10 years ago. At one time these patients were very stable. Today, these patients are coming home from a much shorter hospital stay and require services and more complex care than they once did. In order to shift from institutional care, the resources have to be available, including providers with the appropriate skills to handle the new, more complex care that is now required, which may include nurses, hospice, infusion therapy, and a variety of other services.

Mag Morelli clarified that home health care agencies provide skilled nursing care, which is a very high level of care. This is different than home care, which may include things like meals on wheels.

Rep. Cook talked about the way in which reimbursements are structured. She gave the example of medication administration, and the requirement that only nurses, at the nurse's rate, can fill med boxes, even if a patient can take the meds themselves. She noted that such a service is important, and can be very complicated and time consuming. It is also very expensive. She also said that every time we reduce funding, we reduce services.

Deb Hoyt discussed the fact that patients can have extremely complicated or intensive health care needs, and that service providers must be reimbursed in a more balanced way. She stated that rebalancing is working and, between 2009 and 2011 it has saved the state of Connecticut \$533.5 million in the Medicaid program, according to a DSS report to the state legislature.

According to the Long-Term Care Services and Support report, one of the goals of the state is to achieve adequate and sustainable provider reimbursement levels for long term services and supports. She said that another goal is to capture and reinvest cost savings into the long term services and supports system.

Rep. Abercrombie commented that it is important to have a strong provider network for in home and community services. If these providers go out of business, the individuals served would have to receive care in nursing homes at a much higher cost to the state. Examples were given of moving people out of both Connecticut Valley Hospital and Southbury Training School into the community. Rep. Abercrombie said that we have to remember that these are people, and they deserve to be living and participating in the community.

Mag Morelli discussed the home health reimbursement comparison. In a previous session, a coalition was formed to bring attention to the home care program, and the different service providers that are needed to care for someone in the home. They were looking at the rate structure which has not changed in a decade. Through this, they got a 1% increase across the board. After that, they asked DSS to do a more in-depth study of the rates for various providers. The study that was returned was a disappointing, haphazard comparison between other states and Connecticut.

It was hoped that the study would look at what it actually costs to provide a particular service in a given part of the state, and to look at how to best allocate funds to structure rates well. Letters were sent to Aging, Human Services, and Appropriations by Leading Age, Connecticut Health Care at Home, and the Commission on Aging asking the legislature to request a new study be done with more appropriate information. Rep. Abercrombie said that a letter was not sent from Appropriations and Human Services as it was the midst of a very busy session, and there wasn't time to look into the problems with the report. She said that she believed that Human Services would be willing to put together a letter to DSS to ask for a different report.

Rep. Wood asked if she could get a copy of Kate McEvoy's letter emailed to her, and for a listing of all of the members and what organizations they are each with. In addition, Rep. Abercrombie asked for a glossary of terms, a list of home care programs and what services they provide, whether their funding is through state or federal money, who is contracted with the ASO, and what is involved in those contracts.

It was mentioned that the DSS study discussed only non-skilled services and should also include skilled services. If a comparison is made to other states, it should be made to comparable states. It was also asked what other entities, besides DSS might be able to offer information about what it costs to provide a particular service in different areas of the state.

It was noted that Medicare puts out a report annually that includes detailed analysis of the cost of every service nationally and a national rate or cost of service for each discipline. This rate is adjusted for each state's wage mix. Mag Morelli said that Deb Hoyt will get this cost information on skilled services. Mag will get similar data on non-skilled services. They looked to DSS to ensure the impartiality of the report.

Rep. Cook stated that the Northwest corner has a different cost consideration than other parts of the state. Travel time and conditions should be considered. Flat rates on reimbursements take those other factors into consideration.

Rep. Wood said that she felt that we should look at whether Department of Public Health regulations and bureaucracy inhibit practicality and common sense. She felt that DPH should be at the table for these conversations. Rep. Abercrombie said that the short time available before the session begins made it difficult to pull in all of the issues.

Rep. Dillon recommended that the differences between costs to provide services in different parts of the state, and the different contexts that different parts of the state work within be looked at more carefully. When comparing states, she warned that more than just the rates themselves should be considered. Things like the entire financial system behind the rates may be different. She said that if you are reducing the line item on the institutional side, you will see an increase in the community side. The important consideration is whether dollars are being spent well.

Rep. Abercrombie said that a regional approach may be a good way to look at these issues.

Kathy Morgan suggested that we look to the Medicare system which already has a region model, and recognizes that costs are different in different parts of the state. She also mentioned that DPH and DSS are often at odds, with DPH wanting providers to do more and DSS wanting them to do less, leaving providers caught in the middle. She also suggested a look at whether the cost of providing the services is more, or if there are just more people in the system.

Tracy Wodatch said that another Medicare piece that could be looked at is a tiered structure based on acuity. If there were three or four tiers of acuity that a patient fits into after assessment, rates could match costs better.

Rep. Abercrombie stated that basing the rates on an acuity model may be more fair and flexible than an a la carte system. She gave high needs children in home care as an example.

There is incentive for all parties to move from a visit model to a value model. Providers can better manage their costs. This model comes from Medicare. There is a certain amount of money that comes with an assessed acuity level. Providers have to manage the case within those available funds. Massachusetts may be an example of this model.

Deb Hoyt said that Medicare is, in some cases, moving to somewhat of a bundled rate, based on a type of procedure or incident. She gave the example of a rate for a hip replacement with an amount of money attached to that procedure and all of the care that goes with it. The hospital, nursing home and home care providers would work out how it is divided for services, based on their approach for care.

Rep. Abercrombie announced that upcoming meetings would be October 13, and October 26th, and that subsequent meeting dates would be chosen at a later date. She also asked for thoughts on what should be on the next agenda.

Tracy Wodatch recommended talking about the various home care programs available and what services are provided in the home care setting. She thought explaining skilled vs. non-skilled services, waivers, pediatric services, and all of the different programs would be useful.

Mag Morelli suggested that we devote one meeting to skilled services and discuss non-skilled at another. Included in these discussions would be a list of the programs, who are the skilled providers, levels of care, and list of state contracts.

A paradigm shift has occurred, but the reimbursement rate has not adjusted. More people are moving from hospitals to nursing homes more quickly, and nursing homes moving more people into the community. Moving to a value based system makes sense. If there is a commitment toward moving those dollars, there will be a cost savings in health care and that is what the affordable care act is about.

Rep. Abercrombie thanked everyone for coming to the meeting and adjourned.

Kristen Traini
Committee Clerk
