CT HOME HEALTH STUDY WORK GROUP

Understanding Licensed Home Health

Presented by members of the
CT Association for Healthcare at Home
November 2015

CONNECTICUT ASSOCIATION FOR HEALTHCARE AT HOME℠

Overview of Home Health Care

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GLOSSARY OF TERMS

- RN: Registered Nurse
- HHA: Home Health Aide
- LPN: Licensed Practical Nurse
- CMS: Centers for Medicare and Medicaid Services
- CoPs: Conditions of Participation (Regulations to provide and bill for Medicare)
- DPH: Dept of Public Health
- PPS: Prospective Payment System (Current episodic reimbursement for Medicare)
- PCA: Personal Care Assistant (not provided under licensed agency—private duty, HM/Companion or self-directed)
- L&C: Licensed by DPH, Certified by Medicare
- MFP: Money Follows the Person

HOME CARE SERVICES

- **Licensed and Certified Home Health Care Agency-CGS 19a-490(d)**
  - Licensed by the Dept of Public Health
  - Certified by Medicare
- **Licensed Homemaker/Home Health Aide Agency-CGS 19a490 (e)**
- **Registered Companion Homemaker Agency-CGS 20-670**
- **Private Duty Registries**
- **Privately Hired Caregivers**
- **Self-Directed Care**

L & C HOME HEALTH CARE AGENCY

L & C Home Health Care Agency-CGS 19a-490(d):

- Full service agency that provides skilled services (nursing, therapy services and social work) as well as homemaker-home health aide services.
- May also provide specialty services such as hospice, behavioral health, pediatrics and telemonitoring.
- Services may be paid for by Medicare, Medicaid, Private Insurance, or private pay.
- Holds a license with the State of Connecticut and is surveyed by the Department of Public Health.
- These agencies may choose to provide other non-licensed services under a separate business line outside of their license, such as PCAs which are not regulated by DPH.

LICENSED HOMEMAKER / HOME HEALTH AIDE AGENCY

Licensed Homemaker/Home Health Aide Agency-CGS 19a490 (e):

- Provides services to the private pay population.
- Holds a license with the State of Connecticut and is surveyed by the Department of Public Health.
- Can provide companions, homemakers, home health aides and live-in caregivers.
- Services may be paid for privately, by Medicaid and some long term care insurances.
- Only 4-5 agencies with this type of license

REGISTERED COMPANION HOMEMAKER AGENCY

Registered Companion Homemaker Agency-CGS 20-670:

- A registered business with the Department of Consumer Protection.
- Effective October 1, 2006 an agency that provides these services must be registered as an employer.
- Can provide personal care assistants, companions, homemakers, and live-in caregivers to chronic and stable private pay or Medicaid clients.
- There is no DPH oversight or survey process.

PRIVATE DUTY REGISTRIES

Private Duty Registries:

- Providers who act as referral sources or “matchmaking services” for private pay personal care.
- Services may include nursing, personal care assistants, companions and homemakers.
- The client may or may not be responsible for taxes and liability insurance, unemployment, social security, and workers compensation. Registry is responsible for informing client of their responsibilities.

PRIVATELY HIRED CAREGIVERS

Privately Hired Caregivers-

- The client is the employer for these individuals who provide private pay personal care.
- The client is responsible to pay unemployment, social security, workers compensation, taxes and liability insurance.

SELF-DIRECTED CARE

Self-Directed Care:

- The client is the employer for these individuals, but utilizes a fiscal intermediary (Allied) for payroll and all applicable taxes/insurances.
- The client may also choose to use an agency for case management services (Must be approved by Allied).
- These clients are serviced under Medicaid or Medicaid Waiver programs.

DIFFERENCES BETWEEN DPH LICENSED AND DCP REGISTERED

- To bill Medicare/Medicaid, Home Health Care Agencies must also become Medicare certified (54 page CMS form 855a which also requires substantial submission of additional financials and intense additional Medicare survey beyond DPH licensure)
  - Approximately 90 agencies in CT
  - Agencies must comply with state licensure regulations and Medicare Conditions of Participation regulations
- DCP registered can only bill Medicaid/private pay—application is 3 pages and fee is $375.00—Background check requirements, surety bond, DCP may audit but rare (estimated 600-700+ agencies).

LICENSED HOME HEALTH CARE AGENCIES

- Interdisciplinary Team of Skilled Health Care Professionals
  - Registered Nurses including several types of specialty nurses
    - Cardio-Pulmonary and Telehealth, IV, Diabetes, Wounds, Hospice, Behavioral Health, Pediatrics, Maternal Child Health
  - Physical, Occupational and Speech Therapists
  - Medical Social Workers and Licensed Clinical Social Workers (not covered under Medicaid)
  - Some agencies also provide Respiratory Therapy and Registered Dietitians (without reimbursement)
- Paraprofessional staff include:
  - Home Health Aides and Homemaker-Companions

REGULATORY OVERSIGHT

- DPH performs licensure (based on state regulations) and Medicare certification surveys (based on Medicare Conditions of Participation)
  - Examples of CT only requirements beyond Medicare
    - Must have a qualifying clinical supervisor (RN with specific criteria) for every 15 FTEs of direct care professional staff
    - Home Health Aides: must be oriented to each individual patient plan of care and supervised every 2 weeks

MEDICAID FEE SCHEDULE

- Codes/rates used in Home Health
  - Full nursing visit $95.20
  - Med Admin nursing visit $61.13
  - Home Health Aide (HHA) $24.64 (1 hour)
  - HHA med admin $28.00
  - Physical Therapy $81.29
  - Occupational Therapy $83.65
  - Speech Therapy $83.65

SKILLED HOME HEALTH SERVICES

- Chronic Disease Management promoting self-care management and avoidance of hospital readmissions based on person-centeredness
  - High Tech Wound Care including Wound vacs, drains, complex and non-healing chronic wounds
  - Telemonitoring including in home EKGs and oxygen saturation levels
  - Zoe Monitors to predict early heart failure
  - Left ventricular assistive devices (LVADs) to allow patient waiting for heart transplant to live at home instead of hospital
  - Coagulation testing (PT/INR) and Blood Glucose monitoring
  - Diet and Disease education
- Medication Management including injections, vaccination programs, IVs, administration/compliance programs for Behavioral health, medication reconciliation
- Education and care of feeding tubes and nutrition, ostomy care, urinary catheters, bowel and bladder training

SKILLED HOME HEALTH SERVICES

(Continued)

- High tech respiratory care for pleurex drainage catheters, chest tubes, CPAP/BiPAP machines, tracheostomy care, ventilators, oxygen, breathing treatments, percussion life vests, oximetry readings and suctioning
- Therapy for exercise and strengthening programs, ultrasound, electric stimulation, chest percussion, lymphadema management, cognitive re-training, speech and language therapy
- Hospice care to include symptom management, pain pumps, IVs, alternative therapies, counseling, volunteers and spiritual care
- Home Health Aide (HHA)—non-skilled personal care for bathing, transfer assists, mechanical lifts, dressing, exercises, meal prep
- Note: an HHA must have RN oversight and supervision

Title XIX Rate
Adjustment History

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TITLE XIX RATE ADJUSTMENT HISTORY COMPARED TO CPI INDEX

	Title XIX Rate Adjustments	CPI Change*	Medical CPI Change*
1994	0.0%	2.5%	4.7%
1995	0.0%	2.9%	4.5%
1996	0.0%	2.9%	3.5%
1997	0.0%	2.3%	2.8%
1998	**2.1%**	1.3%	3.2%
1999	0.0%	2.2%	3.4%
2000	**2.0%**	3.5%	4.1%
2001	**2.0%**	2.7%	4.6%
2002	**1.5%**	1.4%	4.7%
2003	0.0%	2.2%	4.1%
2004	0.0%	2.6%	4.5%
2005	**4.0%**	3.4%	4.2%
2006	0.0%	3.2%	4.0%
2007	**3.0%**	2.8%	4.4%
2008	0.0%	3.8%	3.7%
2009	0.0%	-0.4%	3.2%
2010	0.0%	1.6%	3.4%
2011	0.0%	3.2%	3.0%
2012	0.0%	1.7%	3.2%
2013	0.0%	1.5%	2.0%
2014	0.0%	0.8%	3.0%
2015	**1.0%**	------	------
Cumulative 1994–2015	15.6%	48.1%	78.2%

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*Source: Bureau of Labor Statistics

Annual Exposure to Non-Payment of Claims and Cost of Business

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EXPOSURE TO NON PAYMENT

- Medicare additional documentation requests (ADR's)
- Medicare Recovery Audit Contractor (RAC) review
- Inability to obtain Physician signature required on Face to Face encounter and Certificate of Termination Illness documents
- Office of Inspector General dually eligible (TPL) review – Medicare and Medicaid
- For Medicaid - Physician signature is required on all orders prior to billing for services, medications, change in service. (Different from Face to Face document)

EXPOSURE TO NON PAYMENT

- DSS and Access Agency audits with exposure to extrapolation
- Risk of ineligibility of Medicaid coverage for all patients at all times
- Inability to obtain authorizations prior to providing care to patients
- 3% of annual Net Patient Revenue is written off due to increased regulatory scrutiny

EXTRA OVERHEAD COSTS

Added staffing and staffing related costs due to increased regulatory requirements

- Medical Records Staff
- Quality Review Staff
- Pre-Billing Staff
- Billing and Collections Staff
- Costs of Hiring Staff

5% of our total annual operating expenses relate to increased regulatory requirements

Complex Medical Case

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ONGOING HOME HEALTH CHALLENGES

- Complexity, acuity and historical evolution
- Clients generally have not yet qualified for the Medicare benefit due to age or…
  - Massive eligibility problems
  - Falls on Home Care
  - Forms are difficult to understand
  - No family and cannot locate paperwork
  - MFP patients are resource intensive with a high level of case management needed by a licensed individual
  - This is unreimbursed cost
  - Resource connections are disjointed and hard to access

CASE 1:
TYPICAL CLINICAL PROFILE

End stage kidney disease with uncontrolled diabetes

secondary psychiatric issues

- Stabilized in Hospital, stay 3-4 days, overwhelmed with new complication
- Previously 1 ½ weeks, prepped for dialysis, must follow up with nephrology on own
- Nurse must orchestrate transportation to doctors and dialysis
- In addition to nursing services regarding therapy (high cost service for prevention of deterioration), cost of care far below reimbursement

CASE 2: MEDICAL AND PSYCH PROFILE

- Kidney disease, HIV induced dementia (14 Month Nursing Home Stay)
  - Patient has no clothes, food, meal delivery, or lifeline, first visit patient opened door with no pants
  - Patient burned himself shortly after coming home
  - Without social work intervention (unreimbursed) back to nursing home or ER

CASE 3: POST SURGICAL HOSPITAL PT WITH SURGICAL WOUNDS, DIABETES

- Sent home the next day with pressure for fast discharge
- Education not done in Hospital or done when patient still groggy from anesthesia/ overwhelmed
- Nutrition is critical to recovery but cannot afford healthy food
- Home care clinician has massive responsibility with limited visits authorized

CHALLENGES OF UNREIMBURSED / BURDENS ON HOME CARE

- Lack of MDs: Home Care is MD only oversight…APRNs cannot sign plan of care. Federal Law.
  - Example – patient has a blood sugar of 500+. Nurse calls the clinic and the message says they will call back within 48 hours so the nurse sends the patient to the hospital. By the time the doctor does call back the patient has been to the hospital, treated and sent home.
- Difficulties with transportation services
  - Pt must be able to come out of house with no assist into transport vehicle
  - Requires 48 hours notice
  - Most patients cannot stand outside for hours so decide not to go

CHALLENGES OF UNREIMBURSED / BURDENS ON HOME CARE (cont'd)

- Family support systems are not strong
  - Typical family caregiver in the past is now working or the patient is home alone during the day if they do live with family.
- Medication Oversight and Management
  - Patient is not able to get their medication either because of lack of funds for co-pays or no transportation to pharmacy.
  - In the past patient used to get 90 day supplies delivered but Medicaid is no longer approving this.
- Social Services and Counseling
  - Depression, friends are dying, they are isolated in the community (due to lack of transportation), feeling sad and worthless, inadequate financial status

A Textbook Example Of Behavioral Health Home Care

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CONTINUUM HOME HEALTH, INC.

CENSUS	535	
Medicaid Patients	520	(97%)
Medicare/Commercial Patients	15	(3%)
Home visits per year		170,000
Cost to State per visit		$55
Average visits per patient per month		27
Cost to State per patient day		$49

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PATIENT POPULATION

Adult, Urban , Poor, predominantly people with severe and profound mental illness

Diagnoses:

Mental Health/Substance Abuse	95%
Comorbidities:	
Orthopedic	33%
Cardiac	23%
Oncologic	13%
Neurologic	13%
Diabetes	10%

These patients cannot function independently in the community without Home Care support.

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CONTINUUM HOME HEALTH, INC.

Results of Operations

For the Years Ended June 30th

	2013	2014	2015
Revenue	$7,838,000	$8,614,000	$8,952,709
Bottom Line	<292,335>	36,000	<117,295>

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HIDDEN COSTS OF CARING FOR THE BEHAVIORAL HEALTH POPULATION

• Spend Downs	$240,000
• Financial Counseling	$106,000
• Co-Pays	$ 22,000
• Cultural	$166,000
	$534,000

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3 QUICK PATIENT STORIES

- Mentally ill male, physically obese, sexually abused.
- 70 year old male, autistic and psychotic .
- Male, late forties, history of suicide.

Continuous Skilled Nursing
Pediatric Services

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CONTINUOUS SKILLED NURSING PEDIATRIC SERVICES

- By Definition, **continuous skilled nursing** is a total of two or more hours of home health nursing services provided in a 24 hour period.
- Approximately 88% of the pediatric populations we serve receive benefits from Medicaid or Medicaid waiver programs. Seventy percent of those receive assistance from the **Medicaid Katie Beckett Waiver Program**. The Katie Beckett waiver program permits persons with physical disabilities, 21 years of age or younger, with or without co-occurring developmental disabilities, who are institutionalized or at risk for institutionalization to qualify for Medicaid home and community-based services needed to avoid institutionalization

CONTINUOUS SKILLED NURSING PEDIATRIC SERVICES

- The largest groups of patients that receive continuous skilled nursing care in the state of Connecticut are children who are medically fragile. **The need for continuous skilled nursing care for these medically fragile patients has heightened in the wake of the increase in advances of bio-medical engineering and technology**. Infants that were unable to survive 15 years ago are now being saved due to this technology, but many require life-sustaining equipment to live.
- These children are **discharged directly from Neonatal or Pediatric Intensive Care Units into their homes.** Many of them require feeding tubes for nutrition, tracheostomy tubes to maintain a patent airway and ventilators to assist them to breathe.

CONTINUOUS SKILLED NURSING PEDIATRIC SERVICES

- **These children require 24 hour care**. Without access to continuous skilled nursing care, it would be necessary for these patients to be transferred to an acute or chronic disease hospital or the patient might remain home unsafely without proper care.
- Many of these families are extremely stressed with having a medically fragile child to care for and still need to perform activities of daily living such as work to provide for their families, care for other children they may have and perhaps get a few hours of sleep to sustain their efforts.

CONTINUOUS SKILLED NURSING PEDIATRIC SERVICES

- While the need for more continuous skilled nursing for this population is increasing, the numbers of properly trained skilled care-givers are decreasing. The **increased acuity** of these patients requires **properly trained** nurses with advanced critical thinking skills. There is difficulty in recruiting these specially trained nurses due to the lower pay they receive in homecare secondary to the Medicaid reimbursement rates.
- In addition, **Connecticut State Regulations for Home Care require direct supervision** of these trained nurses to ensure proper oversight to deliver quality care as well as coordination of care. These supervision costs are not reimbursable.

CONTINUOUS SKILLED NURSING PEDIATRIC SERVICES

- **The costs for providing these services are increasing directly related to complexity of the care of the child and the skill level of the caregiver that is required to care for their complex needs.** The average cost of care in a Pediatric Intensive Care Unit in Connecticut is $7,200 per day. The average cost of care of this same patient in the home for continuous skilled nursing services is $1,008 per day. The current average Medicaid reimbursement for this same service is $963 per day.
- The **best example of success** is seen through the eyes of a five year old boy who was discharged from the hospital for the first time at 9 months of age. He has received 23 hours a day of continuous skilled nursing services from PSA and by his own primary care doctor's admission was not expected to survive past his first birthday. He is now attending kindergarten and off ventilator support, in large part because of the care he has been provided in the home with his family.

CASE STUDIES FROM OTHER STATES: Better Outcomes, Lower Cost

- Telemonitoring
- Presumptive Eligibility

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DEFINING TELEMONITORING

- In-home telemonitoring (or, RPM/RMS) involves the deployment of easy-to-use technologies that help patients and physicians track conditions at home.
- Once tracked, the information is securely relayed to health care professionals in another location to provide assessment and treatment.

BLUETOOTH SCALE

BLUETOOTH GLUCOMETER

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BLUETOOTH PULSE OXIMETER

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TELEMONITORING BENEFITS

- Early detection
- Decreased utilization
- Lower readmissions
- Increased access
- Address physician shortage

COST SAVINGS HIGHLIGHTS

- CO TM pilot reduced 30-day readmissions by 62% for patients with CHF, COPD, and diabetes. **ER visits dropped 92%.**
- PA-based Geisinger Health Plan's TM program for patients with CHF **reduced hospital readmissions by 44%**.
- NY Eddy VNA's TM study saw **hospitalizations drop 55%, ER visits drop 29%, and overall medical costs drop 42%.**
- In 2013, the VA's Care Coordination Home Telehealth (CCHT) program provided services to over 600,000 veterans and **reduced bed days of care by 53%, hospital admissions by 30%, and saved nearly $2,000 per patient per year.**

MCO TELEMONITORING PROGRAM

Comparision of Cost Previous to Starting Program and Post		Grand Total
Cost **Previous** to Starting Program	$	862,595.02
Cost **Post** Starting Program	$	254,015.32
Difference	**$**	**608,579.70**

Type of Hospital Visits	Drop in # of Instances	Drop in Cost
Emergency Room	61	$46,390.05
Inpatient Readmit within 30 Days	18	$126,281.35
Inpatient Hospital Stays	47	$435,908.30

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MILBURN ET AL. STUDY (2014)

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The value of remote monitoring systems for treatment of chronic disease

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Caring for patients with chronic illnesses is costly—75% of U.S. healthcare spending can be attributed to treating chronic conditions (CDC, 2009a,b). Several components contribute to the cost of treating chronic disease. There are the direct costs associated with treating the disease, and those associated with complications that arise as a result of the disease. There are also indirect costs associated with loss of productivity and quality of life. Technological advances in remote monitoring systems (RMS) may provide a more cost-effective and less labor-intensive way to manage chronic disease by focusing on preventive measures and continuous monitoring instead of emergency care and hospital admissions. In this paper, we develop a model that estimates the total potential savings associated with broad introduction of RMS, and considers how capacity constraints and fairness concerns should impact RMS allocation to target populations. To illustrate the value and insight the model may provide, we conduct a small computational study that focuses on direct costs that would be real costs to a healthcare provider or payer for a subset of the most common chronic diseases: diabetes, heart failure, and hypertension. The computational study shows that, under reasonable assumptions, broad introduction of RMS will lead to substantial cost savings for target populations. The study provides proof of concept that the model could serve as a useful tool for policy makers, as it allows a decision maker to modify cost, risk, and capacity parameters to determine reasonable

MILBURN ET AL. STUDY (2014)

- **Abstract:** "[W]e conduct a small computational study that focuses on direct costs that would be real costs to a healthcare provider or payer for a subset of the most common chronic diseases: diabetes, heart failure, and hypertension. **The computational study shows that, under reasonable assumptions, broad introduction of RMS [telemonitoring/RPM] will lead to substantial cost savings for target populations**. The study provides proof of concept that the model could serve as a useful tool for policymakers…"

MILBURN ET AL. STUDY (2014)

KY Medicaid Savings for TM Diabetic Intervention, Per Patient Per Year			
Pop.	**Cost of Traditional Care**	**Cost of TM Care**	**Savings**
Type 1 Diabetes	4,198 enrollees x $5,666.50 = $23,787,967	4,198 enrollees x $4,881.40 = $20,492,117	$23,787,967 – $20, 492,117 = **$3,295,850**
Type 2 Diabetes	79,758.2 enrollees x $6,950.50 = $554,359,369.10	79,758.2 enrollees x $6,244.76 = $498,070,817.03	$554,359,369.10 - $498,070,817.03 = **56,288,552.07**

- All told, deploying TM interventions with KY's Medicaid diabetic population could save the state **over $59 million annually**.

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PRESUMPTIVE ELIGIBILITY

- **What is Presumptive Eligibility?**
  - PE 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 within 10 days of referral for Medicaid homecare services.
- **Why does CT need it?**
  - Medicaid eligible patients in CT can often wait weeks to obtain homecare services burdening family caregivers and resulting in expensive emergency room and hospital visits.
  - States with PE have reduced patient wait time for homecare services by up to 66%.

PE HIGHLIGHTS

- **Washington**
  - WA's PE program shrank the average wait time to determine Medicaid financial eligibility 66%.
  - WA officials determined PE clients saved Medicaid an average of $1,964 a month.
- **Colorado**
  - CO's PE pilot cost $106,879 but saved $407,012 by diverting patients from costly nursing home care into HCBS.

PE HIGHLIGHTS

- **Kansas**
  - KU researchers found KS's PE pilot would need to divert just 5 people away from institutional care to be cost effective.
    - In the end the pilot diverted 22 of 200 program participants with less than a 1% error rate.
- **Ohio**
  - PE has helped OH reduce the % of its Medicaid budget spent on institutional care from 60% to 48%.
  - The error rate in assessments is about 1%.

"FAST TRACK HH APPROVAL PROGRAM FOR SENIORS"

- **Update from Sen. Kennedy's October 20 Press Release:**
  - Program went into effect in July and is expected to run for at least 6 months
  - 127 applicants have been served to date
    - DSS is currently working to increase the rate of approval
  - Expedited approval supports CT's goal of having 75% of senior care provided at home, with only 25% of care provided in a nursing home
    - The average Medicaid cost per day for home care is $58 compared to an average daily cost of $205 for a nursing home stay
  - Faster approval of CHCPE applications is estimated to save over $6,000 per month for each senior who is diverted from a skilled nursing facility

CT Home Care Program for the Elders (CHCPE)

CHCPE

- Run by the DSS Home and Community-Based Services Unit (HCBSU)
- Formerly the Alternate Care Unit (ACU)

CHCPE ELIGIBILITY

- 65 years of age or older
- a Connecticut resident
- at risk of nursing home placement
  - needs assistance with critical needs such as bathing, dressing, eating, taking medications, toileting
- meet the program's financial eligibility criteria
  - https://www.ascendami.com/CTHomeCareForElders/default/HomeCareForEldersInstructions.aspx

CHCPE ELIGIBILITY INSTRUCTIONS

CHCPE Eligibility Instructions

INCOME AND ASSET INFORMATION

WHAT IS COUNTED FOR YOUR GROSS MONTHLY INCOME? Your total income before any deductions including any deductions for Medicare premiums.
Count only your income and no one else's. (If married, do not count your spouse's income.)
Count all income you get on a regular basis like your wages, pension, Social Security, Veterans benefits, and Supplemental Security Income. **WHAT ARE YOUR COUNTABLE ASSETS? DO NOT COUNT** your house, furnishings, personal belongings (clothes, jewelry) or the motor vehicle that is your essential means of transportation.
Also, do not count:

- **Burial Funds** - Irrevocable up to $5,400.00 for each person OR Revocable up to $1,800.00.
- **Burial Plots** - For single individuals, one plot. For married individuals, one plot for each spouse and certain other family members under certain conditions. A plot may include a casket, outer container and opening and closing of the grave.
- **Life Insurance Policies** - If the total face value of all policies does not exceed $1,500.00. (Otherwise count total cash surrender value of all policies.)

COUNT ASSETS OWNED BY YOU OR YOUR SPOUSE. All jointly held assets must be counted in full as yours unless you can show they are owned by someone else (not your spouse). This includes things like: real estate not used as your home, non-essential motor vehicles, campers, boats, bank/credit union accounts (savings, checking, CD, IRA, Vacation or Christmas Club), stocks, revocable trust funds, bonds, U.S. Savings Bonds, total cash surrender value of life insurance with a total face value that exceeds $1,500.00. **MEDICAID WAIVER INCOME LIMIT** - *$2,199.00 per month or less* **STATE FUNDED INCOME LIMIT** - *No Limit*

ASSET LIMITS --	**MEDICAID WAIVER***	**STATE FUNDED****
Individual --	$1,600.00	Individual -- $35,766.00
Couple --	$3,200.00 (both receiving services)	Couple Combined Assets -- $47,688.00
Couple --	$25,444.00* (one receiving services)	(one or both receiving services)

*** A higher amount may be allowed if you have a spousal assessment done (see Notice to Married Couples).**
**** Participation in program is based on availability of funds. State Funded clients are required to pay 7% of the cost of their services.**
If your income and assets are within these amounts you may qualify for services.

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CO-PAY REQUIREMENT

- As of July 1, 2015 clients who are on the state-funded portion of the program are required to pay a 9% copay per Public Act 15-5. Failure to pay the copay will result in the termination of services under the CT Home Care Program for Elders.

GOAL OF CHCPE

- Help eligible clients continue living at home instead of going to a nursing home.
- How?
  - Each applicant's needs are reviewed to determine if the applicant may remain at home with the help of home care services.

CHCPE SERVICES

- Care Management Services
- Adult Day Health Services
- Companion Services
- Home Delivered Meals
- Homemaker Services
- Assisted Living Services
- *Personal Care Attendant Services - family members are NOT eligible to be paid for taking care of relatives with very rare exceptions.
- *Chore Assistance - only available as part of a package of services to applicants who meet all other eligibility criteria.
- Adult Family Living
- Bill Payer
- Support Broker
- Care Transitions
- Chronic Disease Self-Management
- Assistive Technology

CHCPE FINANCIAL AND FUNCTIONAL ELIGIBILITY

- CHCPE has five categories of service. Every CHCPE individual is assigned to a category based on the functional and financial criteria at the time of the initial assessment. Clients can be changed from one category to another based on a change in their functioning level or financial status.
- http://www.ct.gov/dss/cwp/view.asp?A=2353&Q=558344

CHCPE CATEGORIES OF SERVICE

- **Category 1**: limited homecare for moderately frail elders at risk for hospitalization or short-term nursing home care with 1 or 2 critical needs.
- **Category 2:** intermediate home care for very frail elders with assets above Medicaid limits in need of short or long-term nursing home care with 3 or more critical needs.
- **Category 3:** extensive home care for very frail elders who would otherwise be in a nursing home on Medicaid with at least 3 or more critical needs.
- **Category 4:** CT Home Care Program for Disabled Adults (CHCPDA) with diagnosis of a degenerative, neurological condition, at least 3 critical needs and do *not* meet the Medicaid income and/or asset criteria
- **Category 5:** clients of the federal Medicaid 1915i home and community based services state plan option. Level same as *Category 1* clients except active Medicaid recipients and monthly income up to 150% of the Federal Poverty Level (FPL). *Category 5* services do not have a specific cost limit, though some services have specific limits such as a limit on the number of hours per week for PCA and Homemaker Services.

APPLIED INCOME

- If a client's income is over the Medicaid limit, they may be required to contribute toward the cost of their care.
- If a client's income exceeds the set amount, the client will be responsible for paying a monthly applied income amount.
  - The amount may be lowered with certain items submitted and taken into consideration. These are: paying from own funds for additional services, prescriptions, health insurance, and providing additional support to his/her spouse, medical bills.

CT Medicaid Waiver Programs

Overview of Medicaid Waiver Programs in CT

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CHCPE

Connecticut HomeCare Program for Elders (CHCPE)-

- Serves elders (65 years of age and older) who are either at risk of institutionalization or meet nursing home level of care. Clients must meet functional and financial eligibility criteria. Services include homemaker, companion, personal emergency response system, meals on wheels, adult day care, chore, mental health counseling, assisted living, personal care attendant, assistive technology, adult family living, care management, minor home modifications.

KATIE BECKETT WAIVER

- Serves children and young adults with severe disabilities under age 22.
- Services include case management and Medicaid coverage aimed at keeping the child or young adult in the community instead of an institutionalized setting.
- The Home and Community-Based Services that allow the enrollee to remain in the community are provided under the Medicaid state plan.
- A maximum of 300 slots is funded under legislation. Parents' income and assets are not factored into the initial eligibility. This offers families of all income levels the opportunity to access services they otherwise may not be able to afford.

PERSONAL CARE ATTENDANT (PCA) WAIVER

- Provides personal care assistance services included in a care plan to maintain adults with chronic, severe, and permanent disabilities in the community. Without these services, the adult would otherwise require institutionalization.
  - Care plan is developed by a Department social worker, in partnership with the adult. Effective January 1, 2015, the plans are developed with the consumer by an Access Agency care manager.
  - Adults must be age 18-64 to apply, must have significant need for hands on assistance with at least two activities of daily living (eating, bathing, dressing, transferring, toileting), must lack family and community supports to meet the need, and must meet all technical, procedural and financial requirements of the Medicaid program.
  - Medicaid for Employees with Disabilities is an option.
  - Eligible adults must be able to direct their own care and supervise private household employees, or have a Conservator to do so.
  - An adult deemed eligible for the PCA Waiver is eligible for all Medicaid-covered services.

ACQUIRED BRAIN INJURY (ABI) WAIVERS

- There are two ABI Waiver programs, known as ABI Waiver I and ABI Waiver II. Both employ the principles of person-centered planning to provide a range of non-medical, home and community-based services, to help maintain adults who have an acquired brain injury (not a developmental or degenerative disorder), in the community. Without these services, the adult would otherwise require placement in institutional settings.
- Adults must be age 18-64 to apply, must be able to participate in the development of a service plan in partnership with a Department social worker, or have a Conservator to do so, and must meet all technical, procedural and financial requirements of the Medicaid program. Medicaid for Employees with Disabilities is an option. An adult deemed eligible for the ABI Waiver is eligible for all Medicaid-covered services.

COMPREHENSIVE WAIVER (DDS)

- Provides services for participants with intellectual and/or developmental disabilities that have significant physical, behavioral or medical support needs.
  - adult day health, community companion homes/community living arrangements, group day supports, live-in caregiver, respite, supported employment, independent support broker, adult companion, assisted living, behavioral support, continuous residential supports, environmental modifications, health care coordination, individual goods and services, individualized day supports, individualized home supports, interpreter, nutrition, parenting support, personal emergency response systems, personal support, senior supports, specialized medical equipment and supplies, transportation and vehicle modifications.

INDIVIDUAL AND FAMILY SUPPORTS WAIVER (DDS)

- Designed to support individuals who live in their own homes or in their family homes and need less extensive supports than individuals on the Comprehensive Waiver.
  - Provides adult day health, community companion homes (formerly community training homes), group day supports, individual supported employment (formerly supported employment), live-in companion, prevocational services, respite, independent support broker, behavioral support, companion supports (formerly adult companion), continuous residential supports, environmental mods, group supported employment (formerly supported employment), health care coordination, individualized day supports, individualized home supports, individually directed goods and services, interpreter, nutrition, parenting support, personal emergency response systems, personal support, senior supports, specialized medical equipment and supplies, transportation and vehicle modifications.

EMPLOYMENT AND DAY SUPPORTS WAIVER (DDS)

- Targets young adults transitioning from school to work with similar services as the other DDS waivers.
  - Provides adult day health, community based day support options, respite, supported employment, independent support broker, behavioral support, individual goods and services, individualized day support, interpreter, specialized medical equipment and supplies and transportation.

AUTISM WAIVERS (DDS)

Early Childhood Autism Waiver

- Serves three-and four-year-olds with autism. Services provided are an ABA-certified clinician and a life skills coach.

Autism Waiver

- Serves individuals ages three and older with an IQ of greater than 70. Services are provided in the person's own home or family home.
  - Provides community companion homes, live-in companion, respite, assistive technology, clinical behavioral support, community mentor, individuals good and services, interpreter, job coaching, life skills coach, non-medical transportation, personal emergency response systems, social skills group and a specialized driving assessment for individuals.

DMHAS WAIVER

- Serves persons with serious mental illness who otherwise require nursing facility level of care with the goal of keeping the person in the community rather than a nursing home. Waiver services complement and/or supplement services available to participants through the Medicaid State Plan and other federal, state and local public programs, as well as natural supports that families and communities provide.

MEDICAID WAIVER ELIGIBILITY

Income

- All of the Medicaid waivers have a gross income limit of 300% of the base Supplemental Security Income (SSI) rate. The 300% amount of SSI, effective January 1, 2015, is $2,199 a month for a single individual. This figure is a gross income-eligibility test. No adjustment to income is allowed. If gross income is less than the limit, the requirement is met. If income exceeds the limit, the client is ineligible for a Medicaid waiver.

Assets

- Medicaid waivers have two asset limits, dependent on the age and disability status of the applicant. If the client has eligibility based on elder status (over 65), disability (age 18-64), or blindness, the asset limit is $1,600. If the client is a child (under 18), the asset limit of $1,000 is used. Only the recipient's assets are considered. Clients with excess assets are ineligible for services until the month that assets are reduced to within the asset limit.

Assets and the Community Spouse

- The spouse of a client approved for a Medicaid waiver program becomes what is called the Medicare Catastrophic Care Act (MCCA) Community Spouse. As part of the initial eligibility determination, any assets held either individually or jointly are deemed to be available using the criteria below. Once eligibility is established for the institutionalized (waiver) spouse, the deeming ceases. The MCCA Community Spouse is allowed half of all assets, subject to a minimum and maximum. For 2014, the minimum amount protected for the community spouse was $23,448 and the maximum is $117,240. These amounts increase to $23,844 and $119,220 for 2015.

Money Follows the Person (MFP) & Community First Choice (CHC)

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MONEY FOLLOWS THE PERSON

- A federal demonstration grant, received by the CT DSS from CMS
  - **Dedicated to assuring CT residents access to a full range of high quality, long-term care options that maximize autonomy, choice and dignity.**
  - Helps Medicaid-eligible individuals currently living in long-term care facilities – such as nursing homes, hospitals and other qualified institutions – successfully transition back into the community.

ELIGIBILITY

To participate in the program, the individual

- Must be eligible for Medicaid and living in a long-term care or hospital setting for at least three months
- Should have an interest in living in the community and be eligible for one of the community service packages.

CONNECTICUT ASSOCIATION FOR HEALTHCARE AT HOME℠

Source: https://ctmfp.com/Information.aspx

ELIGIBILITY

Based on individual needs, MFP provides the funds, services and support needed for a successful transition into the community.

In addition to returning to the home, housing options include individual apartments, assisted living and group homes.

A Transition Coordinator advocates in the transition process, working with the patient and care team on a one-to-one basis to develop a plan that's right.

Source: https://ctmfp.com/Information.aspx

COST OF CARE

MFP pays care in the community as well as various expenses that come when a person moves into a more independent situation.

Based on circumstances and needs, an individual may be eligible to receive help with home modifications, rent and security deposits, along with one-time setup costs for a new apartment.

Source: https://ctmfp.com/Information.aspx

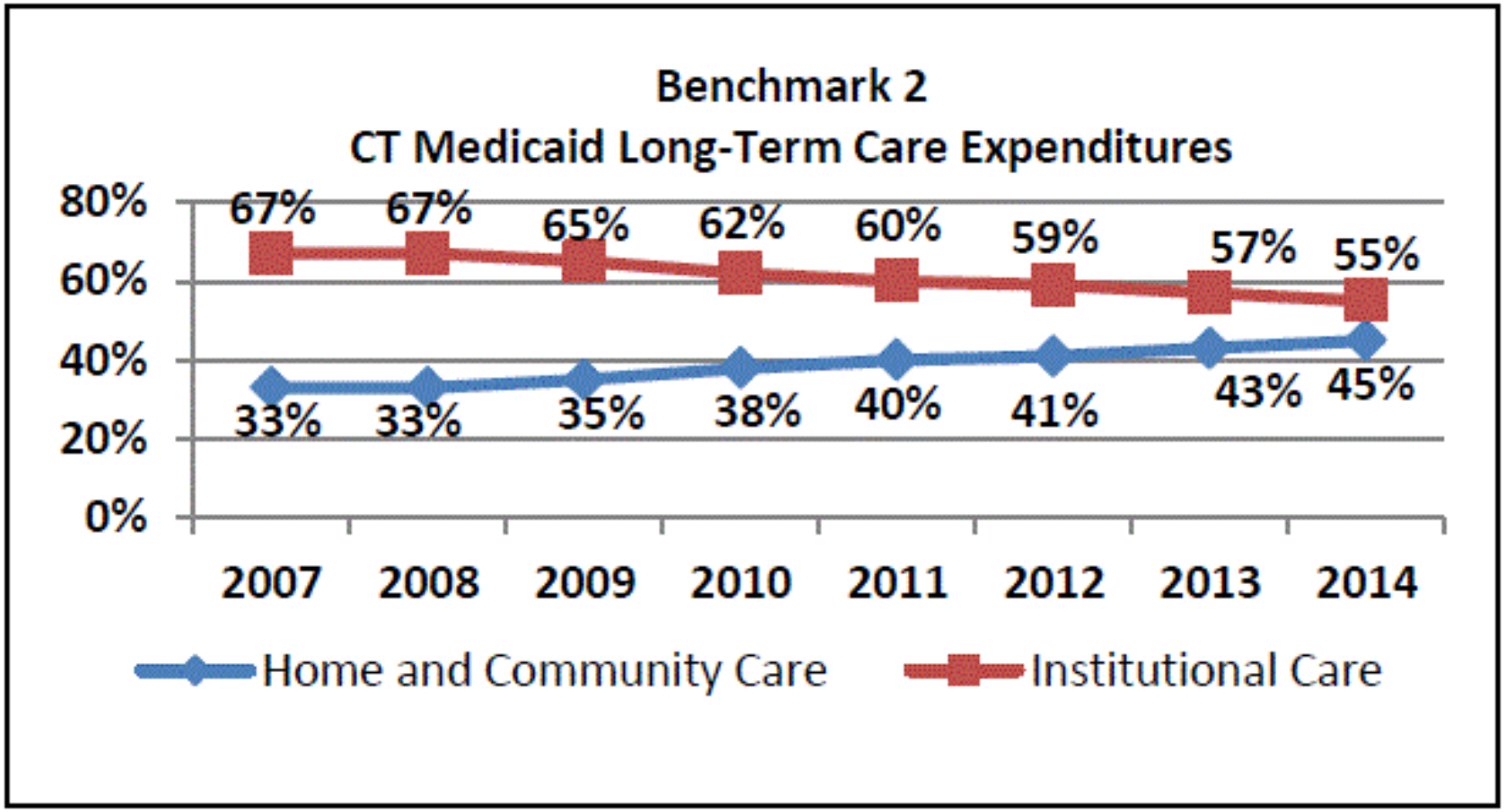
MFP SUPPORT

A Transition Coordinator will work with the patient and their care team to help find a place to live and identify service providers such as nurses, physical therapists or home health aides in the community.

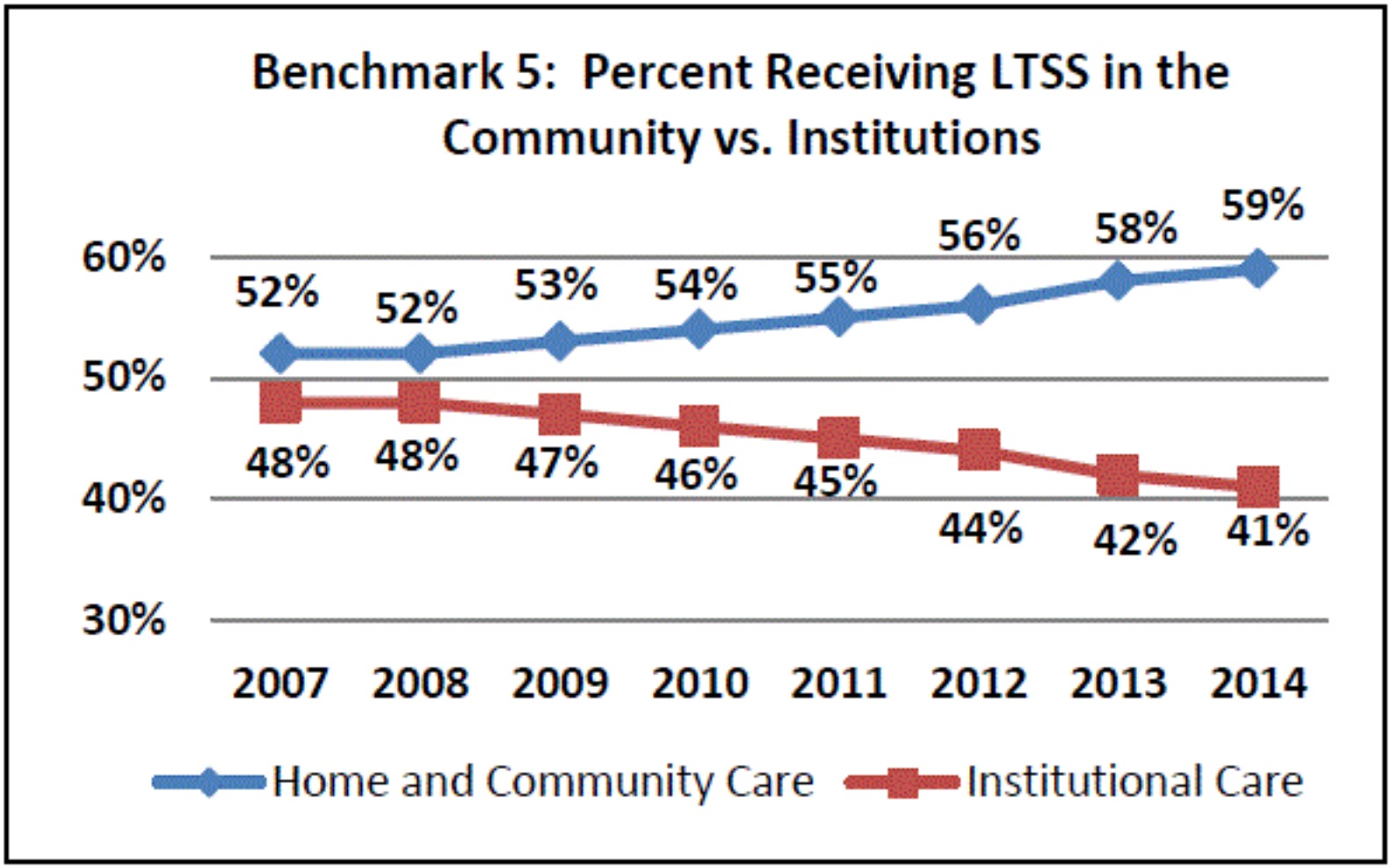
Source: https://ctmfp.com/Information.aspx

5 MAJOR GOALS OF MFP

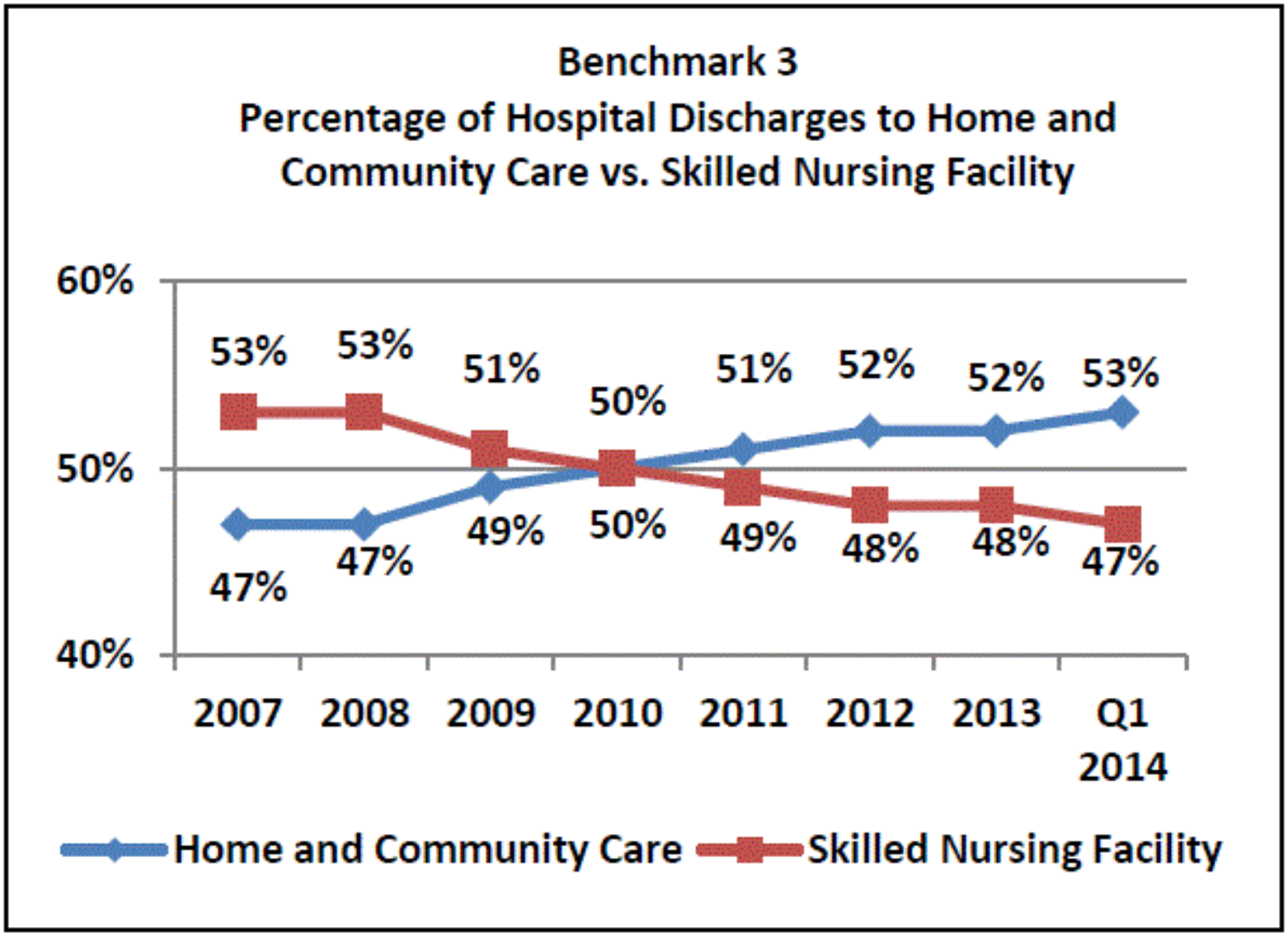
1. Increase dollars spent on home and community based services.
2. Increase the percent of people receiving their long-term services in the community relative to those in institutions.
3. Decrease the number of hospital discharges to nursing facilities for those requiring care after discharge.
4. Increase the probability of people returning to the community within the first three months of admission to an institution
5. Transition individuals out of institutions and back into the community



Data taken from the CT MFP Quarterly Report 2015: Quarter 2.



Data taken from the CT MFP Quarterly Report 2015: Quarter 2.



Data taken from the CT MFP Quarterly Report 2015: Quarter 2.

COMMUNITY FIRST CHOICE

Community First Choice (CFC)

- A new program in Connecticut offered to active Medicaid members as part of the Affordable Care Act. This program allows individuals to receive supports and services in their home. These services can include—but are not limited to—help preparing meals and doing household chores, and assistance with activities of daily living (bathing, dressing, transferring, etc.). Educational services will be available to help increase independence, and learn how to manage in-home staff.

Source: https://ctmfp.com/InformationCFC.aspx

COMMUNITY FIRST CHOICE

Eligibility

- CFC is open to any Medicaid member that can self-direct services and meets Institutional Level of Care. Institutional Level of Care means patients would likely need to be in an institution, such as a nursing home, if they do not have home and community based services. This program allows an eligible person to have care and support in their home.

Source: https://ctmfp.com/InformationCFC.aspx

Medicare PPS Overview

GUIDING PRINCIPLES

- Align and fairly balance the interests of patients, taxpayers, providers and payers
- Providers paid for a “period of care”
- Foster innovation & efficiency
- Control Medicaid health care costs
- Allow providers to manage care plan with fixed payment
- Move slowly and with collaboration (DSS, DPH)

MEDICARE PAYMENT METHODOLOGY

- Established in CY 2000 to replace a payment per visit methodology
- Episodic – 60 day period of care
- Payment based on patient assessments (OASIS)
- 153 HHRG's
- National Standard Episodic Payment Amount
- Payment based on actual costs of services and utilization
- Rebased all payment rates for CY 2014 based on actual costs & utilization
- All rates are adjusted for wage mix factor
- Home Health Costs and Profits carefully monitored by MedPAC

CMS/MEDICARE COST REPORT ANALYSIS

- The *cost report* contains provider information such as facility characteristics, utilization data, *cost* and charges by *cost* center (in total and for *Medicare*), *Medicare* settlement data, and financial statement data
- CMS analysis of 6,252 cost reports for CY 2011 (after trimming)
- Determined actual cost of services by service (skill, discipline)
- Established updated episodic cost
  - *Average number of visits by skill x actual cost of services*

- Market Basket Increase - The Office of the Actuary (OACT), within the Centers for Medicare and Medicaid Services (CMS), is responsible for producing the CMS market basket

FEDERAL WAGE INDEX FOR CT COUNTIES

Example (1.2526 = 25.26% more than national average)

County	Wage Index
Hartford, Middlesex, Tolland	1.1116
New Haven	1.2526
New London	1.2056
Windham	1.1667
Fairfield	1.3405
Litchfield (CT Rate)	1.1196
Rural Add-on	3%

TABLE 6—2011 AVERAGE COSTS PER VISIT AND AVERAGE NUMBER OF VISITS FOR A 60-DAY EPISODE

Discipline	2011 Average costs per visit	2011 Average number of visits	2011 60-Day episode costs
Skilled Nursing	$131.51	9.43	$1,240.14
Home Health Aide	65.22	2.80	182.62
Physical Therapy	160.69	4.86	780.95
Occupational Therapy	159.55	1.15	183.48
Speech–Language Pathology	170.80	0.21	35.87
Medical Social Services	218.91	0.14	30.65
Total		**18.59**	**2,453.71**

Source: CY 2011 Medicare claims data and 2011 Medicare cost report data as of December 31, 2012.

MEDICARE CY'13 ESTIMATED COST PER VISIT & REIMBURSEMENT CY'16 PER VISIT RATES

(HHS 12/02/2013 Vol.78 No.231 Part III, CMS Final Rule 1450-F, Table 12)

Rates below are not wage mix adjusted

Discipline / Skill / Service Type	Medicare Average CY'11 $ Costs	Medicare Average CY'13 $ Costs	CY '16 Medicare Visit Rate $
Skilled Nursing	131.51	140.13	134.90
Home Health Aid	65.22	70.69	61.09
Physical Therapy	160.69	170.70	147.47
Occupational Therapy	159.55	169.50	148.47
Speech Language Pathology	170.80	181.29	160.27
Medical Social Services	218.91	231.69	216.23

MEDICARE VS. MEDICAID RATES (CT)

(excludes wage mix adjustment)

Discipline / Skill / Service Type Per Visit	CY '15 Medicare Visit Rate $	2015 Current Medicaid Rates $	$ Difference Per visit Medicaid vs. Medicare	% Medicaid Rate vs. Medicare Rate
Skilled Nursing	147.91	95.20	-52.71	64%
Home Health Aid	66.98	28.00	-38.98	42%
Physical Therapy	161.70	81.29	-80.41	50 %
Occupational Therapy	162.80	83.65	-79.15	51 %
Speech Language Pathology	175.74	83.65	-92.09	48 %
Medical Social Services	237.10	NA	NA	

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NEXT STEPS

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