



CT HOME HEALTH AND DSS LEAN PROCESS IMPROVEMENT PUBLIC/PRIVATE PARTNERSHIP

*Goal: Sustainability of Medicaid
Skilled Home Health Care Delivery*

**CT Association for Healthcare at Home
For: MAPOC Complex Care Committee
April 25, 2019
1pm to 3pm**



**CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME™**

What is Home Health?

WHAT IS HOME HEALTH?

- Approximately **95 CT Home Health Care and 29 Hospice agencies** licensed by the CT Dept. of Public Health (DPH), audited by the CT Dept. of Social Services (DSS), and federally certified by The Centers for Medicare and Medicaid Services (CMS)
 - Services include post-acute med/surg care, rehabilitation/therapy, chronic care management, medication management, behavioral home health, pediatric nursing, palliative care and hospice.
- **A highly regulated industry** delivering care (nursing, therapy, social work) in compliance with physician orders and approved patient-centered care plans. Home health reduces unnecessary and costly hospital readmissions/ED visits and institutionalization by keeping individuals with chronic conditions stable at home.
- **Home Health Care is not Home Care:** Our state license and Medicare certification requirements make us distinctly different from other community-based providers who provide supportive, non-medical personal care services including personal care assistant, homemaker-companion, and live-in to assist with activities of daily living such as bathing, meal preparation and transportation.



What brings us here?

COMMITMENT

CT Home Health Providers and the Association have a Commitment to the Medicaid Program and its Clients

- Decades as Committed Partner with DSS and Access Agencies
- Shared Goal of Person-Centered, Home-Based Care (High Cost/High Need Medicaid Clients, CT Home Care Program, MFP, Waiver Programs)
- Active Partner who Brings Solutions to Improve Care and Reduce DSS Expenses (Medication Admin Delegation and Management of Behavioral Health clients, Electronic Visit Verification, Medicaid Face to Face Encounter)
- Dependable Provider Sector that Enables Consistent State Medicaid Budget Savings (SFY 2017 \$360.9 Million and Total >\$1.7 Billion in last 12 SFYs 2006-2017)

CONCERNED ABOUT THE FUTURE

Concerns About the Sustainability of CT's Home Health Providers

- Growing Demographics and need to meet Workforce Demands
- CT Home Health Agency Closures, Consolidation
- Home Health Providers Opting Out of Medicaid Program
- Added Business Complexity, Clinical and Regulatory Compliance Pressures, Audits, Surveys (DPH and DSS)
- Higher Acuity, Medically Complex Patient Population Now Receiving Home Health (Medical and Behavioral)
- Flat Medicaid Provider Reimbursement Over 12-Year Period
- Federal Medicare Reimbursement Cuts of 17.5% (CMS Rebasing) Over Past 4 years, and CMS Seeking Future Reductions
- Additional Staff and Training Required to Meet DSS Program Requirements (Med Admin, EVV, Medicaid F2F, New G-code)
- Provider Financial Loss on Every Medicaid Client Served (\$0.60 on \$1.00)

REQUIRED NEW APPROACH

Need to Approach Medicaid Home Health Care Delivery Differently and Collaboratively with all Stakeholders

Recognize that we are Working Within a “Permanent State Fiscal Crisis” Environment

- Uncertain Reimbursement Rate Increases
- Shift From “Reimbursement Per Visit” to Quality and Value
- Federal Medicare and Medicaid Changes
 - Move to Managed Care
 - New Patient Driven Groupings Model (PDGM) eff 1/2020

Time for Self-Examination and Reflection as a Provider Sector

- Offer Constructive and Collaborative Solutions
- We are a Provider Community with Extensive Expertise and Commitment and Desire to Bring Positive Change

COLLABORATIVE PARTNERS

How Can the Association and Home Health Agencies Be Better State Medicaid Partners?

Work To Change What We Can Control

- Identify Reason for Home Health Providers Exiting Program or Reducing Medicaid Access
- Engaged LEAN Sensei Summer 2017 - 3 Working Sessions
 - Create Work Flow Diagram - Walking Medicaid Client From Referral to Provider Payment
 - Identified Redundant, Manual and Time Consuming Processes
 - Engaged Access Agencies for their Input and Edits to LEAN Findings - Sept. 2017
- Several meetings with DSS to Share Findings – 2017-2019

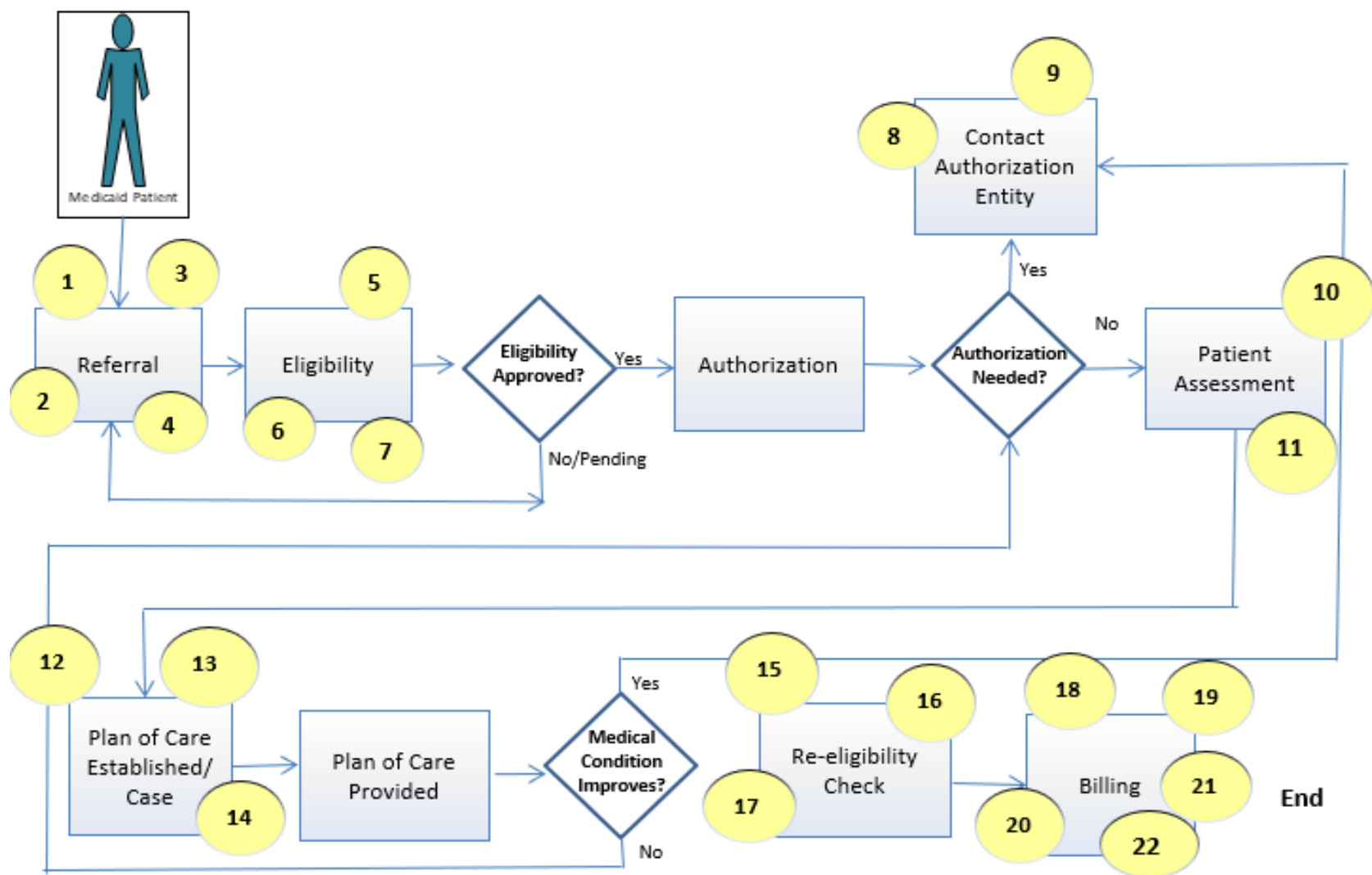
LEAN PROCESS APPROACH

Goal: Take Medicaid client through home health system from referral to billing the claim and receiving payment

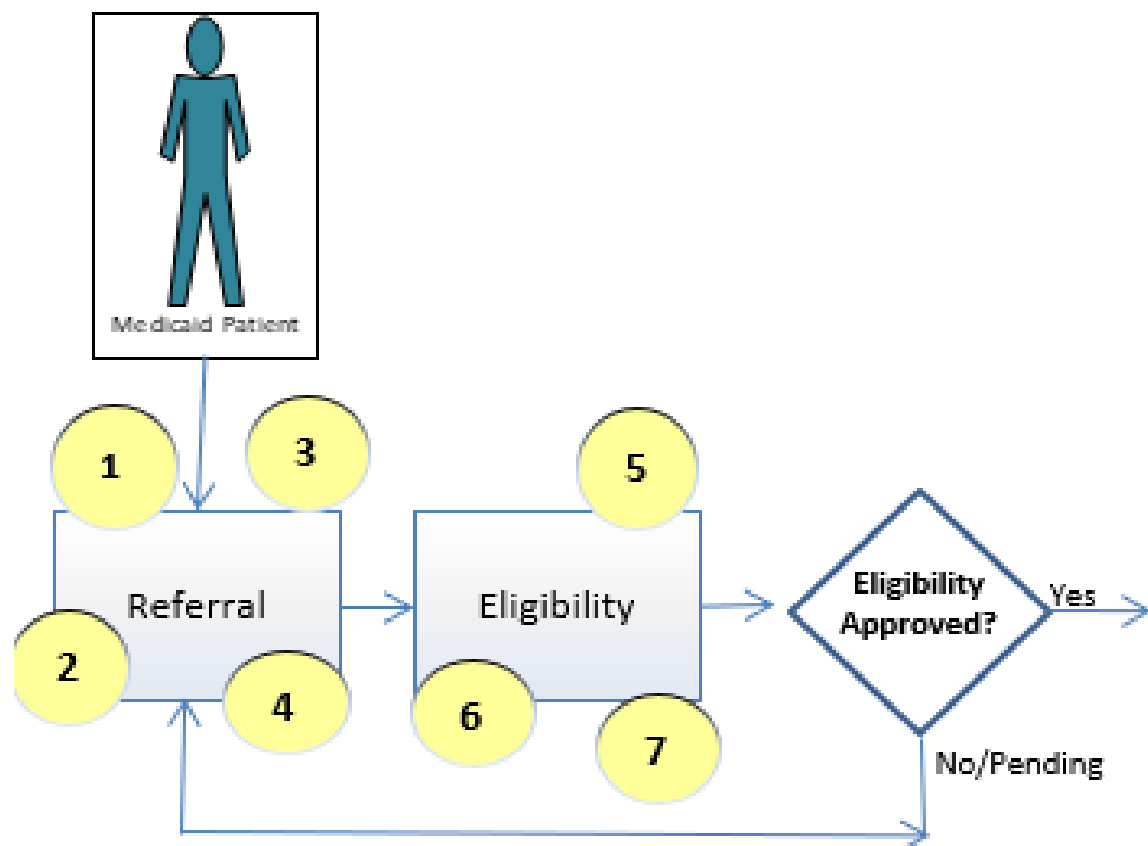
Identified 9 areas within process requiring DSS, Access Agency and Home Health Care Provider efficiencies:

- | | |
|----------------------------|---------------------------|
| • Referral | Plan of Care Provided |
| • Eligibility | Re-eligibility/Auth check |
| • Authorization | Billing |
| • Patient Assessment | Payment |
| • Plan of Care Established | |

The Medicaid Home Health Care Delivery Process is complicated and has many indicators pointing to root-cause problems.



REFERRAL AND ELIGIBILITY



1. Referral source may need to call multiple providers before referral is accepted.

2. Member access is a function of provider capacity.

3. Third party insurance limitations.

4. Limited specialty services (ie: IV) limit access.

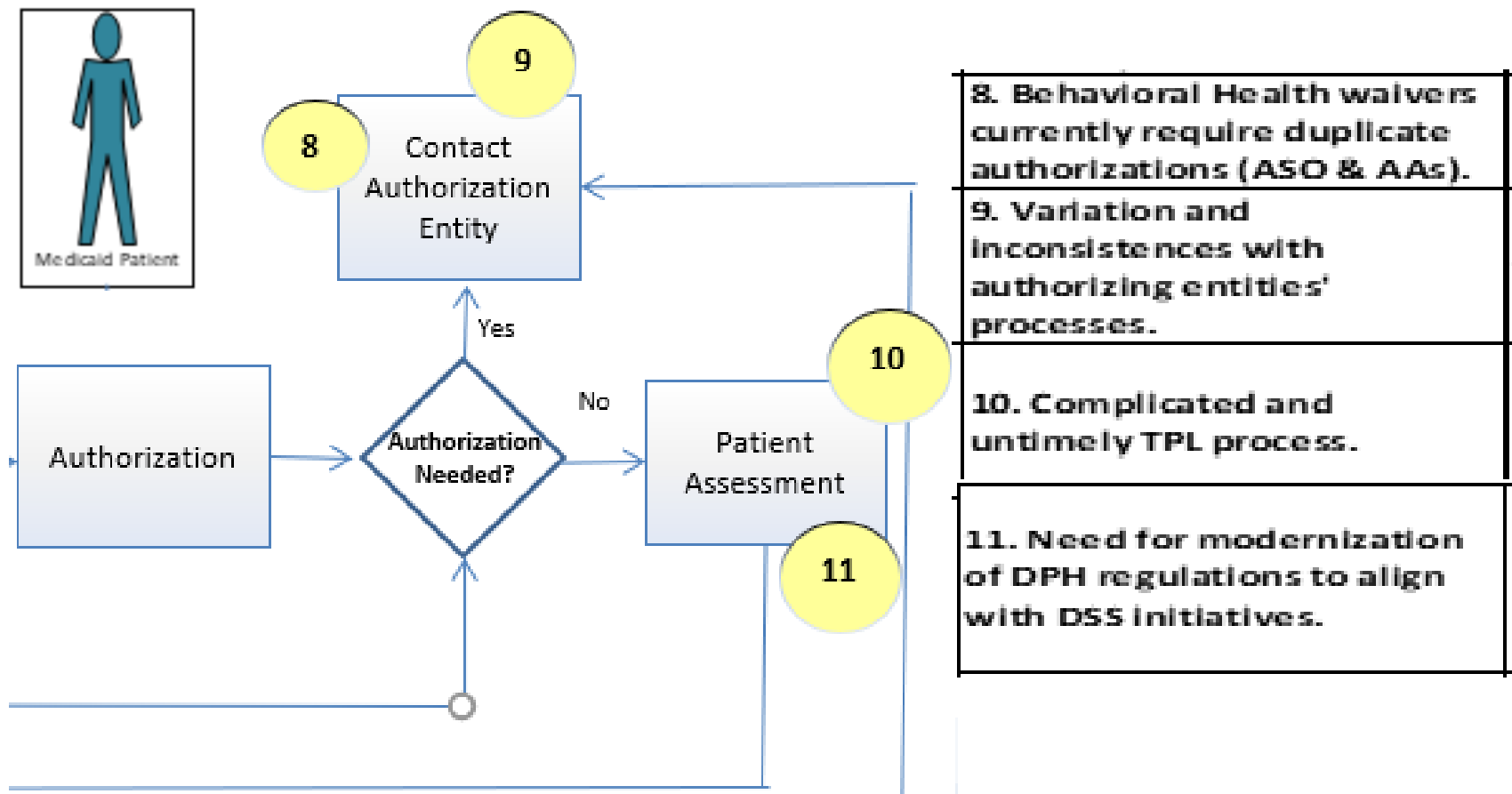
5. Delayed access = decreased health outcomes and potential for higher costs.

6. Home health agencies deliver patient care in good faith during pending eligibility or redetermination.

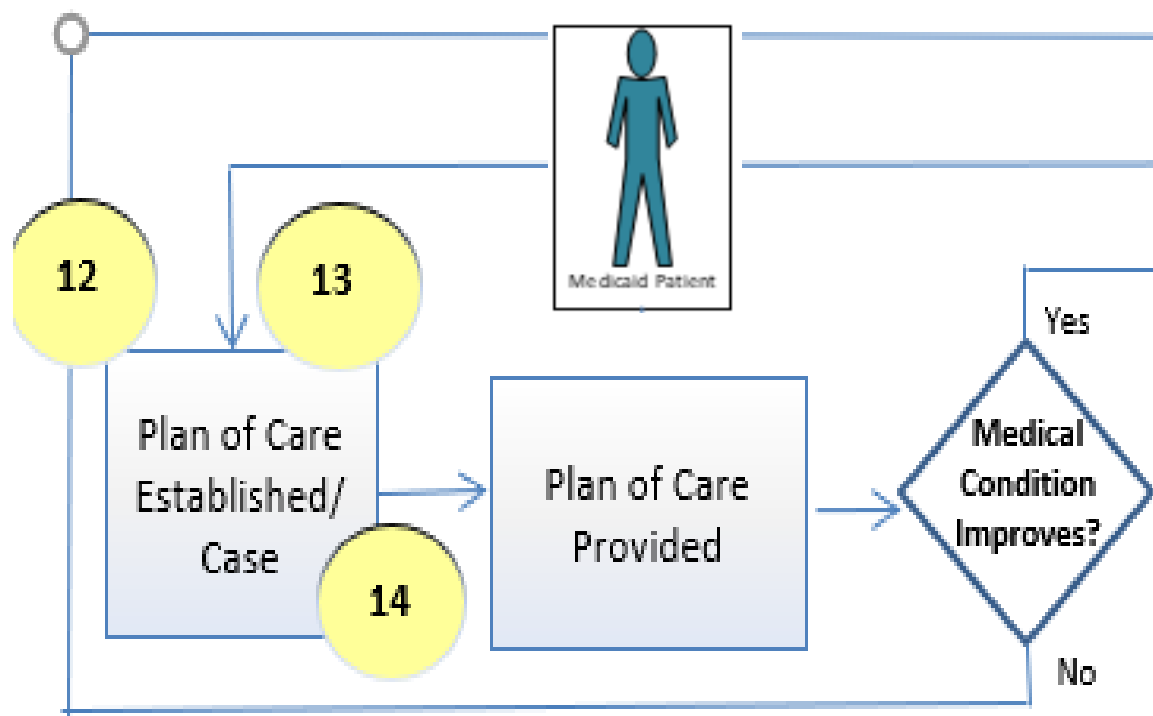
7. Delayed eligibility issues put agencies at financial risk (spenddowns and lost revenue).



AUTHORIZATION AND ASSESSMENT



PLAN OF CARE

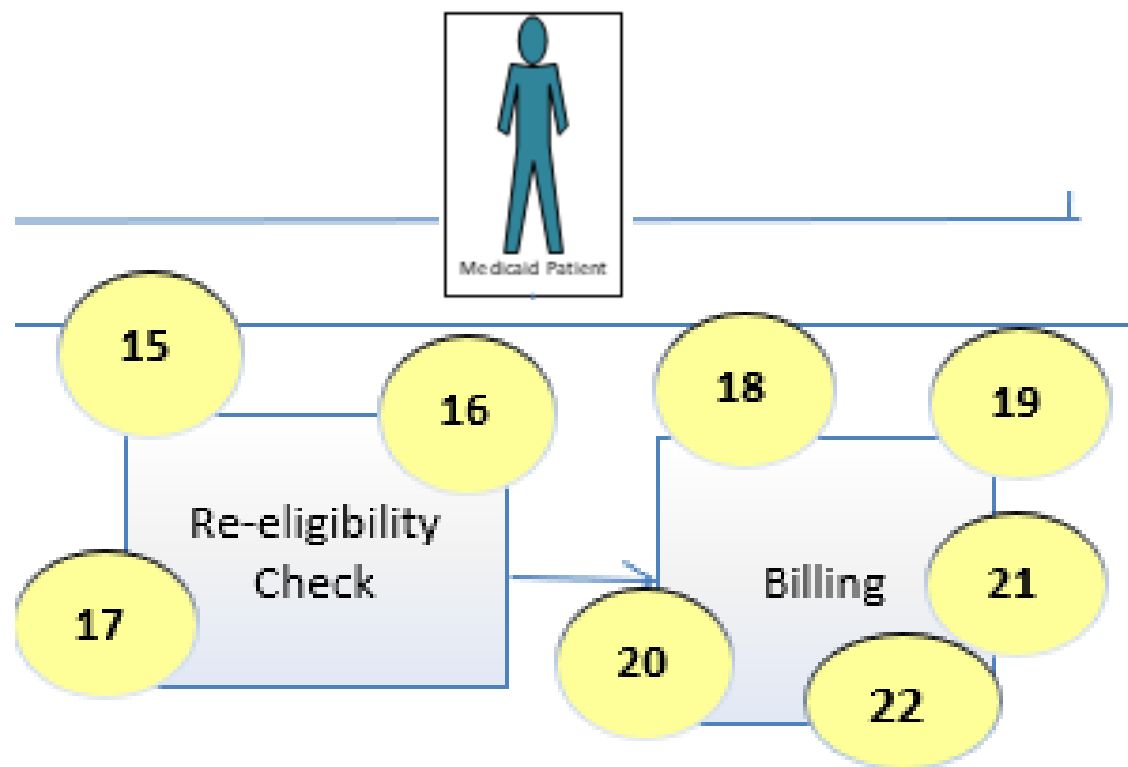


12. Variation in perspective between authorizing entity and provider regarding level of care.

13. DSS & DPH conflicting oversight (financial vs. regulatory).

14. If waiver with cost cap, frequent communications required.

BILLING/RE-ELIGIBILITY



15. Lack of notification of eligibility termination to AAs and providers.

16. AAs and provider financial liability.

17. AAs and provider time and resources to find alternatives for ineligible cases.

18. Speed of implementation without advanced stakeholder input.

19. EVV TPL process malfunction.

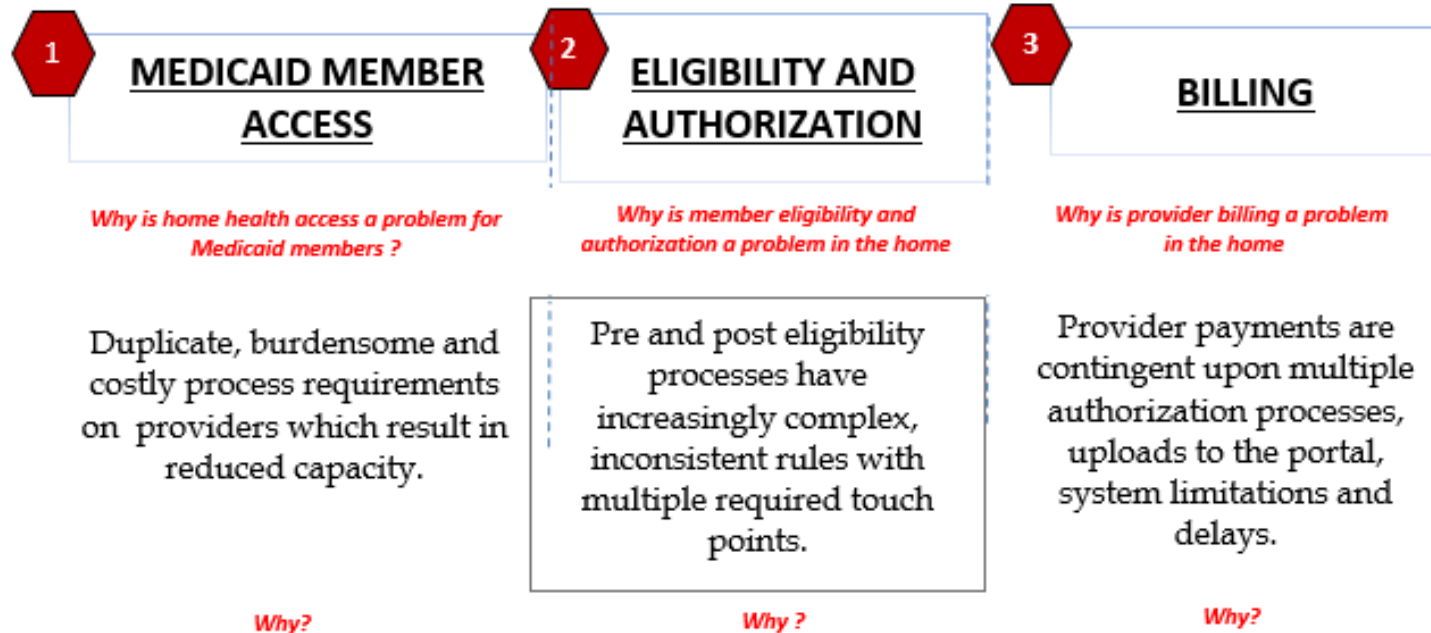
20. Duplicative DSS EVV mandate process.

21. Technical denials and delays in AA and provider payment.

22. Signed physician orders and Medicaid Face to Face.

ROOT CAUSE

Three major themes emerged from the process mapping exercise:



Root Cause: *Increased complexity in the CT Medicaid Home and Community-Based Care Delivery Process compounded by frequent system updates, mandated requirements and limited opportunity for advanced provider input.*

ACTION TAKEN

- Developed four Work Groups:
 - LTSS Eligibility/Re-Eligibility Process
 - Authorization/Billing
 - Electronic Visit Verification (EVV)
 - DPH Regulatory Revisions
- Held multiple meetings per work group with many suggestions raised.
- Proposed Goal/Solution and Time Frame submitted to DSS May 2018
- Action now sits with DSS to operationalize based on budget and resources.

Questions/Discussion?



CONNECTICUT ASSOCIATION FOR **HEALTHCARE AT HOME** SM

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