



TESTIMONY BEFORE THE HUMAN SERVICES COMMITTEE

REGARDING S.B. 662

AN ACT CONCERNING MEDICAID ELIGIBILITY AND REIMBURSEMENT

March 11, 2008

Senator Harris, Representative Villano, and members of the Human Services Committee, my name is Incy Muir and I am Chair of the Board of Directors of the Connecticut Association for Home Care & Hospice (CAHCH), whose members serve over 80,000 elderly, disabled and terminally ill Connecticut citizens. I am also Executive Director of the Farmington Valley VNA. The Association is pleased to **strongly support** SB 662.

**Adjustments to Medicaid Rates for Home Care**

The data presented below clearly shows that Medicaid rates for home health care are wholly inadequate. Our ongoing concerns have been heightened by recent actions by the federal government, which lowered Medicare home health rates by 12 percent over the next four years, further imperiling home care's precarious finances.

**2006 CT Medicaid Home Health Rates Compared to Costs**

	<b>2006 Median Cost</b>	<b>2006 Medicaid Rate</b>	<b>% Below Cost</b>
Skilled Nursing Visit	\$ 129	\$ 92	-29.0%
Physical Therapy Visit	\$ 110	\$ 80	-27.1%
Occupational Therapy Visit	\$ 102	\$ 78	-23.3%
Speech Therapy Visit	\$ 110	\$ 78	-29.3%
Social Work Visit	\$ 140		
Home Health Aide Per Hour	\$ 35	\$ 24	-32.7%

Source: 43 CT home health agencies Medicare cost reports  
Sample does not include hospital based agencies  
Home health aide average hours per visit = 1.4 in 2006

Last year rates were increased by only 3 percent, while other providers, with whom home care competes for scarce labor, received more significant adjustments. The second year of the biennial budget contains no increase. Agencies continue to face increased wage costs due to labor shortages, as well as double-digit growth in health insurance & staff mileage costs.

Medicaid rates that are significantly below costs fundamentally undermine our ability to provide the preferred form of care for patients, their families and the taxpayer. In 2006, the CT Home Care Program for Elders saved the State \$115 million through reduced nursing home use.<sup>1</sup> Moving towards a “rebalanced” long term care system, as called for by the recently completed Long Term Care Needs Assessment (and the Governor’s proposed budget), will simply not be possible without adequately funding home care.

*We urge you to enact an automatic cost of living adjustment and 29 percent rate increase for selected home care services as called for in Sections 4 & 6 of the bill, respectively.*

#### **Section 4 - Improve Access to Flu Shots for Medicaid Patients**

Section 4 of the bill requires the Commissioner of Social Services to establish a fee schedule for flu and pneumonia vaccination of Medicaid patients by nurses from home health agencies. The fees and requirements would be the same as Medicare.

Vaccination for influenza and pneumonia are proven to be highly effective preventative measures. For many years, home health agencies have conducted efficient flu shot clinics in the community, increasing immunization rates for Medicare patients.

Unfortunately, there is currently no way for home health agencies to bill Medicaid for this important preventative measure, creating an unwise access barrier for this vulnerable population.

*We are pleased to support the proposal and recommend that the following language be added:*

- *in the case of a vaccine being administered to a Medicaid patient in the home, the Commissioner shall develop a fee for the vaccine in addition to the fee otherwise available for administration of medication;*
- *the Department shall promulgate regulations, but shall also implement this section while regulations are pending.*

#### **Section 6 - Pilot Test Telemonitoring**

Section 6 of the bill provides for a pilot project to test the feasibility and appropriateness of telemonitors for up to 150 fee for service Medicaid patients with certain diagnoses.

Since the introduction of telemonitors in home care during the last decade, the technology has already significantly evolved to smaller, user-friendly devices that work through regular phone lines to send data to a remote location monitored by a clinician. Over 20 percent of home health agencies in CT already use telemonitors with some of their patients. Outcomes include: reductions in unnecessary hospitalizations and emergency room visits, reduction in home care

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<sup>1</sup> Annual Report by DSS on the CT Home Care Program for Elders - CT’s Medicaid waiver program.

visits and increases in patient self-management of their own care. Patients report high levels of satisfaction with this service.

Unfortunately, there is no direct method to finance this important new technology for Medicaid patients.

*We strongly recommend swift enactment of this modest pilot project, with an amendment to clarify that any of three mentioned diagnoses<sup>2</sup> would potentially qualify a person to participate in the project.*

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SB 662 contains three other areas of interest to home care that were not specifically addressed in our 2008 State Legislative Agenda. Following are some comments:

### **Section 11- Extrapolation**

The Association is pleased to report that our members' experience on Department of Social Services (DSS) financial audits has significantly improved from the myriad problems we had two years ago. This improvement is no doubt due to the enactment of several bills in 2005, which clarified policy on physician signatures on the plan of care and electronic recordkeeping, as well as provided due process protections for audits. The Department has also improved its communication with providers, giving us better insight on audit trends and issues to watch.

Although, there still remains a high degree of concern about the potential misuse or misapplication of extrapolation in DSS audits, *we recommend continued legislative oversight at this point*. If specific issues arise, they should be resolved in writing by the Department and legislation pursued only if a satisfactory outcome has not been achieved.

### **Section 4 – Redefinition of Medication Administration Visit**

The Association has ongoing concerns that some skilled nursing visits may be unnecessarily classified as a visit "limited to the administration of medication" when, in fact, the patient has a number of medical conditions that are being addressed in addition to the administration of medications. When visits are classified as medication administration, the rate is significantly reduced (compared to a full skilled nursing visit), despite the fact that the nurse may be spending significant time on other medical issues in addition to administering medication. We will continue to work with the Department on improving the how the definition of a visit limited to administration is applied in practice and seek statutory change if necessary.

### **Section 16 – Money Follows the Person Pilot Program**

Our comments will be addressed in separately submitted testimony.

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<sup>2</sup> Language should be amended to state that qualifying illnesses would be: congestive heart failure, diabetes OR chronic obstructive pulmonary disease.