CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME℠

TESTIMONY

Delivered by Deborah R. Hoyt, President and CEO
The Connecticut Association for Healthcare at Home

Appropriations Committee
Public Hearing on the Department of Social Services (DSS) Budget
February 11, 2016

Good afternoon Senator Bye, Representative Walker and honorable members of the Appropriations Committee. My name is Deborah Hoyt, President and CEO of the Connecticut Association for Healthcare at Home.

The Association is the united voice for state licensed home health and hospice agencies that foster cost-effective, person-centered healthcare for Connecticut's Medicaid population in the setting they prefer most – their own homes.

Connecticut's home and community-based service providers SAVED the Department of Social Services (DSS) more than $621.2- million over a six year period (2009-2014) by providing high-tech nursing, chronic care management, wound care and rehabilitation services to Medicaid clients in the Money Follows the Person (MFP) and CT Home Care Program for Elders (CHCPE), among other waiver programs.

A recently released report (attached) by Connecticut AARP/Health Management Associates on Connecticut home and community-based services concludes that:

- "Home and Community-Based Services are a cost-effective alternative to institutional care, and source of significant savings to the State of CT General Fund."
- "Connecticut can serve nearly three individuals in the community for every person served in a nursing home."
- "Home and Community-Based Services are an important resource for family caregivers supporting their loved ones ...who are trying to balance their care giving responsibilities with their own work responsibilities."

Additionally, a 2013 AARP review of 38 Home and Community-Based studies from 25 states revealed a common theme: "consistent evidence of cost containment and a slower rate of spending growth (are a byproduct of) states expanding home and community-based services."

Connecticut's DSS's own data supports this. A savings of $621.2-million over six years – an average of over $103-million per year, demonstrates that home health care in Connecticut is working. Ensuring the viability of our home health agencies and this cost-effective healthcare delivery system should be paramount to this Committee.

Lt. Governor Nancy Wyman has convened a Healthcare Cabinet to explore opportunities for cost savings to Connecticut's Medicaid program spending. Surely, building upon what is already working and supporting the viability of the source of the cost savings would be a worthwhile approach.

While we respectfully recognize that the State faces serious budget challenges in the near-term, it must address the longstanding underfunding of licensed Medicaid home health providers.

Connecticut must ensure the network of CT's licensed home healthcare providers receive adequate reimbursement for services provided to meet the goals of the State's Medicaid Long-Term Services and Supports 3-Year Plan; achieve CT's Rebalancing Plan (transitioning Medicaid beneficiaries from nursing homes to community settings); and attaining CT's Goals under the federally-supported Money Follows the Person Program (MFP).

We must also ensure access for Medicaid beneficiaries to licensed home health providers under the emerging value-driven healthcare service delivery models driven by the Affordable Care Act (ACA).

At a minimum, we request that DSS maintain CT Medicaid Home Health Provider Reimbursement in 2016 with the objective of developing a home health reimbursement system which parallels the Medicare LUPA rate methodology as proposed in the CT Medicaid Home Health Legislative Work Group report delivered to Human Services Committee in January 2016 (attached).

In addition, supporting Medicaid reimbursement to Home Health providers focused on technologies proven to increase patient outcomes, such as home telemonitoring of clients with chronic care conditions, avoids costly rehospitalization and recoups the investment of reimbursing home health agencies for home telemonitoring equipment.

Several of you may recall in the early 2000's that the CT legislature worked hard to establish a reinvestment account to fund the future stability of home health agencies from the millions in savings that these agencies achieved for the State. Regrettably, a few years ago that investment account was closed as it didn't receive a penny of funding.

You are likely aware that Medicaid home health agency reimbursement only covers approximately 60 cents on the dollar of a home care agency's costs to provide care to these state clients. And the volume of Medicaid clients and the complexity of their health care needs are increasing.

Home health agencies have made a significant sacrifice and contribution for more than 100 years in Connecticut. They have tightened their belts in terms of efficiency, complied with new regulations and laws requiring minimum wage and employer health benefits, and kept up with an 11.4% cost of living increase without an increase in Medicaid reimbursement until the January 1, 2015 increase of 1%.

In fact, the last DSS rate increase home health agencies received prior to the last year's increase was effective July 1, 2007, almost 9 years ago.

While we are greatly appreciative of the 1% adjustment at a time when other agencies were being cut, it just isn't enough. One percent translates into an increase of a modest .24 cents for a home health aide visit and .94 cents for a skilled nurse.

The strategy of offering incremental adjustments in years when the state budget can squeeze out a few cents is not a holistic or viable option to meet the state's growing need for home based care move forward.

We appreciate the challenges facing the Appropriations Committee and want to work with you on sustainable solutions based on available data. Please consider the Association and its providers as a resource. Thank you for the opportunity to provide testimony before you today. I welcome any questions you may have.

Contact:

Deborah Hoyt

hoyt@cthealthcareathome.org

203-774-4939

Home- and Community-Based Services in Connecticut are Cost-Effective Investments

Connecticut can serve nearly three individuals in the community for every person served in a nursing home.

Introduction

The need for long-term services and supports (LTSS), including both institutional care and home- and community-based services (HCBS), is increasing as the population ages. By 2030, more than one in four Connecticut residents will be 60 or older.[1] Medicaid is the primary payer of LTSS and in Connecticut, Medicaid LTSS expenditures account for 40 percent of all Medicaid spending and 15 percent of total state expenditures.[2] The Connecticut Home Care Program for Elders (CHCPE) is a publicly-funded program that helps older adults who meet functional criteria to stay at home and in their communities. The CHCPE relies on Medicaid and state funding to cover the costs of services for persons eligible for Medicaid and some who are not.

HCBS are a cost-effective alternative to institutional care, and source of significant savings to the State of Connecticut General Fund.

Medicaid, the primary payer for nursing facility care in Connecticut, pays for 70 percent of all nursing facility stays. In Connecticut, the average monthly nursing home cost per Medicaid client is about $5,800. In contrast, the CHCPE program costs $1,985 on average to support an individual living in the community who would otherwise be eligible for nursing home care. Thus, for the cost of serving just one person in a nursing facility, the state could serve nearly three eligible individuals in the community.[3]

Further (as shown in the table below), in SFY 2014, the state share of Medicaid-funded HCBS in the CHCPE program was $154,461,755. The estimated total cost of avoided nursing facility admissions for this population was $242,124,480, saving the state $87,662,725.[4]

SFY 2014 HCBS-Related Savings to CT General Fund	
State share of CHCPE Medicaid spending:	$154,461,755
Estimated state cost of avoided nursing home admissions:	$242,124,480
State Savings:	**$ 87,661,725**

Source: CT Department of Social Services

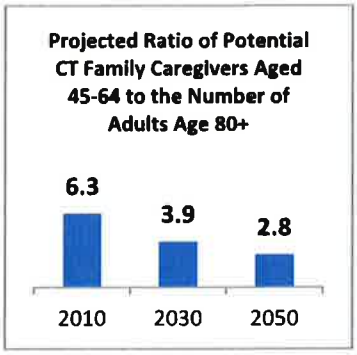
If approved by the federal government, pursuing a Medicaid waiver to match the state-only portion of the CHCPE (similar to a waiver approved for Minnesota[5]) could result in more General Fund savings – possibly as much as $15.7 million annually.[6]

Most adults prefer to live in their own homes and communities rather than go into an institution.

In a 2010 nationwide survey, the vast majority of respondents age 65 and older (88 percent) indicated that they wanted to stay in their own homes and communities.[7] Satisfaction with HCBS is also very high, with 90 percent of Connecticut seniors and adults with disabilities who transitioned from institutions into the community between 2008 and 2015 happy with the support they received post-transition.[8] Yet, Connecticut Medicaid continues to serve many individuals in nursing facilities — nearly 24,000 — compared to the 15,000 served in the CHCPE program.[9,10] Further, more than half of all Medicaid dollars spent in Connecticut for LTSS are for institutional care.[11]

HCBS are an important resource for family caregivers supporting their loved ones.

An estimated 459,000 unpaid family caregivers support loved ones in Connecticut providing 427 million hours of care with an economic value to the state of $5.93 billion — double the amount the state spends in Medicaid-funded LTSS.[12]



In the future however, fewer family caregivers will be available to support their loved ones as they age. A recent analysis suggests that the ratio of potential family caregivers age 45 to 64 relative to the number of adults age 80 and over in Connecticut will decline substantially over the next 25 years — from 6.3 caregivers for each older adult in 2010 to 3.9 in 2030 and to only 2.8 by 2050.[13] This declining caregiver ratio suggests that formal (paid) HCBS will become even more essential going forward.

HCBS benefit employers and family caregivers who are trying to balance their caregiving responsibilities with their work responsibilities.

A national survey found 60 percent of family caregivers are currently employed, and six in ten of those caregivers reported at least one change to their work situation due to their caregiving role. This includes being absent from work for extended periods, moving from full to part-time status, or even leaving the workforce entirely.[14] Having adequate programs like respite and other HCBS can support working caregivers, allowing them to remain in the workforce, as well as support employers who can retain skilled and experienced employees.

"If approved by the federal government, pursuing a Medicaid waiver to match the state-only portion of the CHCPE . . . could result in more General Fund savings – possibly as much as $15.7 million annually."

Cost sharing for HCBS creates a significant barrier to those services and increases the risk of institutionalization.

Since 2010, Connecticut has required cost sharing in the form of a co-pay for individuals who participate in the state-funded (non-Medicaid) part of the CHCPE. These individuals would otherwise be eligible for care in a nursing facility but, because of their income or assets, are not financially eligible for Medicaid. The state initiated multiple changes to the co-pay requirements in the past several years, and recently proposed to further increase the amount of the co-pay.

Imposing cost sharing for HCBS can create a significant barrier to those services for some individuals, increasing the risk of institutionalization. The initial co-pay introduced in January 2010 was 15 percent of the service costs. Following co-pay implementation, the program experienced a 17.3 percent decline in enrollment, with almost one in five individuals who dis-enrolled citing an inability or unwillingness to pay the cost sharing required.[15] In July 2010, the state reduced the co-pay to 6 percent and by the end of that state fiscal year, program enrollment increased by almost 8 percent.[16] Currently, the program imposes a 9 percent co-pay on program participants.

Conclusion

A 2013 AARP review of 38 HCBS studies from 25 states reveals a common theme: "consistent evidence of cost containment and a slower rate of spending growth as states expanded HCBS."[17] State funding for Connecticut's Home Care Program for Elders is a prudent investment that can benefit consumers and caregivers, but also saves state taxpayers money by avoiding costlier institutional stays. The state could save more General Fund dollars – as much as $15.7 million – if the federal government were willing to approve a Medicaid waiver to provide federal matching dollars for the state-funded portion of the CHCPE.

[1] State Department on Aging (2014). Connecticut State Plan on Aging.
[2] Connecticut Long-Term Care Planning Committee (2016). Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut, A Report to the General Assembly.
[3] HMA calculations based on data available from the CHCPE Annual Report for SFY 2014. This estimate includes both individuals who are Medicaid-funded and state-funded (Category 2) and who meet the institutional level of care. The monthly CHCPE spending calculation may underestimate the actual state contribution Category 2 participants.
[4] State of Connecticut, Department of Social Services (2015). Connecticut Home Care Program for Elders: Annual Report for SFY 2014.
[5] State of Minnesota (2012). Minnesota Reform 2020 Section 1115 Waiver Proposal to CMS.
[6] HMA calculation based on data available from the CHCPE Annual Report for SFY 2014. This calculation is based on an estimated total spend of $31.3 million for Category 2 participants in CHCPE (SFY 2014).
[7] AARP (2010). Home and Community Preferences of the 45+ Population.
[8] University of Connecticut, Center on Aging (2015). Money Follows the Person Quality of Live Dashboard, September 30, 2015.
[9] State of Connecticut, Department of Social Services (2015). Connecticut Home Care Program for Elders: Annual Report for SFY 2014.
[10] Connecticut Department of Social Services (2015). Nursing Facility Census, September-October 2015.
[11] Connecticut Long-Term Care Planning Committee (2016). Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut, A Report to the General Assembly.
[12] AARP Public Policy Institute (2015). Valuing the Invaluable: 2015 Update.
[13] AARP Public Policy Institute (2013). The Aging of the Baby Boom and the Growing Care Gap: A Look at the Future Declines in the Availability of Family Caregivers.
[14] AARP Public Policy Institute & National Alliance for Caregiving (2015). Caregiving in the U.S.: 2015 Report.
[15] Connecticut Department of Social Services (2010). Home Care at a Glance: SFY 2010 Annual Report to the Legislature.
[16] Connecticut Commission on Aging (2012). CT Home Care Program for Elders – Participation Trends.
[17] AARP Public Policy Institute (2013). State Studies Find Home and Community-Based Services to Be Cost-Effective.

CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

CT Medicaid Home Health Legislative Work Group
2016 Provider/Association Recommendations

State Department of Public Health (DPH) Regulatory Recommendations:

1. **Modernization of Licensed Home Health Care Regulations to align with Affordable Care Act Payment Reforms and bring CT in line with other states across the nation** (last comprehensive review of CT home health regulations date back to 1979). ***List of specific language change recommendations in separate document.***

2. **Address Intensity of DPH Scrutiny and Enforcement Practices on CT Home Health Providers** – Transition to a more "reasonable" interpretation and enforcement process of home health care agencies to bring CT in line with other state Public Health regulatory bodies and Medicare survey and certification practices.

   CT is an outlier in Medicare citation frequency (surveyed by CT DPH) compared to Boston Region 1 (6 New England States). See attached data on pages 2 and 3.

   - CT's citations for the top 5 home health deficiencies accounted for 80% of all citations across all 6 New England States.
   - CT's citations for the top 5 hospice agency deficiencies accounted for 78% of all citations across all 6 New England States.
   - In CT, 5 out of the 19 hospice agencies surveyed by DPH over the most recent period received the more serious "condition level" deficiency – a significantly large percentage compared to the other New England states.

3. **Change Third Party Liability (TPL) Process** – Licensed Home Health providers have been placed in the middle of a Medicare-Medicaid payer liability issue and as a result must participate in a very costly and burdensome process which furthers financial losses; with funds being taken back years after care was provided.

   a. Transition TPL program by July 1, 2016 to an effective prospective process which ensure that Medicaid is the payor of last resort for dually-eligible Medicare/ Medicaid beneficiaries. DSS to report back to the legislature on Jan. 1, 2017.

      - CT is one of 4 states in the nation with this burdensome retrospective process (year 8 of TPL project process).

CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

CT HOME HEALTH: Medicare Top Citation Frequency Report

As Enforced by the CT Dept of Public Health "Survey Team"

Fiscal Year 2015 (Oct 2014 - Sept. 2015)

CMS Region 1 (Reg. 1) = 6 New England States

CT = Connecticut

Active Providers	Reg. 1 - 408	CT - 92
Total Number of Surveys FY 15	Reg. 1 - 182	CT - 41
Percent surveys completed vs. all providers	45%	45%

Tag	Tag Description	Reg. 1 - # Citations	CT - # Citations	% CT Citations vs. Reg. 1	Reg. 1 - % Surveys Cited	CT - % Surveys Cited
G0337	Assessment Includes Review of all Medications	25	20	80.00%	13.70%	48.80%
G0158	Written Plan of Care Established & Periodically Reviewed	30	20	67.00%	16.50%	48.80%
G0174	RN Furnishes Services Requiring Substantial / Specialized Nursing Care	19	18	95%	10.40%	43.90%
G0121	Compliance with Accepted Professional Standards / Principles	22	16	73.00%	12.10%	39.00%
G0172	RN Regularly Reevaluates Patient Nursing Needs	15	15	100.00%	8.20%	36.60%

In conclusion, CT had an aberrantly high percentage of home health citations vs. any of the other New England states in Region 1.
G0172 was cited solely in CT (100%) and G174 was cited 95% (18/19).

* G-tags are specific tags within the Medicare Conditions of Participation (regulations) for Home Health

**In addition, DPH applied 7 Condition level deficiencies in FY15.
A Condition Level Deficiency is more serious than a G-tag and is administered if certain more significant G-tags are out of compliance. Monetary penalties can be applied on a per diem basis until compliance is met. In CT, all but 1 (6/7) had monetary penalties.

CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

CT HOSPICE: Medicare Top Citation Frequency Report

As Enforced by the CT Dept of Public Health "Survey Team"

Fiscal Year 2015 (Oct 2014 - Sept. 2015)

CMS Region 1 (Reg. 1) = 6 New England States

CT = Connecticut

Active Providers	Reg. 1 - 163	CT - 31
Total Number of Surveys	Reg. 1 - 69	CT - 19
Percent surveys completed vs. all providers	42%	61%

Tag	Tag Description	Reg. 1 - # Citations	CT - # Citations	% CT Citations vs. Reg. 1	Reg. 1 - % Surveys Cited	CT - % Surveys Cited
L0591	Nursing Services	14	13	93.00%	20.30%	68.40%
L0798	Federal, State, Local Laws & Regulations	15	11	73.00%	21.70%	57.90%
L0541	Approach to Service Delivery	7	7	100.00%	10.10%	36.80%
L0543	Plan of Care	15	7	47.00%	21.70%	36.80%
L0644	Role	7	7	100.00%	10.10%	36.80%
L0530	Content of Comprehensive Assessment	7	6	86.00%	10.10%	31.60%
L0625	Hospice Aide Assignments and Duties	7	5	71.00%	10.10%	26.30%

In conclusion, CT had an aberrantly high percentage of hospice citations vs. any of the other New England states in Region 1.
L0541 and L0644 were cited solely in CT (100%) and L0591 was cited 93% (13/14).

* L-tags are specific tags within the Medicare Conditions of Participation (regulations) for Hospice

**In addition, DPH applied 5 Condition level deficiencies in FY15 of the 19 Hospices surveyed.
A Condition Level Deficiency is more serious than an L-tag and is given if more significant L-tags are out of compliance.

CT Medicaid Home Health Legislative Work Group
2016 Provider/Association Recommendations

Legislative Recommendations to Increase Medicaid Home Health Efficiency:

1. **Pass Legislation and Implement Presumptive Eligibility (PE) in CT based upon positive CT pilot study results.**

Presumptive Eligibility (PE0 saves money by expediting access to homecare and keeping seniors and disabled individuals out of the nursing home and hospital. CT's goal is 75% Medicaid home/community-based care versus 25% institutional care by year 2020.

Sen. Ted Kennedy's Presumptive Eligibility Connecticut Pilot Study:
The pilot began July 2015. As of Oct. 2015 (3 months into the study), 127 applicants had been served to date. Faster approval of CHCPE applications **is estimated to save the CT Medicaid budget more than $6,000 per month per individual who is diverted from a skilled nursing facility.**

Examples of Presumptive Eligibility Success in Other States:
Washington State shrank the average wait time to determine Medicaid financial eligibility by 66%. State officials determined PE clients saved Medicaid an average of $1,964 a month, per individual.
Colorado's PE pilot cost $106,879 to implement but saved the State $407,012 by diverting patients from costly nursing home care into home and community based settings.

---

1. **Implement Medicaid Coverage for Home Health Telemonitoring Services.**

Home Telemonitoring (TM) saves Medicare dollars through early detection of medical complications, decreased utilization, lower institutional admissions and readmissions, and increased patient engagement.

Home Health Telemonitoring Success in other States:
Colorado's TM pilot reduced 30-day readmissions by 62% for patients with CHF, COPD, and diabetes. ER visits dropped 92%.
Pennsylvania-based Geisinger Health Plan's TM program for patients with CHF reduced hospital readmissions by 44%.
New York Eddy VNA's TM study saw hospitalizations drop 55%, ER visits drop 29%, and overall medical costs drop 42%.
The Veterans Administration 2013 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.

CT Medicaid Home Health Legislative Work Group
2016 Provider/Association Recommendations

State Dept. of Social Services (DSS) Regulatory Enforcement Recommendations:

Create a Workgroup including representatives from DSS, CT Association for Healthcare at Home, Leading Age and other relevant community-based providers to identify and address State Medicaid Administrative burdens on licensed home health agencies and shared with DPH to align state regulations and enforcement of home health providers.

Further enhance the 2015 DSS Audit Process Improvements of State Medicaid Home Health Programs to ensure provider audit fairness.

Example: Services provided by home health agencies under the CT Home Care Program for Elders (CHCPE), Money Follows the Person (MFP), and CT Medicaid Waiver programs are already pre-authorized and should not be subject to "reasonable/necessary judgment" during the DSS audit process.

CT Medicaid Home Health Legislative Work Group
2016 Provider/Association Recommendations

Behavioral Home Health Nursing/Medication Administration:

Preserve Behavioral Home Health Services and Reimbursement to Providers to manage Medicaid costs and ensure appropriate utilization.

Current utilization strategies and collaboration with Value Options (VO) are working and have reduced medication administration home visits per patient by more than 20% over the past 4 years. Do not reduce provider reimbursement on January 1, 2016.

Trained home health behavioral nurses are enabling more than 10,000 high-risk Medicaid psychiatric clients with serious and persistent mental illness to live safely within CT's 169 towns and cities.

Without routine medication and nursing care, these individuals will end up in settings such as hospital emergency departments, police departments, correctional facilities, and institutionalized care adding cost and pressures on State resources.

The behavioral home health recovery model which promotes safe, independent community living has saved CT's Medicaid budget over $26-million over the past 3 years.

CT Medicaid Home Health Legislative Work Group
2016 Provider/Association Recommendations

Vision for the Future: CT Medicaid Reimbursement to Licensed Home Health Providers

Association Recommendations:

Maintain CT Medicaid Home Health Provider Reimbursement in 2016 with the near-term objective of developing a home health reimbursement system which parallels the Medicare LUPA rate methodology that will align CT's rebalancing goals, and ensure Medicaid client cost effective access and home health provider viability.

- Develop a process by Jan. 1, 2017 with an implementation date of no later than July 1, 2017 which revises the Medicaid payment system for licensed home health providers to more closely reflect reasonable and customary costs.
- DSS has acknowledged that Medicare is today's standard and LUPA rates properly reflect actual costs and wage variation.

- Providers are sensitive to the fiscal issues of the current State Budget. However, failure to appropriately invest to maintain access to "healthcare at home" will result in a dramatic shift back to high-cost institutional care and rapid worsening of the State's Medicaid budget. A sound remedy to maintain State budget savings and access to home health providers is a reimbursement system based upon a reasonable percentage of the Medicare LUPA rate with predetermined annual percentage increases over a period of 2-4 years.
    - The initial established % rate cannot be less than the current reimbursement for any licensed home health agency.
    - Once the rates have reached the LUPA funding rates (2-4 years) the current Medicare 'add-ons" would be eliminated.
    - Providers would not be permitted to receive a rate (including "add-ons") greater than the Medicare LUPA rate at any time during the rate system transition.

Medicaid access to care challenges have become a reality in 2015 as home health provider agencies are closing, consolidating, and electing to limit or opt out of accepting Medicaid clients, particularly under certain waiver programs including MFP, as financial losses per case are up to 40% compared to actual costs to provide the care.

The State of CT has no financially sound alternative to addressing the long-time underfunding of licensed Medicaid home health providers. As Medicaid clients are denied home health care, the only option will be to care for these clients in nursing homes or hospital emergency rooms.

The long term financial consequences on CT's Medicaid budget, for the growing number of Medicaid clients and their family members, on town social service agencies and the home health agencies and their employees (layoffs) is counter to the philosophy and gains achieved by the rebalancing efforts.

The above recommendations are consistent with Connecticut's Long Term Care Plan Dated: Jan. 2016 which states:

- **Achieve adequate and sustainable provider reimbursement levels that support the cost of long-term services** and supports and quality requirements for all segments of the long-term services and supports continuum in order to ensure capacity to meet the evolving needs and demographics of Connecticut residents. **DSS reports that home health providers are reimbursed at 67% of cost.**
- **Provide greater flexibility in the budgeting and use of Medicaid funds** for long-term services and supports.
- **Capture and reinvest cost savings across the long-term services and supports continuum.**
    - Reinvest savings resulting from Money Follows the Person, the Balancing Incentive Program and other emerging Medicaid long-term services and supports programs to enhance the availability and capacity of home and community based services.
- **Explore reforming the Medicaid rate setting system** to reflect quality, reimbursement related to the actual costs of care, the acuity level of the consumers and uncompensated care for all LTSS providers across the continuum consistent with long-term services and supports rebalancing, rightsizing and a range of home and community-based service initiatives.

<u>Specialty Home Health Services:</u>
Preserve Hi-Tech Pediatric Home Health Services and Reimbursement to Providers.

Caring for pediatric patients with serious and complex medical conditions in the home versus in a Children's Medical Center, keeps the family together, allows parents to keep their jobs, alleviates travel and overnights in the hospital to visit sick child, and engages family members in the child's life, all with greater satisfaction and at a significant cost savings to Medicaid.