



CT HOME HEALTH STUDY WORK GROUP

Understanding Licensed Home Health

Presented by: Members of the
CT Association for Healthcare at Home
October 2015

PROGRAM AGENDA

- Overview of Home Health Care (Tracy Wodatch, CT Association for Healthcare at Home)
- History of Home Health and Medicaid Rates (Bill Sullivan, VNS of CT)
- HH Specialty Services—case examples
 - Complex medical (Kim Nystrom and Kathy Morgan—New England Home Care)
 - Behavioral Health (Marty Morrissey—Continuum)
 - Pediatric (Jeanne Silverwatch—Pediatric Services of America)
- HH Reimbursement system (Rich Corcoran—Corcoran Consulting Group, LLC)
- HH Costs of doing business (Cindy Gibbons—Masonicare)



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



TITLE XIX RATE ADJUSTMENT HISTORY COMPARED TO CPI INDEX

| | <u>Title XIX Rate Adjustments</u> | <u>CPI Change*</u> | <u>Medical CPI Change*</u> |
|----------------------|---|------------------------|------------------------------------|
| 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 | <u>1.0%</u> | ----- | ----- |
| Cumulative 1994–2015 | 15.6% | 48.1% | 78.2% |

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 | <u>535</u> | |
| 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 | |

PATIENT POPULATION

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

Diagnoses:

| | |
|-------------------------------|------------|
| Mental Health/Substance Abuse | <u>95%</u> |
|-------------------------------|------------|

Comorbidities:

| | |
|------------|-----|
| Orthopedic | 33% |
|------------|-----|

| | |
|---------|-----|
| Cardiac | 23% |
|---------|-----|

| | |
|-----------|-----|
| Oncologic | 13% |
|-----------|-----|

| | |
|------------|-----|
| Neurologic | 13% |
|------------|-----|

| | |
|----------|-----|
| Diabetes | 10% |
|----------|-----|

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

CONTINUUM HOME HEALTH, INC.

Results of Operations

For the Years Ended June 30th

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



HIDDEN COSTS OF CARING FOR THE BEHAVIORAL HEALTH POPULATION

| | |
|------------------------|------------------|
| • Spend Downs | \$240,000 |
| • Financial Counseling | \$106,000 |
| • Co-Pays | \$ 22,000 |
| • Cultural | <u>\$166,000</u> |
| | \$534,000 |



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.



Medicare PPS Overview



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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 |
|----------------------------------|------------------------------|-------------------------------|---------------------------|
| <i>Skilled Nursing</i> | \$131.51 | 9.43 | \$1,240.14 |
| <i>Home Health Aide</i> | 65.22 | 2.80 | 182.62 |
| <i>Physical Therapy</i> | 160.69 | 4.86 | 780.95 |
| <i>Occupational Therapy</i> | 159.55 | 1.15 | 183.48 |
| <i>Speech–Language Pathology</i> | 170.80 | 0.21 | 35.87 |
| <i>Medical Social Services</i> | 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 | |



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



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



Other State Behavioral Health Initiatives



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ASSERTIVE COMMUNITY TREATMENT (ACT)

- Collaborative, multidisciplinary team approach to the treatment of people with severe mental illness.
- States such as Ohio and Minnesota have successfully deployed their own ACT programs.
- Research has shown ACT improves clinical outcomes and reduces Medicaid expenditures by keeping patients out of higher cost settings.



ACT IN ACTION: OHIO

- **Ohio Administrative Code 5122-29-29:**
 - “The purpose/intent of ACT team services is to provide the necessary services and supports which maximize recovery, and promote success in employment, housing, and the community.”
 - “(E) The agency must demonstrate that each ACT team meets, at a minimum, the following staff requirements and qualifications:”
 - “**Designated team leader**, who is qualified to supervise the service...”
 - “**Psychiatrist...**”
 - “**A substance abuse team member...**”
 - “**Registered nurse...**”
 - “**Vocational Specialist...**”



BENEFITS OF ACT

- **Case Western Reserve Center for Evidence-Based Practices: “If your community is spending a lot of resources on hospitalization, implementing ACT could help with reducing costs overall.”**
- **Hartford Courant in April 2015: “Mental Health is Main Cause of Hospitalizations in State.”**



NEXT STEPS

- Medicaid patient visit analysis
- Patient Assessment review
- 30/60 day rates
- Medical vs. Psychiatric considerations
- ASO involvement
- Budget neutrality
- DPH / DSS
- Start simple and enhance

