December 5, 2013

The Indiana Association for Home and Hospice Care (IAHHC) is the trade association that represents the home care industry in Indiana. Our members include home health, hospice and personal services agencies (PSAs). Personal services agencies provide non-medical personal care and may be enrolled in the Medicaid program as home and community-based waiver providers. IAHHC is submitting its feedback regarding the draft report to the general assembly by the FSSA Aged, Blind & Disabled (ABD) Taskforce. Our feedback addresses issues raised in the report and issues specific to home care.

IAHHC concurs with the following statement noted in the conclusion section of the report:

> Table 31 provides a comparison of estimated savings under the Risk Based Managed Care (RBMC) versus managed care fee-for-service (FFS) and the different options for population and services exclusions. Were the State to enroll all ABD populations, a financial loss is projected under both models. However, if the State were to exclude Medicaid Rehabilitation Options (MRO) services from RBMC and institutional enrollees, individuals with intellectual disabilities, individuals under age 21 and duals from both models, the State is anticipated to realize savings. The projected state savings with these exclusions is $14.1 million in RBMC versus $8.9 million under managed FFS. The HCBS management model does not project savings because waiver services are already managed through a variety of strategies. Accordingly, none of the models were projected to result in savings for home and community based LTSS expenditures.

IAHHC notes that managed care was originally designed to focus on healthy individuals and families. It was not meant to take care of the needs of a frail and complex population as the Aged, Blind and Disabled (ABD). The ABD population has unique psycho-social needs that are best served by the case managers who perform onsite visits to evaluate the recipient's needs. At this time, there is a strong provider network to serve Medicaid recipients who receive home health, hospice and HCBS waiver services.

IAHHC notes the following considerations for home health, hospice and PSAs if the Medicaid recipients that they serve were to be placed in an RBMC, Managed FFS or HCBS Management Program.

<u>Home Health Services</u>

At this time, the majority of home health recipients are served under the FFS model with a few of the recipients enrolled in the Care Select program. The prior authorization (PA) contractor must approve services based on guidelines outlined in the home health section of the Office of Medicaid Policy and Planning Medical Policy Manual. The guidelines for determining the hours that are approved and the documentation required under each disease process were a result of a class action lawsuit *Taylor v Sullivan.* Under State plan services, current guidelines permit adequate coverage for the primary care giver to work, the primary care giver to go to school, the recipient to attend school, the recipient to work and the sleep time for the primary care giver. In addition, home health services are provided to

individuals who reside alone and these services prevent or minimize inpatient hospitalization and nursing facility placement.

The following populations are served under the Medicaid home health program:

1. Duals with chronic conditions who have a skilled need and require extended care that would not be covered under the Medicare home health program.
2. High tech pediatric patients under the age of 21 that require skilled nursing care.
3. High tech adult patients that require skilled nursing care.
4. Home health recipients that are also receiving HCBS waiver services.

The implementation of RBMC would permit the MCE to establish its own prior authorization criteria which would not be consistent with *Taylor v. Sullivan*. RBMC does not prior authorize extended care and was not set up to do so. IAHHC's members who provide home health services have encountered problems with prior authorization and claims payment when Medicaid recipients have been moved from Traditional Medicaid to RBMC. For example, the MCEs will only approve a few nursing visits when children with high tech needs are "flipped" from Traditional Medicaid to RBMC. The approved hours under the MCE prior authorization criteria does not cover extended care to permit the primary care giver to work. Absent the care provided under Traditional Medicaid, the primary care giver would be put in a situation of having to end their employment to care for their family member.

Another service that would not be covered by RBMC would be sleep time for the primary care giver when the Medicaid recipient requires skilled nursing services to care for high tech pediatric or adult patients or when the individual requires home health aide services to turn the individual every two hours to avoid skin break down. Prolonged lack of sleep for the primary care giver who must work or has a physical limitation that prohibits him/her to provide the care can result in the Medicaid recipient not receiving the care that is needed.

In addition, our members have indicated that there is an administrative burden in having to follow the different prior authorization and claims payment procedures under each MCE. IAHHC is concerned that these patient care issues and administrative burdens would persist and potentially worsen if the State were to implement RBMC.

The duplication of care management/case management services without any indication of improved health outcomes is concerning. Medicaid recipients and their families already have to navigate a complex system with many layers and this would provide an additional burden for them.

<u>Hospice</u>

The Medicaid hospice benefit was legislatively enacted in 1997. State statute requires that the Medicaid hospice benefit mirror the Medicare hospice benefit by having the same covered services and reimbursement methodology. This provides consistent standards for providers with regards to eligibility requirements for hospice, provision of services within the 4 hospice levels of care and reimbursement methodology.

The majority of individuals enrolled in the Medicaid hospice benefit are dually-eligible Medicare/Medicaid recipients who reside in a nursing facility (NF). Medicare pays for the hospice services and Medicaid pays for the room and board at 95% of the nursing facility case mix rate. The hospice then pays the nursing home according to their contract. The report noted that excluding nursing facility residents would ensure no disruption in supplemental payments. The same would apply to

nursing facility residents who elect the Medicare or the Medicaid hospice benefit since these recipients eligibility for nursing facility room and board requires them to meet NF level of care under the Medicaid program.

If the patient is a dually-eligible Medicare/Medicaid recipient residing in the private home, then he/she is not enrolled in the Medicaid hospice benefit since the Medicaid program does not pay for room and board services. Therefore, there is no administrative reason to enroll this population since Medicare pays for the hospice services. IAHHC would note that current Medicaid policy specifies that a Medicare or Medicaid recipient who elects hospice is not eligible for extended hours under the home health program if the primary diagnosis and related conditions on the hospice and the home health plans of care are the same. In order to prevent institutionalization, IAHHC proposes that FSSA should consider permitting extended care hours for Medicare and Medicaid beneficiaries residing in their private home.

The hospice medical director or hospice physician reviews the patient's appropriateness for hospice care each hospice benefit period. The hospice interdisciplinary team is responsible for the coordination of hospice care and working with non-hospice providers to ensure that the overall care of the hospice patient is met, that the care is consistent with the hospice plan of care, and to ensure that there is no duplication of services. Re-assignment or constant plan re-assignment will result in interrupted or uncoordinated care for this fragile population. Therefore, hospice services should continue to be subject to prior authorization (PA) by the FFS PA contractor.

<u>PSAs that Provide HCBS Waiver Services</u>

The local area agencies on aging (AAA) are responsible for performing the level of care determination for the nursing facility level of care waivers. The nursing facility level of care waivers include the Aged and Disabled (A&D) waiver, the Money Follow the Person Grant – A&D Waiver, and the Traumatic Brain Injury (TBI) waiver. The AAAs should remain a strong resource or be the only MCO as they serve as Adult Disabled Resource Centers (ADRC) and are aware of the community resources in their catchment area. Therefore, the AAAs saves the State money by linking recipients to these community resources. The AAAs already has quality measures for quality of life, timely and adequate community integration and health and safety assurances.

We concur that there is also a potential for legal issues arising from state policy which would limit services by population without specific consideration of an individual's needs. At this time, the level of care determination tool used by the AAAs takes into consideration the functional limitations of each individual to determine if the individual meets nursing facility level of care. Based on that review, the case manager determines which services and the hours of service the individual needs to meet his or her needs. The report indicates that components of the HCBS management model are in place for the A&D waiver and the TBI waiver except that the State makes the final determinations and also issues the final authorization of waiver care plans. Current AAA case managers and State staff have an understanding of HCBS waiver programs and recipient eligibility. The providers on each AAA pick list provide a strong provider network that permits patient choice. The current system works. Any need to improve upon the system should be a joint effort between the AAAs and the Division of Aging as part of the existing contractual relationship between the Division of Aging and AAAs, designed to serve Hoosiers in the best manner possible.

Thank you for the opportunity to provide feedback on the draft report to the general assembly. If you have any questions, please do not hesitate to contact Michelle Stein-Ordóñez, Membership Services Director or Jean Macdonald, IAHHC's Director of Home Health Policy. Michelle Stein-Ordóñez may be reached at (317) 775-6672 or by e-mail at michelle@iahhc.org. Jean Macdonald may be reached at (317) 536-1339 or by e-mail at jean@iahhc.org.

Sincerely,

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