Date: January 15, 2016

TO: Secretary Alice Bonner, Assistant Secretary Daniel Tsai, Scott Taberner, Mark Miller, Matt Klitus, Phil Harrison, Almas Dossa

FROM: Patricia M Kelleher, Executive Director, Home Care Alliance of MA

In follow-up to our discussions regarding the Medicaid home health benefit and the proposed management controls, the Home Care Alliance of MA (HCA) appreciates the opportunity to provide these comments, which include some context and some suggested modifications.

We have presented your proposals to our Board and members and, not surprisingly, have had some strong reactions. Probably the two most prevalent big picture concerns (not addressing the specificity of the proposals) are:

1. *Member Agencies Believe that They are Doing a Good Job for MassHealth*
   Agencies feel they are a huge part of the health care safety net, providing valuable services to patients (and families) who otherwise would be placed in costlier care settings and/or become a detriment or even threat to their communities. The agencies we talked at length with have been doing what the state asked of them and by that they mean taking on really difficult cases, managing long term chronic instability and complex medications in a way that keeps these MassHealth members not only out of nursing homes, but from being larger societal problems.

   Agencies talked of their patient caseloads including house bound sex offenders (with ankle bracelets), schizophrenics, patients with bi-polar disorder and serious medical issues brought on by their psychotropic and other medications. Nursing home days in Massachusetts have dropped significantly (almost 2 million days since 2007), outpatient supports for the chronically mentally ill are not readily accessible, and these patients - despite their complexity and because of home-based services - are home and compliant with complex care plans.

2. *The Industry has been Trying to Call Attention to the Growth Problem and its Link to Problem Agencies for years.*
   As you are now aware, HCA has been working for years on a moratorium, Certificate of Need process or Licensure for Massachusetts, which until this point has not seen much

support from the state or federal governments. In discussing these proposals, we were surprised to hear from so many of our member agencies regarding how many times they have reported cases of newer agencies clearly acting in violation of laws and regulations to the federal OIG and other regulators. These newer agencies have been documented and reported for contacting these vulnerable patients, convincing them to switch agencies with promises on daily home health aide services, free transportation and more. The level of frustration among our members with the accrediting and oversight agencies came through loud and clear.

Not surprising, our members are concerned that established, ethical agencies that are good partners are now going to be facing higher administrative costs and lower payment (placing at risk both workers and patients) when the problem – at least to them in terms of newer agencies experiencing outsized growth - has been clear and not acted on for years.

As to the suggested management controls, we submit the following suggestions based on feedback from our member home health agencies.

1. ***Prior Authorization After 15 days on Service***

   As we discussed at the meeting, prior authorization processes, including some of MassHealth managed care partners' current programs, have presented problems for home healthcare. The major problems have to do with difficulty reaching case managers and delay in response time leading to either breaks in care, or lack of payment.

   However, at the meeting we heard a commitment to working with the industry on a process that is more streamlined and transparent and we are likewise willing to work with you on achieving that goal. We have three suggestions, should this item move forward:

- Consider a 30-day, rather than 15-day, initial authorization. While we heard your data indicates a clear break point at 15 days, 30 days seems to be evolving as a standard in managed care and with the VA. It helps when all payors are consistent in their timeframe requirements.

- Tie prior authorization to the elimination of the Third Party Liability project. Once care plans are approved for payment, there should be no need for this onerous, lengthy re-review.

- Exempt the complex care/continuous nursing (under 21 population), who are already tightly case-managed.

- Commit to a small task force of HCA of MA staff and members to evaluate both the process and access issues that may arise. This group should meet the at six months and one year intervals.

We believe that if prior authorization is done correctly, the decrease in the level of abuse would mitigate the need for other management controls discussed below.

2. ***Prohibit Self Referrals from Physicians with Relationships to the Home Health Agency***
   The discussion with our Board and members on this has raised as many questions as were answered. None of the agencies that we have as members can we identify as having MD ownership; few indicated that their Medical Director routinely, if ever, refers cases to them. The closest we could get to this relates to community physician who may sit on an agency's professional advisory committee - as a volunteer – making referrals. Of course, for agencies that are parts of large health systems, their own affiliated physician groups can and do refer.

   Note: Stark rules around the role and compensation of a home health agency medical director that require that if the board or medical director position is compensated, the compensation is set at fair market value, and the compensation should not vary based on the volume or value of any referrals.

Our recommendation is that if something such as this is to be done:

- "relationship" or "affiliation" must be carefully defined to include only ownership stake or a paid position in the company leadership.

- given that the referral problems seems closely associated with the $215 million two year growth (2013-2015), the referral problem should be addressed by profiling, auditing and educating and, if necessary, banning from referrals those physicians associated with the most recent two year growth

3. **Medication Administration Rate**

Our initial reaction to this is that: 1) it is impossible to calculate the savings from this without more data on how it will be defined and implemented; and 2) the proposed rate in almost any scenario is too low. A nurse whose time in a home averages 30 minutes has travel and documentation time, frequent phone interaction with physicians, NPs and families, and now, new case management/prior authorization responsibilities.

In talking with our peers, we have found only several states that have such a rate. Connecticut does, but is in the context of a more complex rate structure than our current

single class rate.
https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=refw242_feesched_hhlth_16.pdf&URI=fee_schedules/refw242_feesched_hhlth_16.pdf

The Connecticut rate for straight medication administration by a nurse is $61.13, close to two-thirds the nursing visit with clinical assessment rate. They also have a rate for medication administration in a setting with more than one patient. That rate is $30.57.

If we are to move forward on this without creating a potential and immediate access issue, we strongly suggest:

- considering the CT rates and approach along with the potential impact of implementation.

- very clearly defining a medication administration visit, including what IS NOT to be defined as such. We would suggest this carve out include, at a minimum, behavioral health patients who also have one or more active medical conditions requiring nursing assessment, and/or a diagnosis of serious and persistent mental illness.

- committing to a full home health rate review, including therapies, which are woefully underpaid.

Other Comments:

- Of course, we fully support efforts to impose a moratorium on any new agencies in MA.

- Believing strongly that not all certified agencies doing this work are equally qualified or regulatory compliant, we would ask MassHealth to consider allowing referral sources, such as community health centers and physicians to only work with a limited network of home health providers. Several health centers have already asked this, but they and we are unsure how this might run afoul of patient choice rules, and if it might require some sort of federal approval. Managed care companies, such as One Care, are essentially already doing this.

- Hyper-focus on new agencies with audit and assessments, not to mention education. Given that deemed accreditation agencies have clearly not been diligent enough when it comes to the MassHealth sector, request federal support for eliminating deemed status for some agencies and allowing more survey activity from MA Department of Public Health

We submit these comments respectfully and with appreciation for the for the collaborative manner in which this issue is being examined. We have any number of member agencies that are willing to talk directly with each of you about their work and how these proposals may impact them. They would also be willing to host Assistant Secretary Tsai or others on a home visit to a MassHealth client.