Testimony of Patricia Kelleher  
Home Care Alliance of Massachusetts, Executive Director  
Before Joint Committee on Elder Affairs  
On Equal Choice Law Oversight Hearing

Chairwoman Jehlen, Chairwoman Wolf, committee members and staff, thank you for the opportunity to submit testimony of our thoughts and concerns surrounding the implementation of the Equal Choice Law. As you know, the home health care industry was very pleased in 2006 when the law was passed and we are further encouraged with the Commonwealth’s openness in accepting input and suggestions.

Long before the 1999 US Supreme Court Decision that highlighted the need to present patients with a choice of where to receive long term care services, visiting nurses were delivering their services to the frail, chronically and terminally ill citizens in the least restrictive setting. Today, visiting nurse associations and home health agencies are an essential, but often overlooked part of the overall healthcare delivery system.

The Equal Choice Law was passed with the intention of saving patients, families and MassHealth millions of dollars by limiting the amount of admissions into inpatient facilities. With that theory in mind, it would seem that Equal Choice and home health go hand in hand. A 2007 study conducted by Carnegie Mellon University and Blue Shield of California proved that a patient-centered management program (PCM) where home care was increased by 22 percent and hospice by 62 percent actually reduced hospital admissions by 38 percent, reduced hospital days by 36 percent, and reduced costs by more than $18,000 per patient. The article heralding this study is attached to my written testimony.

Despite the goals of Equal Choice and the proven track record of home health, the industry has seen little that would indicate an intention – or even recognition – of the need to expand capacity in the community care area. In fact, if anything, we have seen the reverse.

Effective December 1, 2008, as part of Governor Patrick’s 9c cuts, MassHealth reduced the rate for skilled nursing services past 60 days of care by 20 percent. This came in addition to a rate freeze on a rate that was set more than two years ago. So, despite paying a rate that barely covered average direct costs, the state has required that agencies absorb the expenses associated with a 20% rate cut on approximately 40% of visits. It’s difficult for home health agencies to see equity in such a cut and freeze reflected across the long term care system.

MassHealth and the Division of Health Care Finance & Policy have been unable to produce any clinical data on diagnoses or medical needs of affected clients, but our agencies have done so – and some patient stories are attached to my testimony. What we do know is that many, if not most, of these clients who get the long term home care, which was the subject of the Governor’s 9c cut, are nursing home eligible or nursing home at-risk. They are at-risk clients.
who stay at home because of caregiving and care coordination services. In fact, I would venture that many are the very clients contributing to the states 20% drop in nursing home days since 2000, according to Executive Office of Health and Human Services.

Is it no wonder that home health agencies – as partners with the state in providing care at home to a considerable at-risk population and also who have been responsible for a reduction in nursing home days – begin to question the state’s very commitment to the idea of equal choice and community first. Many small to mid-size home health providers are faced with absorbing hundreds of thousands of dollars in Medicaid losses, or reducing their Masshealth caseload. The reality of the fiscal impact is immediately painful; the impression of a retraction from community services is almost more disturbing.

Home health care remains a relatively small part of MassHealth spending – less than 5 percent – but our member home health agencies believe its critical importance as a sentinel service has never been truly analyzed or appreciated. If Equal Choice is to succeed the way in which it was intended, adequate funding for home health care must be included.

Sincerely,

Patricia Kelleher
Executive Director
I would like to share with you a sample of some of the patients in our care that are being impacted by this 20% rate cut:

57 year old woman with Multiple Sclerosis: This patient is completely bedbound and unable to control her bowel or bladder functions. She has an implanted epidural pump to deliver medicine to control the muscle spasms associated with her disease. Due to inconsistency in the availability of her caregivers and her irreversible and untreatable incontinence, she has had chronic wounds on her back, buttocks and other areas for years. These wounds often improve but healing is easily and frequently set back. Recently, the patient developed new wounds when she sat up in a wheelchair for a day to attend her son’s wedding and again when she lost electricity to her pressure control mattress during the recent ice storm. This patient is adamant about staying in her home with her family and her home nursing services make this a possibility for her. She has had home nursing to treat her wounds and monitor her health status off and on since 2001 and has had no hospitalizations in over two years. She is visited twice per week for treatment of five separate wounds. Due to the number of wounds that require care and the caregiver consistency issues that the agency has worked to help her with, visits to this patient can be lengthy. The annual cost to Medicaid to care for this patient, based on twice weekly nursing visits is approximately $9,047. The most appropriate alternative care setting for this patient would be a skilled nursing facility, which would cost $57,000 annually.

12 year old boy with short bowel syndrome: This boy lost most of his small intestine to massive necrosis over two years ago. The result has been severe mal-absorption. He now requires total parenteral nutrition (TPN), which necessitates that he have a central (PICC) line for infusion of this vital nutrition. To supplement his TPN, he has a gastric tube through which he receives about 4 ounces of formula delivered overnight via a feeding pump. He is able to eat only small amounts of food by mouth. He deals frequently with nausea and vomiting and will most likely never be able to survive without TPN. Because he was born with a neurogenic bladder, he also has a tube inserted directly through his abdomen and into his bladder to manage urine output. After his initial illness and surgery, he had a colostomy but has since had this closed. He still needs to be monitored closely for bowel activity. His mother is doing a good job managing his care, but is poor, not well educated and a single mother to the patient and his two younger siblings. She has financial challenges, since his intense care needs prohibit her from working. She has been evicted twice over the past two years. Her need for lots of teaching, encouragement and reinforcement as well as the social issues that impact the family can make for lengthy visits. He has nursing visits 2-3 times per week to address the sterile dressing care of his central line, his need for frequent blood draws
for laboratory tests, evaluation of his overall health (he has had several severe infections in his central line and needs to be monitored closely), and support and teaching to his mother, who is now able to manage his TPN infusions on her own. The annual cost to Medicaid for the care of this patient at home, based on 2.5 nursing visits per week is $11,308.70. The alternative for this patient would most likely be a hospital setting, which would cost the state hundreds of thousands of dollars.

46 year old woman with HIV and bipolar illness: In addition to her HIV and mental illness, this woman has neck and back problems, arthritis, and is co-infected with Hepatitis C. Emotionally, she suffers knowing that her young son is also infected with HIV, which was transmitted to him perinatally. She has a history of frequent hospital admissions (6 in one year), mostly related to her mental illness. She was not keeping medical appointments, had difficulty sticking to her complicated regime of medications and was complaining of severe pain related to her orthopedic issues. After her most recent hospitalization, the VNA nurse worked closely with all the members of her care team (doctor, HIV case manager, and mental health counselor) to develop a plan to stabilize her medically and psychologically. She had a pain consultation by our medical director, who developed a new pain management plan for her, was linked with a new psychiatrist, who prescribed new psychiatric medications, and received a short term intensive visiting schedule to make sure she adhered to her new medication regime. This patient is now lucid, pain free and stable psychiatrically. This is the best she has been clinically in many years. Getting her to her current level of stability involved frequent, intensive nursing visits to assess both physical and psychological status, and manage a complicated regime of medications. The plan is to reduce her visit frequency once she has demonstrated several weeks of stability. The annual cost to Medicaid for the care of this patient at home, at an average of 2.5 visits per week is $11,308.70. The alternative would most likely be a psychiatric inpatient setting or long term care facility.