Rhode Island Partnership for Home Care

Advancing quality healthcare at home

Home Healthcare Provider Community's Public Comments and Questions to the Rhode Island Executive Office of Health and Human Services Related to the Proposed Medicaid Accountable Entities Roadmap

January 27, 2017

I. Understanding the Need to Address the Problem of Current Reimbursement and Financial Stability of Medicaid-Contracted Home Healthcare Providers Prior to Enacting Medicaid Accountable Entities

There is a significant disparity in funding long-term care providers. Nursing homes have received a rate reimbursement increase in five of the last nine years. While within that same time period, Medicaid-contracted home care providers are to receive its first small rate increase this fiscal year (State Fiscal Year 2017 or SFY17). Yet, this rate increase comes with significant restrictions on its use as a compulsory wage-pass through for nurse assistants[1] employed by a licensed home care provider or a licensed home nursing care provider and unprecedented unilateral authority to the Secretary of Health and Human Services over the construct of its enforcement. This increase, which was authorized by the Rhode Island General Assembly to begin as of October 1, 2016 has yet to be fully-implemented, as of the date of this document, by the Executive Office of Health and Human Services and its contracted Medicaid managed care organization, Neighborhood Health Plan of Rhode Island. Prior to this increase that is yet to be fully-realized, the last increase for Medicaid-contracted home care providers was in State Fiscal Year 2008 (SFY08), but most of the funding was rescinded the following fiscal year. Thus, Rhode Island still has not provided a sustainable increase in Medicaid reimbursement rates for home care services since State Fiscal Year 2002 (SFY02).

This disparity has driven funding to nursing facilities to $183 million, which is a $6 million increase over the previous year. However, funding for home and community care has dropped $4.3 million over the previous year to $60.7 million[2] based on utilization caused by current reimbursement rates that restricts hiring and retaining direct care staff and inhibits timely access to quality home care services. This is because home care providers cannot compete on wages and benefits to all professionals and paraprofessionals within our workforce compared to nursing facilities, home care providers in neighboring states, and retail and hospitality establishments operating within our state.

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[1] SFY17 Article 7 stipulates the wage-pass through program for "personal care attendants and home health aides" only. Neither classification is recognized by the Rhode Island Department of Health as a licensed provider type for the home care provider workforce. It was the legislative intent of the Rhode Island General Assembly at the time of the budget's passage that it is applicable only to licensed nurse assistants. Through the authority of HHS Secretary Elizabeth Roberts, homemakers have since been added to this wage-pass through program for services under CPT billing code S5130.

[2] SFY17 appropriations consensus changes, Page 6, November 7, 2016 Caseload Estimating Conference report memorandum, issued on November 18, 2016.

For context, Governor Gina Raimondo proposed a seven-percent (7%) increase with a compulsory wage-pass through for nurse assistants in SFY18 base rates over SFY17 after SFY17 base rate increase is implemented. This is a $2.5 million state allocation increase in SFY18 over SFY17 with the opportunity for an additional $2.5 million federal match for a total of $5 million in SFY18. Currently, the average starting home care nurse assistant hourly wage pre-SFY17 wage-pass through is $10.50 per hour. Upon implementation of the SFY17 wage-pass through program, the projected average starting home care nurse assistant hourly wage will be $10.95 per hour. If the Governor's SFY18 proposal is enacted, the projected average starting home care nurse assistant hourly wage will be $11.39 per hour. As of the date of this document, the current state minimum wage is $9.60 per hour, which is a 90-cent differential to the average starting home care nurse assistant hourly wage. If Governor Raimondo's proposed $10.50 state minimum hourly wage is enacted by the Rhode Island General Assembly, the new differential will be 89-cents. Thus, there will be no movement toward improving the workforce capacity gap for home care nurse assistants as these rate increases are only equivalent to the rise of the state minimum wage.

Furthermore, despite the Governor's recent remarks on the subject, Rhode Island will not be competitive with neighboring Massachusetts:

"The budget I will submit also includes a raise for homecare workers and the people who care for Rhode Islanders with developmental disabilities. These workers ensure that the people we love live their lives with dignity. We should make sure that we value their work. Last year, thanks to Senate President Paiva-Weed's leadership, we gave homecare and direct care workers their first raise in nearly a decade. And I propose that we give them another raise this year. It will make us more competitive with Massachusetts and help us make sure we have the highest quality people taking care of our Rhode Island families."[3]

The Governor's statement is both untrue and misleading. While home care providers appreciate the support of the Governor to increase reimbursement rates, the rate increase of the current fiscal year to be implemented, nor the Governor's proposal for the upcoming fiscal year, increases wages for all direct care workers, such as nurses, physical therapists, occupational therapists and social workers as it was only attributable to nurse assistants. Moreover, per the Governor's remarks, the base rates in Massachusetts for services delivered by nurse assistants is currently 38.01% higher than Rhode Island.[4] If the Governor's proposal is enacted by the General Assembly this legislative session and Massachusetts does not take further action to increase their reimbursement rates, Massachusetts would have a higher reimbursement rate by 20.02%.[5] Comparative to neighboring Connecticut, the base rate is 39.37% higher than Rhode

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[3] Governor Gina Raimondo, State of the State Address, January 17, 2017

[4] Rhode Island's base rate pre-implementation of the SFY17 wage-pass through for nurse assistants is $17.68. Upon implementation of the SFY17 base rate adjustment, the rate is projected to be $19.00. If Governor Raimondo's SFY18 proposed base rate adjustment is enacted, the projected base rate will be $20.33. Please note that figures presented are based on a hourly base reimbursement. Providers are reimbursed by quarter-hour units.

[5] Massachusetts base hourly rate is $24.40 for services delivered by nurse assistants, which is currently 38.01% higher than Rhode Island. Upon implementation of Rhode Island's SFY17 base rate adjustment, the Massachusetts rate is projected to be 28.42% higher than Rhode Island. If Governor Raimondo's SFY18 proposed base rate adjustment is enacted, the Massachusetts rate is projected to be 20.02% higher than Rhode Island.

Island and will be 21.21% higher if the Governor's budget proposal is enacted assuming that Connecticut does not take further action on their reimbursement rates.[6]

Since the last sustainable rate increase in SFY02, operating costs have significantly risen, such as fuel to travel between patients' and clients' homes. With the implementation of the Affordable Care Act[7] (ACA), home care providers have confronted further costs to meet the affordability test to provide health insurance to their employees. Without a rate increase to meet the costs of operating home care agencies, such as accreditation renewals, compliance with the unfunded mandate of electronic visit verification, rent, utilities, mileage reimbursement, just to name a few examples, it makes the already unfriendly business climate in Rhode Island to provide healthcare services in the home only more difficult. Layoffs, agency closures, and barriers to accessibility of services have occurred over this time period and will likely continue under this administration's current minimal investment and expanding regulatory burdens on home care services through the state Medicaid program and its "Reinventing Medicaid"[8] initiative.

We present this issue ahead of any comments on the proposal for the Accountable Entity Roadmap because the fee-for-service reimbursement rates are not competitive for wages and benefits for our workforce within the state's healthcare sector, nor within Medicaid home care in neighboring Massachusetts and Connecticut. Under the concept as described within the roadmap, our industry's fear is that accountable entities will siphon current and prospective patients and clients away from certain home care providers over others based on which agencies are contracted with which accountable entities. Furthermore, because Medicaid home care reimbursement is only two-percent (2%) to seven-percent (7%) higher under Neighborhood Health Plan of Rhode Island than fee-for-service at current reimbursement rates, this accountable entities proposal leaves uncertainty that the accountable entities will offer bundled rates under a value-based payment model that will cover the total cost of care and remain competitive to the labor market and neighboring states' reimbursement rates. If many Medicaid-contracted home care providers are not financially-viable to participate in this initiative, the concern is that the state is further setting up this provider community for failure, leaving more agencies to close and more direct care workers unemployed.

Outstanding Questions Related to Accountable Entities Reimbursing Home Healthcare Providers

1. What services or state-operated Medicaid programs will remain under fee-for-service upon the full implementation of accountable entities by SFY20 as prescribed within the roadmap?

2. How will the "total cost of care" (TCOC) calculation be designed for each home care provider personal care attendant service and skilled nursing service?
    1. Will this include the cost for medical equipment and supplies?

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[6] Connecticut base hourly rate is $24.64 for services delivered by nurse assistants, which is currently 39.37% higher than Rhode Island. Upon implementation of Rhode Island's SFY17 base rate adjustment, the Connecticut rate is projected to be 29.69% higher than Rhode Island. If Governor Raimondo's SFY18 proposed base rate adjustment is enacted, the Connecticut rate is projected to be 21.21% higher than Rhode Island.

[7] U.S. Patient Protection and Affordable Care Act, 2010 P.L. 111-148.

[8] Executive Order 15-08, February 26, 2015.

2. Will this include wage increases and benefit costs?
3. Will this include costs to conform with state minimum wage increases?
4. Will this include mileage reimbursement for direct care workers?
5. Will this include all costs to maintain provider accreditation?
6. Will this include all overhead costs, such as, but not limited to, rent, utilities, workers compensation insurance, professional liability insurance, property and casualty insurance, health insurance compliance, payroll taxes and other federal, state and municipal imposed taxes?

3. How will the accountable entities be measured for establishing and maintaining an adequate network of providers?

4. What provisions will be imposed on the accountable entities targeting the long-term services and supports population to contract with home care providers?
    1. Will participation by home care providers be compulsory or have the option whether to participate?
        1. If optional, will the accountable entities be required to contract with any willing provider?

5. How will the Executive Office of Health and Human Services ensure that the accountable entities' risk-model standards for reimbursement will comply with or not conflict with any accrediting standards for participating home care providers?

6. Because United Healthcare of New England is currently not a participant in the Integrated Care Initiative via the state's CMS 1115 waiver program, will this change under the development of the accountable entities initiative as a participating managed care organization?

II. The Need for Additional Information on Quality Standards for Participating Home Healthcare Providers

The United States Centers for Medicare and Medicaid Services (CMS) embarked on a value-based purchasing pilot for Medicare-certified home health agencies on October 1, 2016.[9] Massachusetts was one of nine states[10] identified for compulsory participation in said initiative. This model has been initiated for less than four months and, as of this document, no quantitative or qualitative data on its first quarter has been publicly released. Thus, it is unknown at this time how this new payment model is performing or underperforming. In fact, CMS does not project to have confidence on this model's implementation until after the initial demonstration period is completed in 2022, pending Section 3021 of the ACA remains intact after the 115th United States Congress completes its "*Repeal and Replace*" legislative actions. At this time, CMS has not announced any intention on expanding this demonstration nationwide.

In addition, there is no federal or state model for implementing value-based purchasing for personal care attendant services delivered by a home care provider. Without a payment

[9] More information can be found at https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model.

[10] All Medicare-certified home health agencies that provide services in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska and Tennessee.

model alternative to fee-for-service, it seems inconceivable to develop standards in which the primary charge for these services is for the home care provider through a homemaker or a licensed nurse assistant to provide support for activities of daily living that maintains the patient or client safety in their home in accordance with the authorized plan of care. Under these services, patients and clients tend to maintain their current level of health for a significant period of time (e.g. years, decades) and do not receive any health interventions. There is no measurement for achieving changes to their health outcomes as many are not authorized for skilled nursing and therapeutic services. These patients and clients only receive a visit from a nurse every sixty (60) to ninety (90) days in accordance with Rhode Island Department of Health regulations and a national accrediting body's requirement for home care providers. Despite the requirement, this regularly-scheduled nurse visit is a service that is not reimbursable under the Medicaid program. Responsibility for health outcomes is not under the current scope of practice for a licensed nurse assistant. Homemakers are not permitted to have contact with the patient or client to support their physical needs, such as bathing, use of a toilet or commode, nutrition and hydration. Furthermore, there are no accrediting body's standards related to health outcomes for personal care attendant services provided by a home care agency.

In fact, the only accreditation standard related to health outcomes is related the new Integrated Care Certification Program by The Joint Commission[11] for home care and nursing care centers. This standard includes the following:

- Greater focus on functions and processes important to clinical care integration;
- Promotion of common patient risk screening criteria;
- Coordination of, and not duplication of, case management efforts and care coordination;
- Use of currently collected data to measure performance and drive improvement in clinical care integration; and
- Establishing a scope of evaluation that will address such issues as processes to support clinical integration, hand-off communications, management of information, patient and family engagement, and performance improvement activities that intersect with clinical care partners and care integration.

Outstanding Questions Related to Accountable Entities Establishing Quality Standards for Home Healthcare Providers

7. Please clarify the program eligibility, as defined beginning on Page 36 for the six identified accountable entities, that will be contracted with the Executive Office of Health and Human Services and the Medicaid managed care organizations as "specialized long-term services and supports" (LTSS) accountable entities as it relates to contracting with home healthcare providers.
    1. Of those engaging in LTSS, what is the experience of those accountable entities with LTSS and specifically with understanding the complexities of operating a home care

[11] The Joint Commission: Integrated Care Certification Program expansion that includes post-acute care environments effective January 1, 2017. https://www.jointcommission.org/certification/integrated_care_certification.aspx.

agency that provides personal care attendant services and a home care agency that provides skilled nursing and therapeutic services?
    2. Will home-based hospice care providers be eligible or mandated to be included in the accountable entities initiative?
        1. If so, what is the experience of those accountable entities with understanding the complexities of operating a home-based hospice care agency?

8. What is the design for the "progressive implementation of an alternative payment methodology" for home-based healthcare services?
    1. Is it the intention to replicate the CMS value-based purchasing model that is being piloted for Medicare home health providers in Massachusetts and eight other states since October 1, 2016?
    2. Without quantifiable nor qualitative data yet from CMS for the first quarter of the model's demonstration, how would the Executive Office of Health and Human Services or the accountable entities replicate such a reimbursement model, especially if CMS does not have the confidence yet to implement any value-based purchasing methodology on home health providers nationwide?
    3. Because there is no federal Medicare nor state Medicaid value-based purchasing or alternative payment methodology for personal care attendant services provided by home care agencies, how would the construct of that model under an accountable entity be designed?

9. What is the risk that this accountable entities demonstration project will be enacted, but no longer funded by CMS upon the completion of the "repeal and replace" legislative actions by U.S. Congress?
    1. Will the Executive Office of Health and Human Services, subject to General Assembly appropriations, fund this initiative, in part or as a whole, independent of federal funding?
    2. If so, which parts of the accountable entity roadmap will remain viable to the "Reinventing Medicaid" initiative regardless of federal funding?

10. For those beneficiaries that require skilled nursing care, why was home-based skilled nursing providers not included for accountable entities to be certified in addressing the need for these services within Table 2 on Page 19 and Appendix A on Page 49 under "Population: Duals/Individuals with Disabilities Requiring LTSS" for "Community Based Services"?

11. Under the same table, Table 2 on Page 19 and Appendix A on Page 49, for "Population: Children", why were home-based skilled providers excluded as these providers were included under "Population: Developmentally Disabled", but not all pediatric patients are developmentally disabled?
    1. Some pediatric patients are medically-fragile that require both school and home-based skilled nursing and personal care supports by the same provider. Additionally, not all developmentally disabled patients are children. Describe how accountable entities will measure quality care provided to children with special healthcare needs in a school-based setting.
    2. What variation will be set under a proposed risk-based payment model for providers delivering care to pediatric patients that tend be "super-utilizers" of hospital-based services and tend to currently have restrictions under the fee-for-service model on the amount of authorized hours for home-based healthcare services?

3. What role will local education authorities have under this accountable entities initiative related to nursing services for pediatric patients requiring one-to-one nursing services during the school day?
4. How will skilled private-duty nursing care (block hourly care) be differentiated from Medicare nursing care visits?
    1. How will low tech/acuity versus high tech/acuity (e.g. tracheostomy care and ventilation or “trach and vent”) nursing care be differentiated?
        1. Will there be a different measuring system and value-based reimbursement structure for managing a high tech/acuity patient or client?
    2. What are the items that will be measured for skilled private-duty nursing care (block hourly care)?
        1. As with personal care attendant services, this type of long-term care is a nursing service in which many patients and clients will not experience improvement in their health outcomes. Would service delivery then be measured based on maintaining current health and safety standards, in which they are already in compliance per Rhode Island Department of Health regulations and accrediting body standards (e.g. health stabilization, minimal infections, and reduced hospital admissions)?

12. Referring to another “super-utilizer” population, what variation of a proposed risk-based payment model for providers delivering care to the Medicaid population with complex behavioral healthcare needs as this population tends to be “super-utilizers” when patients make the decision not to take medication at the prescribed frequency or dosage?

III. Ancillary Public Comments and Questions Not Related to the Previous Sections

13. How will the Executive Office of Health and Human Services ensure that the Medicaid managed care organizations or the accountable entities will remain financially solvent during this demonstration project? This is unclear on Page 32 of the roadmap on the use of waiver funds for administration functions.
    1. Will there be administrative fees for operating this initiative paid directly from the Executive Office of Health and Human Services to the accountable entities or through the managed care organizations?
    2. Will there be administrative fees for operating this initiative paid directly from the Executive Office of Health and Human Services to the managed care organizations in addition to the current administrative fees to the Medicaid managed care organizations under the Integrated Care Initiative?

14. The table on Page 28 of the roadmap is unclear about the delegation of case management. WhIch healthcare party will be tasked with coordinating case management for beneficiaries that are utilizing providers within an accountable entity (e.g. state caseworker, CAP agency caseworker, accountable entity, Medicaid managed care organization, home-based healthcare provider)?
    1. If it is varied, please describe the various scenarios in which case management will be coordinated or delegated by home care service type.
    2. How will the roles of the caseworkers employed by the state government, e.g. Department of Human Services, Department of Behavioral Healthcare Developmental Disabilities and Hospitals, Department of Children Youth and Families, and those

contracted through the various state agencies, e.g. community action programs (alias CAP agencies) change under the implementation of accountable entities?

3. Will co-pay clients, such as those enrolled in programs administered through the Division of Elderly Affairs, be specifically included or excluded in this program?
    1. If excluded, will those beneficiaries remain in a fee-for-service model?

15. How will the authority of the Office of Program Integrity at the Executive Office of Health and Human Services change under the development of accountable entities?
    1. Will the Medicaid managed care organizations continue to conduct their own program integrity audits as they currently do under the Integrated Care Initiative?
        1. Will that authority be transitioned to the accountable entities or remain within the respective Medicaid managed care organization?
    2. On June 1, 2016, the Office of Program Integrity initiated its Medicaid home care electronic visit verification (EVV) program. If EOHHS is initiating an alternative payment model that is episodic-based (e.g. value-based payments, bundled payments), would there remain a need for electronically verify each home visit outside of a fee-for-service payment model via a state agency-housed case (e.g. fee-for-service under the Department of Human Services, the Division of Elderly Affairs, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals) or a Medicaid managed care organization-housed case?
        1. If so, which entity is responsible for oversight of those respective visit verifications for electronic for patients and clients within each accountable entity (e.g. the accountable entity, the managed care organization, the Office of Program Integrity)?
        2. If the answer to the previous question is a party outside of the Office of Program Integrity, will this require a separate contract with the EVV provider, SanData, for use of the EVV system, SanTrax prior to the initiation of an accountable entity to contract with any Medicaid-contracted home care provider?

16. Please elaborate on how the risk-based model within the alternative payment proposal through an accountable entity delineates which provider is at fault in the case where a patient is hospitalized for a preventable reason (e.g. bed sores, cough that should been evaluated by a physician or nurse practitioner sooner).
    1. Are any proposals to an alternative payment model focused on shared risk for all parties within the accountable entity or delineated risk based on an investigative process within the accountable entity?
        1. How would the Executive Office of Health and Human Services or the Medicaid managed care organization oversee any appeals process where delineated risk is faulted on a particular provider?
        2. Within a contract between the accountable entity and either the managed care organization or directly through the Executive Office of Health and Human Services, will there be a provision as it relates to contracted home healthcare providers that the home care provider within an accountable entity will receive timely notification for when a patient or client enters a hospital's emergency department or before a patient is hospitalized?

IV. Recommendations for the Accountable Entities Roadmap

1. Exempt home care providers from participating in accountable entities until fee-for-service rates are in parity with neighboring Massachusetts and Connecticut;

2. Define in greater detail the parameters for home care providers to contract with accountable entities, such as minimum contracting standards, value-based bundled payment formulas compared to the current fee-for-service funding model, and defining the adequacy of an accountable entity's network of providers, including home-based personal care attendant services and skilled nursing care; and

3. Allow for an additional thirty (30) days for additional public comments and questions on this roadmap to be submitted to the Executive Office of Health and Human Services after the meeting with long-term services and supports providers currently scheduled for February 8, 2017.

V. Conclusion

The Rhode Island Partnership for Home Care is eager to learn more about how the Executive Office of Health and Human Services intends to develop this accountable entities initiative. However, Rhode Island has not made enough investment in its Medicaid long-term services and supports program to financially sustain its Medicaid-contracted home care providers, nor has significantly invested its time and resources toward rebalancing the state's post-acute and long-term healthcare system toward home and community-based services. Jumping into yet another "Reinventing Medicaid" initiative without making these predicate investments will only further exacerbate the access to home healthcare crisis for patients and clients in need of healthcare services in their homes to remain safely within their communities, close more Medicaid-contracted home care agencies and further inverse labor market opportunities for direct care workers where demand for care is rising.

VI. About the Partnership

Established in 1990, the Rhode Island Partnership for Home Care represents home care, home nursing care, and hospice provider agencies licensed by the Rhode Island Department of Health that serve patients and clients in every Rhode Island community. Focused on the mission of "*Advancing quality healthcare at home*", the Partnership is committed to promoting quality home healthcare service delivery, ethical healthcare business practices, and positive patient and client outcomes to ensure that access to home care and hospice remains an integral component of our post-acute and long-term healthcare system.

VII. Contact Information

All responses to these public comments and questions by the Rhode Island Partnership for Home Care to the Rhode Island Executive Office of Health and Human Services should be directed to the following contact in writing:

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Any clarification needed by the staff or consultants of the Executive Office of Health and Human Services on these public comments or questions can also be directed to our Executive Director at (401) 351-1010 or director@riphc.org.