State Top Medicaid Issues - 2002

Following is a compilation of responses from 23 state associations on their Top 5 Medicaid issues.

REIMBURSEMENT
Inequitable or inadequate funding 19
Feared rate rollbacks due to budget shortfalls 7
Lack of Annual Cost of Living increases 4
Timeliness of payment 2
Punitive and or outdated reimbursement methodology 2
Rate increase required to pass through to salaries 1
Restructuring home infusion payment system 1
Moving from cost reimbursed to PPS model 1
Implementation of global funding waiver 1
Reimbursement below LUPA rates 1
Mileage not reimbursed 1

UTILIZATION CONTROLS
Medicare maximization (Medicare required to be 1st payor) for dual eligibles 7
Enforcement of “Homebound” requirement 4
Cap on number of Home care visits 3
Burdensome, sketchy or inappropriate PAR process 3
3rd Party Gatekeeper to do PARs 1
Tension/struggle between case manager and home care providers 1
Increased restrictions on what is covered 1
Private Duty Nursing increased denials 1
Program cuts 1

REGULATION TO SAVE MONEY
Forced nurse delegation to HH Aides to save money resulting in quality concerns 3
Billing in 15 minute increments 2
Required use of personal care vs. aides 1
Required use of PCAs instead of aides/hmkrs/companions for frail elderly waiver 1

PROMOTION OF NEW WAYS TO PROVIDE CARE
Allowing non-Medicare certified providers, nurse registries, individual nurses or waiver providers to participate with limited supervision and/or oversight (agencies lose clients and employees) 6
Consumer Directed for young disabled, elderly and children 4
PACE expansion to 10 sites 1
Expansion of programs each with its own regs and reimbursement structure 1
OVER REGULATION

Over-regulation and administrative burdens

- Requiring duplicate assessment process (like OASIS or MDS) 3
- Requirement that Medicaid regs be same as Medicare is hassle 1
- Collecting OASIS on long term care 1
- New Hire background checks on all caregivers with finger printing 1
- Unreasonable Anti Fraud measures 1
- Requirement that EPSDT be provided by Medicare certified agency but OASIS and COPS do not accommodate children 1

OVERALL DEFICIENCIES in STATE’S MEDICAID BENEFIT

- Low Medicaid eligibility & participation 3
- Low or late participation in alternative programs by state 2
- No MSW/social work services 1
- No coverage for Hospice unless dual eligible and in nursing home 1
- Block nursing program for children collapsing 1

GENERAL

- Lack of coordination between state depts. and/or state/local control 2
- Agencies unable to coordinate with Long Term Care (nursing homes?) 2
- Nursing home lobbying has been successful in obtaining priority funding 1
- Not enough pro-Medicaid and pro-home care elected officials 1
- Escalating costs under Medicaid managed care 1
- Providers not doing enough under Olmstead? 1
- Client safety 1
- Fraud (falsification of records, tax evasion) 1
- Lack of licensure for agencies or aides 1
- Timeliness of medical review and appeals 1
- Staffing shortages 1
- Increased acuity of clients as result of Olmstead 1

DETAILS BY STATES

ALABAMA

We only have one here in AL.... equitable funding.

Because of intergovernmental transfers our public health system gets paid about 2x what a hospital based or private agency does for an RN visit. We have not been active with Medicaid for the last several years due to our state administration's lack of concern over Medicaid issues, but with our state agency suing the HHS that may be about to change.

ARKANSAS

Arkansas is going through a budget shortfall which has created cutbacks in Medicaid.

1. Home health visits were capped at 50 a year with an extension of benefit needed for any visits above 50. Medicaid has proposed reducing that number to 25 visits a year with an extension of benefit needed for any visits above 25.
2. Personal care hours were capped at 64 hours a month with an extension of benefits needed for any hours above 64. Medicaid has proposed reducing that number to 32 hours a month with an extension of
benefit needed for any hours above 32.
3. The state has issued a request for proposal for a 3rd party gatekeeper to handle the prior authorization and extension of benefits for home health visits, personal care hours and private duty nursing.
4. Dual eligibility for Medicaid and Medicare patients for aide services. The Department of Health has warned home health agencies that surveyors will be checking to make sure they are providing all aide services under a Medicare PPS episode, not relying on Medicaid-funded aide services.
5. Medicaid has dramatically increased the denial rate for services for the private duty nursing program.

**CALIFORNIA**
1. Maintaining current rates in face of budget deficit
2. Restructuring home infusion payment system
3. Seeking an automatic annual rate increase
4. Allowing providers to participate in Medicaid without being Medicare Certified (federal issue which probably requires legislation).

**COLORADO**
1. reimbursement rates
2. consumer directed care
3. PACE expansion to 10 sites
4. over-regulation by Medicaid
5. nurse delegation forced on home care agencies by rate step-downs to encourage use of aides instead of nursing

**CONNECTICUT**
1. Inadequate Medicaid home care rates.
2. Third Party Liability (TPL)/Medicare Maximization (unique to northeast)
3. Proposal to use PCAs instead of aides/hmkrs/companions for frail elderly on our waiver program: Ct Home Care Program for Elders
4. Lack of MSWs/social work for Medicaid in CT
5. Continual tension/struggles between medicaid's case managers (called access agencies) who do the assessments & care plans for elderly on the waiver program and our provider members who do all that work firsthand for the traditional Medicaid, Medicare, and everyone else.

**FLORIDA**
1. Keeping small fee increase that went into effect 1/1/02. Governor's budget did not annualize it, so increase is eliminated 6/30/02 unless we get legislature to put back in budget.
2. Enforce law that does not allow nurse registries to be Medicaid providers. There are several in FL that are and we are fighting (successfully thus far) to get them disenrolled.
3. Reduce administrative burdens on providers.

**GEORGIA**
1. We continue to fight for an increase in our Medicaid rates. Georgia pays per visit and there is a difference in rates of over $35 for identical services performed by different agencies.
2. We are attempting to do away with our DMA-44 form as a requirement for filing Medicaid claims. The information required on the DMA-44 form is the same as required for OASIS.

**ILLINOIS**
Really, our Medicaid problems can be simplified to two major issues. That is, of course, 1) rate of pay and 2) timeliness of pay. Our rates are currently paid through and determined by the Illinois Department of Public Aid. They are currently set at $65.25 per visit for any discipline (nursing, therapy, aide). The timeliness of pay is terrible. The state feels that they are paying on about a 45 day cycle, some of our members are actually experiencing more like 70-80 days for payment.
In our solutions to these problems, you may find subjects that other states are facing. We are a)
advocating to increase or at least maintain our rates and appropriation in the new state budget, b) we are under constant alert that due to the $850 M hole in the current state budget, that the state can choose to cut our rates at any time, c) we are currently working on a new bill which we have designed to change our Medicaid reimbursement rate to the same as LUPA rates and to have them readjusted annually. This bill is in the earliest stages and we plan to use it primarily to build awareness for now, d) due to low reimbursement, many providers are unable to accept many Medicaid beneficiaries as patients, and e) due to low reimbursement, agencies who have high Medicaid numbers have an even harder time staffing their agencies faced with the competition of the nursing shortage.

KANSAS
1. cuts in provider rates due to state deficit
2. proposal: bill in 15 min increments for skilled services and hh aide for patients on the waivers
3. proposal: not to cover anything that Medicare won't cover, except in respect to the home bound requirement
4. intent to expand self-directed care rather than pay fairly for home health services
5. major quality of care issues where delegation-of-nursing tasks is used

MAINE
1. Medicaid Homebound Requirement
2. Growing gap between reimbursement and cost
3. Regulatory burdens—due to lack of trust. The state requires many forms and "hoops."
4. Duplication of assessment process. State contracts for assessment service that nearly mirrors that of OASIS.
5. Expanded number of programs makes it difficult for providers to offer services as each program has its own set of regulations and reimbursement structure.

MASSACHUSETTS
1. Echo Kentucky and others; not enough in the budget to cover need/demand for services and to pay close to adequate rates
2. Block nursing program (mostly for technology dependent kids) that is collapsing to the point where the child advocates have sued the state over the unavailability of physician ordered home care services
3. Maintenance of homebound criteria for accessing services despite Olmstead
4. Dually eligibles - tension between Medicare & Medicaid over who pays for what and when
5. Announced intention of the state to require the MDS for home care (on top of OASIS) for all clients receiving skilled and/or personal care services

MICHIGAN
1. State level of participation.
2. Inadequate reimbursement rates.
3. Revenue insufficiency limiting access to care (cap on slots available for community based waiver program).
4. "Homebound" eligibility policy limiting access to care.
5. State Medicaid policy permitting reimbursement for individual nurse services.

MINNESOTA
Like everyone else our overriding issue is adequate funding, especially for our wavered services. But I do have five big issue we are working on here in Minnesota.
1. We have introduced legislation, last year, to reimburse for mileage traveled by direct care givers going to, between and from clients. We actually got it passed out of the two health policy committees, but the finance committees backed off because of the rather large fiscal note. We will be refining the bill and reintroducing it in the 2003 budget year.
2. Dually eligibles (Medicare/Medicaid) is a real problem for us because we are a heavy Medicaid using State. It is mainly a Federal issue. States have some interpretative authority, but not enough. We need clarification and definition on who pays for what, when.
3. OASIS - We are finding CMS, and subsequently our Surveyors are getting real tough collecting OASIS
data on the skilled Medicaid clients, most of whom are chronic, long term maintenance clients. This is a bit off the deep end as far as I am concerned.

4. New hire background checks - Our Attorney General has decided our Medicaid population is at extreme risk due to all of the unqualified care givers being hired. (I am being sarcastic here) He has introduced a new background check bill which calls for extensive background checks on all new hire direct care givers, including finger printing. No new hire will be able to give direct care until the checks are completed. Estimates are that it will take up to six months to get a new hire cleared to go out and give direct care.

5. New kind of access issue - Over the last year we have seen a surge in new ethnic based providers come into our provider community. They all are getting their Class A Home Care Provider license and are being held up as examples of how the provider community is evolving to serve specific needs. Then, of course, they have to go to the Counties in which they wish to provide service, and apply to become contracted providers. Here these eager new providers run into a real catch 22. Counties are telling the providers that they need to be MEDICARE Certified in order to provide Medicaid wavered services. Medicare certification criteria is to restrictive for these brand new, one or two employee companies. They are told they need to have 10 Medicare clients, 3 months of operating capital in reserve, and that surety bond. We have had three or four of them come to us in tears over this situation. They can see no way to get the Medicare certification because of the financial burden and their inability to understand how they are to carry 10 Medicare clients when they are not Medicare certified.

MONTANA
Montana has similar issues to Kentucky--REIMBURSEMENT! But other than that, they are:

1) Inadequate reimbursement--payment averages about 50-60% of the cost it now takes to provide skilled visits. In FY 1999 we were paid $61.34/skilled visit, in FY 2002 we're all the way up to $63.50. We know what PPS has done to the average cost/visit....

2) Obsolete reimbursement methodology--Current rates for home health services were established in July 1997 as the average of 60% of the Medicare upper limit for each provider. The rates also included Medicare home health aide visits at that time as part of their computation; in reality, we do minimal to zero Home Health Aide visits under Medicaid in Montana so that volume should not be involved in any calculations.

3) Tunnel vision when working w/Providers—it took us 4 months, intervention from NAHC, and a conference call with our FI to convince Medicaid staff that PPS episodic or LUPA payments are NOT intended to meet all of a dually eligible patient’s nursing needs, and that it IS possible to simultaneously bill Medicare and Medicaid for different services at the same time (e.g. when pt. still requires “skilled” but noncovered services during a HH episode). In other words, Medicare coverage had not changed, but Medicaid interpreted episodic payment to cover ALL needs during that time. And supposedly this was reinforced by their “CMS contact at the regional office in Denver.”

4) Lack of coordination between state departments to formulate best/least costly services for clients.

5) Burdensome prior authorization process with arbitrary limitations on no. of visits that can be provided before more approval needed. Contracted reviewer decides how many therapy visits pt. can have, and in which discipline, even though regulations state annual limit of combined therapy visits are available w/o designating how many in each discipline. PA process can also involve getting refusals from any local private duty nursing agency that they cannot meet pt.’s needs to convince Medicaid that they must pay a certified agency to provide typical skilled visits. NO opportunity for agency payment when PA not obtained due to pt. getting retrospective Medicaid approval or pt./agency not realizing pt. qualified for Medicaid (of course, PA cannot be obtained if pt. does not have Medicaid in place—so it's a catch-22).

NEBRASKA
Here are our top three for the state of Nebraska. I may have a couple more to add as I am waiting to hear from another member.
#1 - The number one issue in NE is that Medicaid does not cover hospice unless the patient is dually eligible for Medicare and Medicaid, and residing in the nursing home. That leaves out a huge number of Medicaid patients who do not have reimbursement for hospice services.

#2 - Our on again, off again precertification process. Currently the prior authorization process for Medicaid Services is on a temporary hold until further notification. NEHHS says it will take 2-4 weeks before resuming but they aren't for sure. This is very tiring for agency staff who have to do the work.

#3 - Rates could always be better. In some situations, they don't even cover costs.

#4 - Asking Med Aides to do things that LPNs really should be doing especially with pediatric patients.

NEW HAMPSHIRE
1. Reimbursement rates (static rates, only revised when we bring political pressure; do not adequately recognize full cost to deliver care--we have statewide unit rates, not visit rates)
2. Personal Care Services--just now being introduced to our HCBC-ECI program
3. Low Medicaid eligibility limits
4. Low, rarely adjusted caps on amount of services that can be delivered to waiver clients.
5. Back to reimbursement--proposed wage pass through (didn't pass the legislature last year, but was proposed as the ONLY rate increase, no adjustment would have been allowed for admin or other direct costs. Ultimately we didn't even get that through--no rate increases budgeted for the current biennium.)

NEW JERSEY
1) Reimbursement inadequacies - especially the rate paid for Personal Care Assistant Cases (home health aides, by and large), and the rate paid for RNs in the state's "Model Waivers" used to bring intensive care patients back home, whether medically fragile infants/children or fragile/handicapped adults (vent-dependent, etc.) The Model Waiver patients require RN's with special expertise and the hourly Medicaid rates no longer cost their cost for agencies.

2) Consumer-directed care "Directions" - we need to work closely with our state Medicaid staff as they enter into a "Systems Change Grant" process and determine whether the RWJ Grant-funded "Cash and Counseling" model should be expanded.

3) Role of Home Health Aides versus other types of caregivers - Our Medicaid program is interested in both expanding the role of the certified home health aide to more tasks delegated by nurses, and making provision for new workers, such as housekeepers and cleaning services, to remove the non-patient chores from home health aides. Theoretically, both are great concepts, but the reality of implementing them is a daunting challenge for all involved in the process - if, in fact, these changes ever come to pass.

4) Coordination of Home and Community-based Services: Every state, I suspect, has a different pattern for determining how, who and what care will be approved, what provider types and agencies can do what, etc. New Jersey is a "Home Rule State", with considerable county empowerment. This makes coordination more of a challenge and a problem for us than it might be in some other states. Our Medicaid Home Care Regulations are old, out-of-date, and badly need revision - along with the process of oversight and coordination by the State Medicaid Program. We will be starting to meet with the Medicaid staff to begin the process later this month - with all our fingers and toes crossed for progress in the right (and sensible) direction.

5) "Med-Max" is certainly a headache for our Medicare-certified agencies, together with the whole issue of serving the dual-eligible client and figuring out which payor is appropriate for which service, can you combine payor services, etc. Our state Medicaid staff are not quite as "gung-ho" about Med-Max as in some other states, so the headache is not an all-consuming issue, but it could easily become one if either federal CMS regs change or state Medicaid staff change their way of thinking. Our state is cursed with the largest state deficit in the Union this year, and some bright bureaucrat could decide that Med-Max should be increased to help the state with its shortfall. In the long run, they won't gain any more $$ than they have already gotten from us, but they could make it a much larger headache - that's for sure!

NEW MEXICO
1) Medicaid Budget shortfalls and of course lots of things related such as cuts to programs, reduction of eligibility requirements 235% back down to 185%, escalating costs under Medicaid managed care.

2). Going from cost reimbursed into a PPS model...still trying to talk with Medicaid and come up with a
plan that does not hurt the provider.
3). Olmstead...are we doing enough?
4). How to deal with Long Term Care and policies related.
5) An attempt to resolve all issues with a global funding waiver with really no plan on how to pay for it...thank you joie

OHIO
The first four items are what we have presented to policymakers asking for change. There are problems related to using independent providers in the waiver program:
1. Limited supervision of independent providers.
2. Client safety.
3. Potential state liability as they treat IPs as independent subcontracts, however, potential that they really are an employee of the state.
4. Fraud, i.e. falsification of records, tax evasion.
Besides the above the agencies are very upset that IPs are paid the same as home care agencies. Even through the agencies must be Certified or Accredited. The IPs have few requirements. Many agencies experienced their own employees leaving and taking with them the agency's client, so the agency experienced loss of employees and loss of clients. It has not been pretty. We have been working on this issue for 3 years and little progress has been made.
In Ohio there is no licensure of Home Care no licensure of registration of home care aides.

TEXAS
1. Reimbursement and methodologies used to calculate rates for Medicaid long-term care programs and waivers. Texas has a rather punitive methodology for these programs, and each year a higher percentage of providers do not have their costs covered. Despite the softening of the economy, agencies are still having significant difficulty finding qualified nurses and personal care attendants.
2. Remove requirement that EPSDT home care services be provided by a Medicare-certified agency--many of the Medicare COPs, including OASIS, simply do not accommodate how services must be provided to children.
3. Restrictive prior authorization requirements imposed by the state and the Medicaid intermediary that prohibit the delivery of cost-effective Medicaid home health and EPSDT services.
4. Increased acuity of clients being served in the community, particularly due to Olmstead. We are now having persons who move from a nursing home into the community requiring 24-hour care--agencies cannot always staff these cases and the clients sometimes lack family supports and back-up.
5. Introduction of a Vendor Fiscal Intermediary model for personal care attendant services in Medicaid, where the client is the employer of the attendant and contracts with an entity (which in Texas is usually a home care agency) to perform the payroll functions. As agencies become more and more strictly regulated, how can they compete with this model of service delivery?

VIRGINIA
1. budget problems and a current shortfall that will only worsen over the next several years
2. Virginia's program is among the stingiest in the nation in terms of recipient eligibility requirements
3. grossly inadequate reimbursement for the medicaid personal care waiver services and the lack of a mechanism for regular reimbursement adjustment
4. inadequate reimbursement for the other medicaid waiver services and the lack of a mechanism for regular reimbursement adjustment.
5. specifically providers - the state government's recalcitrance to make virginia medicaid home health regulations the same as those for medicare certified home health is a major hassle.

WASHINGTON
1. Medicaid rates per visit and per hour
2. Increased restrictions on what is covered and not covered in a home health visit
3. Brief visit payments
4. Coordination between home health care and long-term care services,
with people falling between the cracks

WEST VIRGINIA
1. Adequate and TIMELY reimbursement. Presently WV reimburses providers at about 15% below the Medicare rate for like services. Also, reimbursement is not timely and providers sometimes wait up to 6 months for payment.
2. Conflict with medicaid reimbursed waiver programs. Although our providers seem to be able to work with the waiver providers there is little accountability of the waiver providers from the state which often causes quality issues for the certified home health provider.
3. Interpretation of homebound status has been a major conflict in WV. Although this issue has been somewhat resolved interpretation of regulation from the Medicaid department is often not appropriate.
4. Timeliness of the medical review and appeals process.

We have had a positive working relationship with Medicaid for about the last 4 years although some issues remain to be resolved. At one time here Medicaid was denying every claim related to children because they stated it was "impossible for a child to be homebound", need I say more. That issue has been resolved.

WISCONSIN
1. Our first priority is Medicaid funding for home health services. The Kaiser Family Foundation's survey found that Wisconsin is among 10 states that are at immediate risk for cuts to MA reimbursement rates. Our state budget is about 10% in the red and everyone is looking for places to cut. Cuts to home care rates would be a disaster, because we're already operating in the red. In preparation for the battle, we recently surveyed our members on their MA costs, then balanced them against their reimbursements. The results are below.

Thirty (30) of our 90 members replied.

**RN/LPN costs:**
27 provided data.
*Average loss is $39.31*
15 could break out paperwork costs
*Average paperwork cost is $51.07*

**HHA costs:**
26 provided data
*Average loss is $27.09*
12 could break out paperwork costs
*Average paperwork cost is $23.10*

**PT costs:**
23 provided data
*Average loss is $34.92*
10 could break out paperwork costs
*Average paperwork cost is $29.05*

**OT costs:**
19 provided data
*Average loss is $36.21*
7 could break out paperwork costs
*Average paperwork cost is $15.64*

**ST costs:**
13 provided data
*Average loss is $24.10*
4 could break out paperwork costs
*Average paperwork cost is $11.56*

**Medication Management costs:**
18 provided data
*Average loss is $55.13*
10 could break out paperwork costs

**Average paperwork cost is $52.63**

**PCW costs:**
19 provided data

**Average loss is $18.60**
13 could break out paperwork costs

**Average paperwork cost is $11.17**

**PD RN costs:**
3 provided data

**Average loss is $7.94**
1 could break out paperwork costs

**Average paperwork cost is $26**

**PD LPN costs:**
3 provided data

**Average loss is $6.47**
1 could break out paperwork costs

**Average paperwork cost is $19.50**

2. Our second priority is revision and simplification of our state home care regulations. As you can see above, our paperwork costs are frequently the reason we’re in the red. Now, among the dozens of gripes we have about the regulatory burden, we are still working out what our priorities are.

3. Our third priority is repeal of a set of moronic so-called anti-fraud measures based under the guise the last state budget bill. We introducing a bill within the next couple of weeks, and we’ve built a strong coalition among other MA providers.

4. Our fourth priority will be to shift the state’s MA preference for institutional care over community care. For the many years that Tommy Thompson was our governor, the nursing homes pumped tens of thousands of dollars into his campaign war chests and we’re still feeling the effects.

5. Our fifth priority will be to elect pro-Medicaid and pro-home care candidates in the upcoming legislative and gubernatorial elections.