



HUMAN SERVICES
DEPARTMENT

**Presentation to Legislative Health and Human
Services Committee**

Long-Term Care Services/Personal Care Services

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Key Policy Changes → Expansion

- ▶ Effective 1 / 1 / 2014, two key policy changes are driving increased utilization and expenditures for Home and Community-Based Services (HCBS):
 - Centennial Care (CC) waiver allows any individual enrolled in CC who meets a nursing facility (NF) level of care to receive HCBS waiver services, including Personal Care Services (PCS), without having to wait for a waiver slot
 - Medicaid Adult Expansion:
 - Newly eligible adults also able to receive HCBS services without waiver slot if meet nursing facility level of care criteria

Pre-Centennial Care: PCS Utilization/Expenditures- 2013

Calendar Year 2013	Users	Expenditures	Unit Cost	Average Spend per User	
Long Term Services & Supports (LTSS)/PCS	January - December	19,500	\$ 263,072,327	\$ 13.51	\$ 13,491

Post Centennial Care: PCS Utilization and Expenditures- 2014

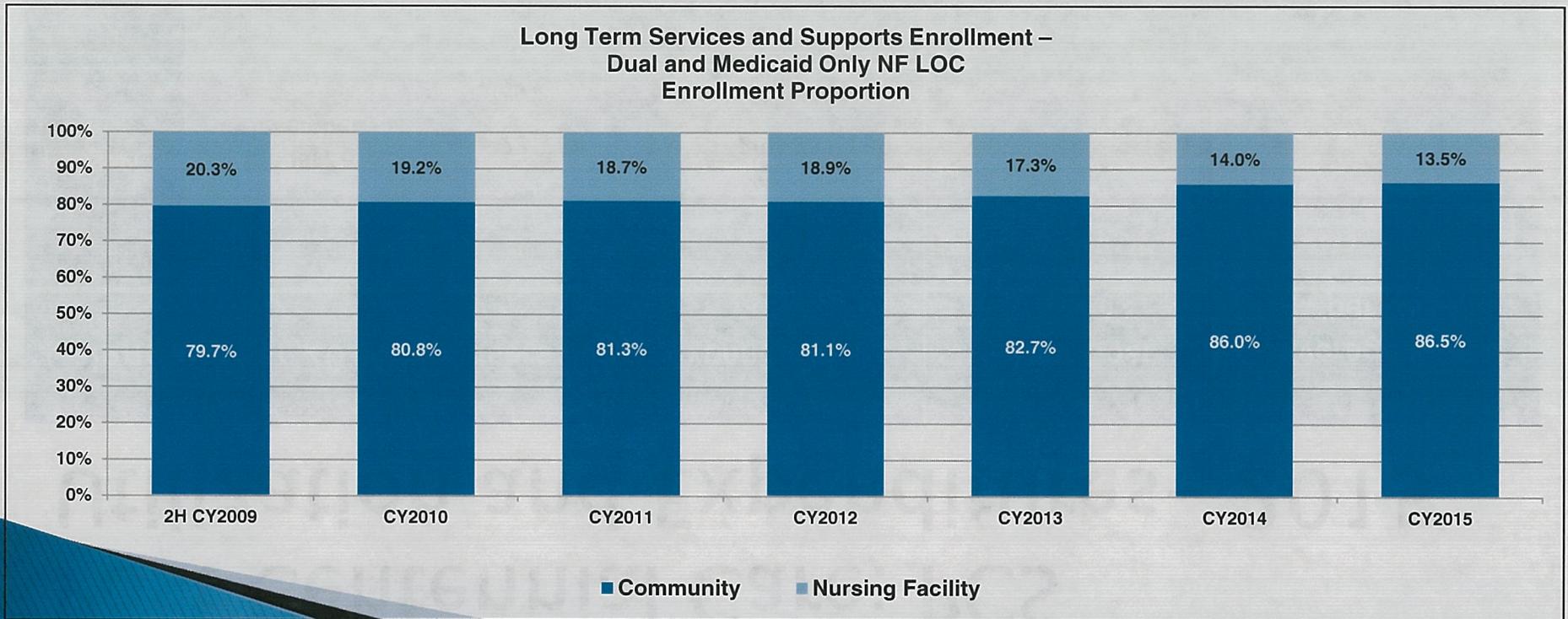
Calendar Year 2014		Users	Expenditures	Unit Cost	Average Spend per User
LTSS/PCS	January - December	22,218	\$ 265,258,506	\$ 13.89	\$ 11,939
Adult Expansion	January - December	1,427	\$ 749,434	\$ 13.81	\$ 525
LTSS + Adult	Total	23,645	\$266,007,940	\$ 13.89	\$ 11,250

Post Centennial Care: PCS Utilization and Expenditures – 2015

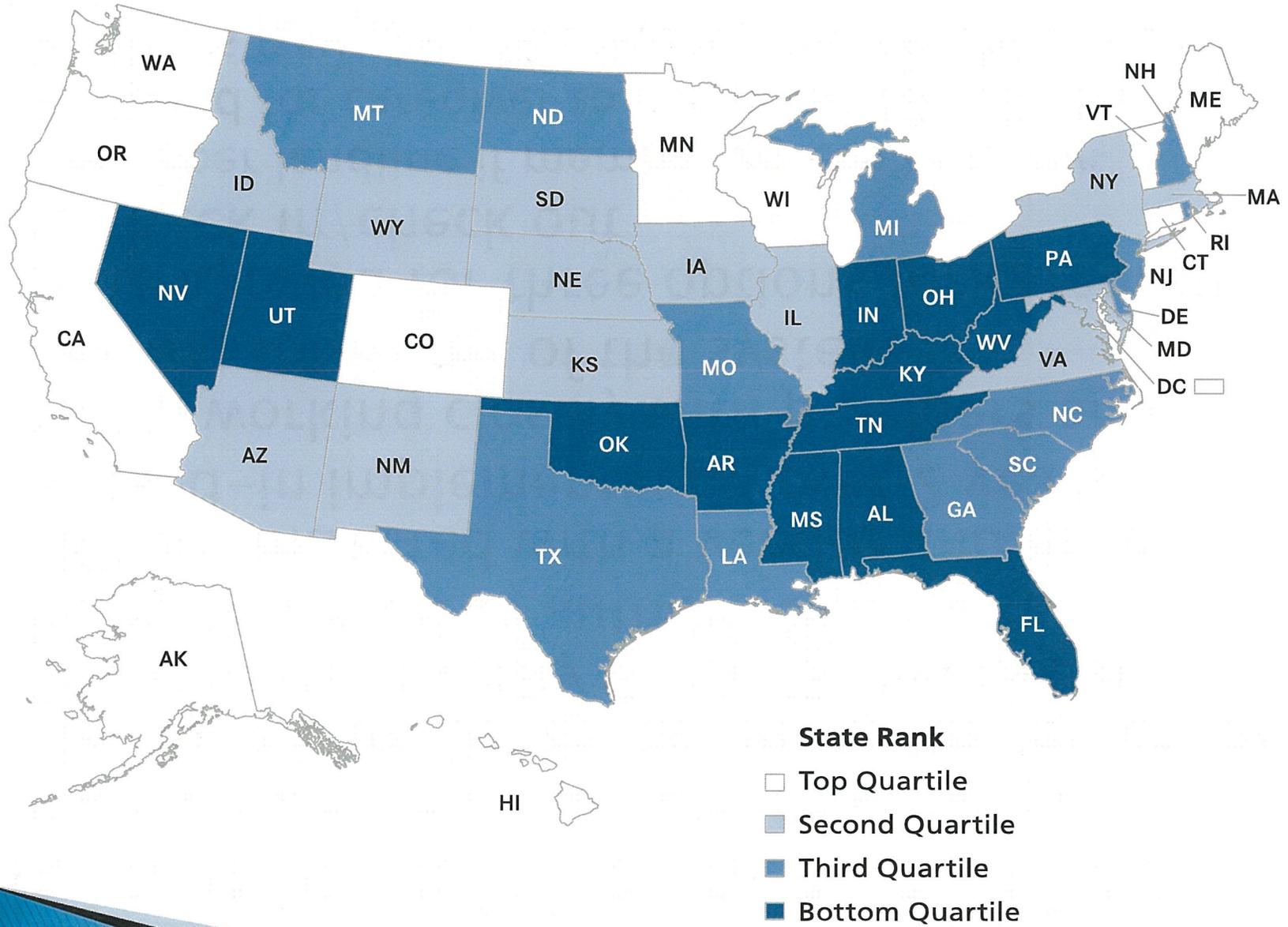
Calendar Year 2015		Users	Expenditures	Unit Cost	Average Spend per User
LTSS/PCS	January – December	23,784	\$ 269,281,139	\$ 14.19	\$ 11,322
Adult Expansion	January – December	3,099	\$ 11,246,257	\$ 14.20	\$ 3,629
LTSS + Adult	Total	26,883	\$ 280,527,396	\$ 14.19	\$ 10,435

NF Services vs Community Benefit

- ▶ Managed care has had positive impact on the proportion of Community Benefit utilization vs Nursing Facility stays
- ▶ Centennial Care introduced the Community Benefit and removed the requirement for a waiver slot to access home & community based services



State Ranking on Overall LTSS System Performance



Source: State Long-Term Services and Supports Scorecard, 2014.

Electronic Visit Verification (EVV)

- ▶ Requirement in Centennial Care for the Managed Care Organizations to implement an EVV system to verify that PCS services are being delivered as authorized
- ▶ MCOs contracted with a vendor and have phased-in implementation over 2 years
- ▶ MCOs working closely with providers and bearing total cost of the system
- ▶ State allowed for three options for caregivers to check in/check out
 - Member landline if member agrees to allow
 - Stipend for caregiver to use personal cell phone
 - Tablets issued by PCS agency and purchased by MCO

Electronic Visit Verification

- ▶ Federal Office of the Inspector General has identified personal care services provided in Medicaid as high risk for fraud, waste and abuse
 - ▶ The United States House Energy & Commerce Subcommittee on Health Passed Legislation requiring EVV for Medicaid personal care & home health care services
 - ▶ HR Bill 2446 was rolled into section 207 of HR Bill 2646 and passed the House by a vote of 422–2 on July 6, 2016. It has now moved to the Senate for review.
 - ▶ The Federal bill will penalize any State that does not require the use of an EVV system for personal care by January 1, 2019 and home care services by January 1, 2023.
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Medicaid Cost Containment

Provider Payments Subcommittee

Charge: Recommendations for reducing provider reimbursement rates effective 7/1/16 in accordance with HB2.

- Savings goal = \$30 million GF
 - Recommendations received from subcommittee on April 8th and included only 1% reduction for Community Benefit Providers
 - HSD proposal issued on April 22nd based on subcommittee's recommendations, but with additional reductions to achieve savings goal.
 - HSD elected not to increase the 1% reduction for Community Benefit providers
 - Provider rate reduction savings = \$26-\$33.5 million GF
 - After reductions, FY17 deficit projected at \$34 million GF
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