

**LB 952 - Testimony
Appropriations Committee
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Good afternoon, Senator Heidemann and members of the Appropriations Committee. My name is Vivianne Chaumont (V-I-V-I-A-N-N-E C-H-A-U-M-O-N-T), Director of the Division of Medicaid and Long-Term Care with the Nebraska Department of Health and Human Services. I am here to testify in opposition of LB 952.

Nebraska State Statute 68-905 states that the Medicaid program shall be appropriately managed and fiscally sustainable. I believe we, as a state, have made a concerted effort to bend the cost curve of the Medicaid program to ensure the program is sustainable. However, this has required difficult decisions particularly in light of federal mandates. In Fiscal Year 2011, the Nebraska and CHIP Programs spent more than \$1.57 billion meeting the needs of vulnerable Nebraskans. These numbers represent the ongoing needs of more than 235,000 individuals and the very real solutions we provide as a State.

It is important to note that between fiscal year 2010 and 2011, there was an increase of 10,894 Nebraskans served by Medicaid and CHIP and the total increase in average monthly eligible individuals was 4.9%. Medicaid eligibility is projected to increase by an additional 4.2% in fiscal year 2012. In December of 2011, eligibles had increased to more than 237,000.

Managing the growth of the Medicaid program requires difficult decisions and impacts real people. However, the program must be sustainable for the 237,000 plus individuals that rely on the program every day.

The proposals included in my December 1, 2011 letter, and included in LB 952, is in keeping with our mandate to manage the growth of the Medicaid program.

The Governor recommends reductions of \$3,382,913 in General Funds and \$4,302,032 in Federal Funds for the Medicaid Program for FY 2013, as well as reductions of \$8,319 in General Funds and \$18,681 in Federal Funds for the Children's Health Insurance Program for FY 2013, to reflect savings from proposed changes to the Medicaid and CHIP programs. These reductions are based on the Department's December 1 letter to the legislature and would have an implementation date of January 1, 2013.

One recommendation increases co-payments for physical, speech and occupational therapy visits from \$1 to \$2 per visit. We currently have a \$2 per visit co-payment for practitioners such as physicians and dentists as well as for behavioral health therapy visits. This increase allows the program to be consistent with the application of co-payments.

The non-emergency use of Emergency Departments by Medicaid clients has long been recognized as a costly problem. Non-emergency issues and chronic conditions should be treated by a primary care provider, not by an expensive visit to a hospital Emergency Department. The co-payment of \$50 per non-emergency visit to the Emergency Department is a cost effective way to discourage those who do not need to visit an Emergency Department from doing so. If the visit was indeed an emergency, the co-payment will not be required.

The overuse of Emergency Department use for non-emergency diagnoses is well documented through the current Patient Center Medical Home Pilot Program. Both practices in the pilot have implemented programs within their clinic to track Emergency Department misuse and work to improve appropriate utilization.

In the August 2, 2011 Medical Home Council Meeting, physicians from both practices brought examples of inappropriate use of the Emergency Departments and asked for assistance in finding solutions. In one clinic, nearly 100 patients were identified as misusing Emergency Departments in a 3 month period. In another clinic, 274 clients were identified in a 6 month period. The clients stated various reasons for choosing to use the Emergency Department for non-emergency care: client wait time, after clinic hours, outstanding charges with the clinic. Numerous clients presented at the clinic office and when told the wait time was 30 minutes, left the clinic to walk across the block to the Emergency Department. The physicians with the clinic are then pulled out of the clinic to provide services to the Emergency Department to the client that had just walked to the hospital.

We are proposing a reduction of home health services to 240 hours per year. As of 2008 data, 29 states have identified limits on home health services including 3 surrounding states with limits of 100, 120 and 240 visits per year. This limitation will impact less than 5% of current clients receiving home health services. The limitation mainly impacts clients who are authorized for a large amount of home health aide hours. There has been concern expressed that this will result in institutional care. This is not the intent. We believe it is important for people to be able to stay at home and have in fact developed programs for that purpose. Appropriate care for clients can be provided through the Home and Community Based waivers and Personal Assistance Services. The hourly rates of those services are about half of the hourly rate of home health aide services. The Home and Community Based waiver can currently serve these clients. I want to add, however, that we know out-of-home care is not always more costly.

The Nurse Practice Act allows Personal Assistance Services and waiver providers to be reimbursed by Medicaid for any task that an individual can be trained to do for a family member. These tasks include ostomy, wound, skin and ventilator care such as suctioning; provision and application of medication; injections into veins, muscles or skin, insertion and care of catheters. The variety of these services, along with home health services up to 240 hours per year, provides options for people to continue to live in the community.

Person A is a man in his 30s with quadriplegia as the result of a spinal cord injury. He has a tracheostomy and requires the assistance of a ventilator 24 hours/day. He requires assistance with ventilator care and monitoring, catheter care and all activities of daily living. Almost 2 years ago, this client chose to transition from Home Health services to the Aged and Disabled Waiver. He continues to receive Waiver chore services in his home. One of his chore providers is a home health agency. The current cost of his Waiver services is approximately \$16,500 per month 27% less than the charge for nursing facility care and substantially less than what the services would cost if provided only by home health.

Person B is a man in his 40s with quadriplegia, who requires 24-hour a day assistance from a ventilator as a result of a spinal cord injury. He requires assistance with all activities of daily living. He lives in his own apartment and self directs his own care. He has managed his own care successfully for a number of years. His current care is provided by a combination of RNs, LPNs, home health aides and personal assistance service providers. He currently has 14 individual personal assistance providers he has trained to safely provide his care. If he chose to transition to the Aged and Disabled Waiver, he could continue to receive services from his current providers, schedule his caregivers and direct his own care. He would also have the availability of a services coordinator, should he need or want this assistance. The cost of his care would decrease.

Person C is a woman in her 40s with quadriplegia as the result of a spinal cord injury. She does not require ventilator assistance or have a tracheostomy, but does require physical assistance with her non-medical activities of daily living. She is able to assist with her catheter care. She currently receives a combination of RN, LPN and home health aide services through a home health agency. Should she choose to transition to the Aged and Disabled Waiver, her care needs could continue to be met and she would have a services coordinator available to assist in managing her care, rather than having it managed by her paid service provider. The cost of her care would decrease.

Person D is a woman in her 50s with muscular dystrophy. She has a tracheostomy and needs assistance with all activities of daily living. She

currently has 15 personal assistance providers trained to provide her care. She arranges their schedule and self-directs her care. She uses a home health agency as back-up support in case of an emergency.

The Department recommends the elimination of Private Duty Nursing, an optional service under federal law. According to 2008 data, 28 states do not cover this service including 5 of the surrounding states. Those that do have the service place limits. Clients receiving the Private Duty Nursing services would be eligible for the more cost effective community based services such as PAS or Chore through the Home and Community Based Waivers. Additionally, medical child care and respite services through the Home and Community Based waiver could be used to maintain the care of children while parents go to school or work.

Children who would be impacted by the limitations on extended hours of nursing care could also choose to receive Waiver Child Care or Respite services. The Aged and Disabled Waiver program currently enrolls individual providers, home health agencies, and independent nurses as Child Care and Respite providers.

Children with high medical needs are currently authorized for RN or LPN services up to 20 hours per day, to allow the parent or caregiver to work, attend school or sleep. Additional hours are authorized as respite for the parent or caregiver. This means that parents are responsible for providing their child's care for 4-8 hours per day.

The remaining 16 to 20 hours are covered by RNs or LPNs who provides one-to-one care. As a comparison, an individual receiving 24-hour care in a nursing facility or hospital would typically receive services provided by an aide, with occasional services, assessment and monitoring provided by an LPN or RN. It would be rare for a nursing facility or hospital to staff a patient one-to-one with a nurse, 24 hours/day.

If an individual has a family member who needs care, they are often trained to provide this care by a nurse or the physician. This can include ventilator and ostomy care, injections, wound care, etc. Family members are taught to monitor the individual and respond in specific ways, should a problem arise. An amendment to Nebraska's Nurse Practice Act allows non-nurses to provide the same care as a family member and allows those individuals to be reimbursed by Medicaid.

Person E is a young boy with a tracheostomy who uses a ventilator for assistance with breathing 24 hours a day. He has multiple medical needs. He is currently authorized for 48 hours/week while his parents are at work, 56 hours/week to allow them to sleep and 16 hours/week for respite. His parents are responsible for providing 48 hours of his care each week, approximately 7 hours/day. His care needs could be met by Waiver services.

Person F is a young woman who experienced an injury at birth resulting in severe brain damage. She has a tracheostomy, seizures and other medical conditions. She is currently authorized for 16 hours a day of nursing care while her parents work, sleep and have a respite from providing her care. Currently her parents are responsible for providing 8 hours a day of her care. When she turns 21 in a few months, her family will need to look at other options for her care. Her needs could be met through waiver services.

When faced with cost limitation on skilled nursing care, families sometimes choose to provide more of the child's care themselves. Sometimes they rely on a combination of RNs, LPNs and trained individual providers to provide the care and sometimes they consider facility care. If the family chose to consider Waiver services, a service coordinator could explore options for meeting the child's needs in the community within the cost limitations of comparable facility care, prior to her 21st birthday.

I want to share with you some highlights about a few of our clients who receive services through the waiver:

Person G is a married man in his 60's who lives in rural Nebraska. His hometown has a population of under 1500. He has a neuro-muscular disease, which has caused him to use a wheelchair and also depend on a ventilator to survive. He requires complete physical assistance with all basic activities – dressing, bathing eating, as he cannot move his arms, legs, hands, toes. He lives at home, which has undergone some modifications, like a ramp. He has trained providers on how to assist him, and they are paid under \$4000 per month. This is far under what Medicaid would pay to a nursing facility for services. He has friends; he is active in community events; he is home.

Person H is in his late 30's and lives in Lincoln with family. He too has a neuro-muscular disease, has quadriplegia, and is on a vent. He is assisted by another person to eat, get dressed, brush his teeth and shave. Two people generally help on shower days. He and his family are committed to life at home. Various family members provide assistance, as well as other individual providers, who have been trained on his specialized cares. He is rarely hospitalized – which indicates quality services are provided to him.

We have a little 6 year old girl, **Person I**, who lives in Western Nebraska. She uses a wheelchair due to her disabilities. Respite providers have learned how to care for her as she needs someone to help her eat, get dressed, transfer out of the wheelchair. They have been trained on how to use a urinary catheter. She goes to school and other activities. But most importantly she is at home with her Mom and Dad.

It has been stated that waiver services are not a viable option for clients subject to the limits in home health and private duty nursing because of the Waiver Cap. This is simply not true. Currently, if the cost of the individual's care exceeds the standard Waiver cap, then a request can be submitted to Central Office for an exception to the cap. To determine the cap exception amount, the individual's care needs are compared to the cost of providing his or her care in a nursing facility. If necessary, Nebraska can also request to amend the current Medicaid Waiver to accommodate the needs of specific populations, include adding private duty nursing services for individual with high medical needs.

The Department proposes two changes to the Personal Assistance Service program. The first is to require that clients meet the level of care necessary to be eligible for nursing facility care and Home and Community Based waiver in order to receive Personal Assistance Services. This requirement ensures that the service is provided to clients in lieu of the more expensive nursing home care.

The second change is to limit the Personal Assistance Services to 3.5 hours per day or not more than 60 hours per month per client. Using a combination of PAS, home health and waiver services, a client can still have the care necessary to remain in the community. Again, the change in these services will not necessarily result in institutional care.

Individuals who meet nursing facility level of care criteria and require more than 3.5 hours/day of personal assistance services would be eligible for Waiver services. Adults would be eligible for Waiver Chore services and children would be eligible for Waiver Child Care and Respite services.

As of 2008 date, twenty states do not offer PAS programs. Of the six surrounding states, four do not provide this service.

We propose that Medicaid stop paying for oral nutritional supplements such as formula and drinks such as Boost and Ensure. Nutrition taken via a tube or food mixtures given into the blood through an IV would still be covered. Medicaid should not be a food program. Other programs such as the Women, Infants and Children food program and SNAP are in place for nutritional needs. Medicare does not pay for nutritional supplements that are taken orally and this is not a benefit covered by private insurance. I repeat, nutrition taken via tube or IV would still be covered after implementation of the reductions identified in the December 1, 2011 letter.

The Department proposes to limit behavioral health services to 60 outpatient therapy visits per year. This limit would provide parity with the current limit of 60 outpatient physical health therapies per year. The vast majority of Medicaid clients do not currently exceed the limit of 60 mental health therapy visits per year. Limits applied in other states vary from 12 to 52 visits per year. Of the 34 states where the Medicaid

program offers mental health therapy services, a majority limit those services to one time per week or less.

Person J is an adult living in an assisted living facility and diagnosed with bipolar disorder, who had a frequent amount of individual psychotherapy with and without medication management across the entire year. Under the proposed limit, this person would be reduced from having therapy once every 5 days to once every 6 days, which is still more than one therapy session per week all year long. Medication management would still be covered without any limitations per year.

Person K is an adult who did not receive routine therapy sessions but, instead, had nearly daily individual psychotherapy with medication management for two months. It would be highly unlikely, from a clinical perspective, that a person could benefit from that intensive level of psychotherapy.

Person L is a youth who was receiving up to eight family therapy sessions per month, though the client was only four years old. It isn't clear how much intensive psychotherapy a client of this age would benefit from.

Making the necessary changes to the Medicaid program is difficult. Our goal has been to ensure that limited resources are used efficiently and effectively to provide safe and appropriate services. The Medicaid program currently provides services to more than 237,000 clients. We propose these measures to ensure that it remains a viable program for meeting the basic health needs of needy Nebraskans.

Thank you for the opportunity to testify. I would be happy to answer any questions you have.