Caring for Kansans at Home

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TO: Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

FROM: Jane Kelly, Executive Director, Kansas Home Care Association

## *Issues with KanCare for Home Care and Hospice Providers*

## *October 7, 2013*

On behalf of the Kansas Home Care Association, I appreciate this opportunity to make comments on the effects of the Medicaid Managed Care (KanCare) thus far to the Home Care and Hospice providers of our association.

For the agencies that are members of Kansas Home Care Association, which accounts for about half of the Home Care Agencies in Kansas – there are approximately 31,500 patients cared for in their homes. Of that number, approximately 16.5% are Medicaid patients. We can only assume that this number would be doubled with the agencies that are not members of the association.

Let me first start by telling you that home health patients and the agencies that care for them have already absorbed $72.5 billion in Medicare cuts since 2009 from CMS and the federal government. In its draft Home Health Prospective Payment System rule for 1014, the Centers for Medicare and Medicaid Services (CMS) proposes to further reduce Medicare home health funding by instituting a rebasing rate set at the maximum level permitted by law. The rule calls for a cut of 3.5% each year from 2014 to 2017, which would total a full 14% cut to the Medicare home health benefit. What this would mean to Kansas is that by 2017 69.2% of the home health agencies in our state would be operating with a Medicare margin at or below zero percent. That is an average figure...for those in all but the 3rd Congressional district, the figure is much higher.

So, how does this relate to our discussions today? Simply, Kansas home health agencies are NOT starting with a full pocketbook when we get to the Medicaid discussion. No healthcare sector can continue to serve seniors and disabled. We are steadily losing home health agencies because they cannot afford to stay open. This has a direct impact in particular in the rural areas where they have relatively few choices in either acute or long term care. Many of our agencies are county hospital or health department based...we are seeing some of these closing because the hospital has to make cuts somewhere and home health is the likely target. The nurses, home health aides and therapists must travel, many times – many m
which is an added expense.

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All of this has a domino effect – Medicare cuts equal fewer home health agencies to care for patients, which equals fewer providers that can afford to care for Medicaid patients. Even the providers that can afford to hang on with the Medicare cuts will not be able to afford to see the Medicaid patients.

So that brings us to our problems today. The home care AND hospice providers have been seeing a drastic increase in denials for patients that have received authorization before, in unpaid claims, in the amount of time staff has to spend trying to get pre-authorization, in getting questions answered, in trying to correct claims that come back with incorrect information, and many times when they do get payments, they are not for the correct amount. Let's please remember, that although many providers are not-for-profit, these are businesses...could you run your business like this and afford to stay open? Not for long!

Allow me to give you just a few examples of what my providers are seeing.

"I am spending on average 14 hours per week trying to get my claims paid correctly. I have reached out for help from case managers, customer service, provider reps, provider relations advocates and KDHE. Of the claims that have been paid, very few are correct amounts, which leads to more time spent." This same provider says, "With one patient in particular, I did not file the claim initially as the authorization was incorrect. I thought I would save time and frustration by waiting until the authorization was corrected. Then I got a denial for untimely filing. More time spent fighting this."

From another provider, "I pre-authorized to the MCO, and then have to bill Medicare for a service that is clearly not covered. Then bill the MCO, which is double my time. It costs Medicare money to process the claim – then bill the MCO...this takes forever. All for a $50 visit." Hours spent and take such a loss, the question becomes, can we even afford to provide services to Medicaid patients?"

Another provider explains that all of her Medicaid patients were on home health with prior authorization from the state of Kansas through March 31st of this year – all but one has had denials from the MCO's. After going back through these cases – none have been paid fully – most have actually had zero payments or just one or two payments made sporadically through the year without any explanation as to why." This provider is referring to issues with Sunflower State Health – after emailing an official with Sunflower, this provider was called one week later from the area rep, who told her to re-fax all the information and that she would get them through quickly and they would have reimbursement by the end of "next week" which would have been September 13th. To date, they are still waiting. This same rep told the provider's biller not to file a claim dispute because it would take longer. Nothing has happened and she has yet to receive a call back. Again – these are all patients that the provider had pre-authorization for And Sunflower had the information on these patients long ago.

These providers were told that they would be working with the same benefit – clearly they are not. One provider said they noticed that the last week of September their home health and hospice manuals had a statement that was new, saying, "these manuals only apply to the pre-MCO Medicaid program."

Some similar comments from another provider – this provider received a piece of advice from one MCO stating if she didn't think she would have her clinical documentation ready to submit in time, she could use the referral papers from the discharging hospital or ordering doctor to request visits. The provider tried this and received a fax back that her request was incomplete.

To continue with issues with Sunflower – this is from yet a different provider – she has a partial claim from January still outstanding; another claim from April outstanding. Mid-way through these past nine months or so, they decided to make the home health authorization requests to Cenpatico and did not tell anyone. By the time the provider figured it out, Cenpatico denied for untimeliness. After multiple emails and getting pretty pushy – provider got it pushed through and paid – but not at their contracted rate. For HCBS: Patient co-pays are not being deducted correctly or not at all; authorizations are not correct; authorizations not in KS AuthentiCare correct; also not being paid contracted rate.

Provider issues with AmeriGroup – One provider says that after attending a teleconference in May with all three MCOs – they were told each plan's basic authorization request work flow was to make the initial request for the first two weeks of their 60 day certification period, then submit the remaining request after the admission note and Plan of Care and visit frequency were complete. As of September 18th, the provider received a letter from AmeriGroup on a particular patient, which stated, "The McKesson Interqual criteria we use does not allow us to authorize skilled nursing visits over two weeks duration at one time." Provider states, in the nine months she has been working with the MCOs, this is the first she has heard of this, while at the same time, she is getting authorization for OTHER patients (with AmeriGroup) greater than two weeks at a time. If this is the case, obtaining authorizations are going to be exponentially more burdensome then they already are – creating yet again – enormous amounts of staff time for less than the cost of care. Another provider states that with AmeriGroup – patients co-pays are not being deducted correctly, sometimes not at all; authorizations incorrect; authorizations not in KS AuthentiCare correct; claims denied for untimely filing, yet the authorizations are not correct.

For United Health Care – one provider says that a particular patient has been receiving services authorized for nine months with no trouble. On September 10th, the provider received a denial letter for services dating back to July 28th. She has made several calls and submitted written or faxed documentation to appeal this denial. She states that United is one of the most difficult to deal with because she never talks to the same person twice – the second person she talks to can't see the documentation from the first person she talked to, so she has to start completely over with each call. She was finally told that the ordering doctor's office would have to call in and request a peer-to-peer review. Provider spoke with the doctor's nurse who states she called the MCO and was told to expect a call back within 48 hours. That was over a week ago at the time of September 30th and the RN had still not received a call back for this review. The home health provider will have to dismiss the patient from their agency if they cannot get some kind of feedback from the MCO. And I'd like to add here that – if this occurs – you can guess where the patient will end up – in the ER which will cost even more Medicaid dollars! Another provider says about United that their claims in June started paying at 90% for some codes; a claim was paid twice, recouped from an HCBS claim, then a recoupment demand was received.; also not being paid at contracted rate.

Then for their HCBS patients – some claims are randomly being paid at 90%; some of the authorizations are coming back with the correct codes but under their hospice name and not their home health; some authorizations incorrect; some authorizations not in KS AuthentiCare correct; and again, not being paid at their contracted rate.

Many of the agencies that belong to Kansas Home Care Association are also Hospice providers; so for the Hospice issues – one provider says they have a huge hospice room and board problem and doesn't think the MCO even knew there was a room and board component. Another provider says prior authorization for room and board in a long term care facility are erroneously denied; prior authorization for room and board in a long term care facility are erroneously entered as one day; Medical spend downs and 'co-insurance' are being erroneously applied to room and board claims; Patient liability for room and board not being applied correctly to claims; authorizations not being approved until weeks after the request – many times after the patient has already died; 95% of claims have paid incorrectly or not yet paid; provider says rarely do we get the same answer from two people within each MCO, for example where to fax authorization requests, reason for claim denials, even whether we are contracted or not. Sunflower and United both are not paying at contracted rates. Take backs for overpayments are being issued and collected whether they are correct or not.

Lastly, even our associate members, which are vendors, are telling us their accounts receivable have more than doubled due to issues they are having – one vendor (a home infusion company) said this was in particular with AmeriGroup. Also issues with Sunflower. They seem to get response from calls, yet no resolution to the problems.

With home care being a fraction of the cost of hospital or nursing home care, it does not make sense to ask the providers of home health care to operate at less than the cost. They are providing a much needed service to patients, while saving the state literally hundreds of thousands of dollars. Our home care and hospice providers are asked to provide quality care and they do so. They are surveyed by the state and by Medicare for their care and operations – but yet, they must operate more and more in the red because they are seen as a last resort of care instead of the first. There will always be people who, because of the nature of their illness or disability, or because they have no caregivers, will be best off in a nursing facility or other residential care setting. And the nursing home option should be available to them. But most people can be cared for at home and want to be. They deserve the opportunity to get this help in the setting of their choice. And those that provide this care deserve to be paid in a timely and efficient manner and not in such a way as to cost them MORE money in time spent by staff to deal with the problems that they are dealing with right now with Medicaid Managed Care. If Kansas wants to continue to provide cost effective care for those people that qualify for Medicaid, our home health and hospice agencies need to stay open. In order to do this, they need to be able to operate efficiently within the KanCare system.

Thank you for hearing the issues and I do hope we can count on the Oversight Committee to carefully examine the problems and hold the MCOs accountable for the service they were contracted to provide.