



Almost Family, Inc.

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November 28, 2014

Via e-mail and hardcopy
Diona.Mullins@ky.gov

Diona Mullins, Policy Advisor
Office of Health Policy
Kentucky Cabinet for Health and Family Services
275 E. Main Street, 4W-E
Frankfort, Kentucky 40621



Dear Ms. Mullins:

On behalf of Almost Family, Inc. ("AFAM") and as CEO and Chairman of the Board of the Company, I write to respond to the October 8, 2014 Special Memorandum of the Cabinet seeking stakeholder input upon the core principles stated therein for certificate of need modernization. AFAM is a Kentucky based company and a leading regional provider of skilled home health, personal care and ACO health management services operating in 14 states with over 240 offices and 12,000 employees.

As strong supporters of our Kentucky community-based home health agencies and the thousands of elderly and disabled patients we serve, we offer the following comments related to the principles you set forth and urge your attention to these issues. We are confident our proposals position homecare to meet your stated goals to improve the quality of post-acute care in a cost effective manner. As a guide to this response, we have structured it as follows:

- Background on AFAM in Kentucky and Across the Nation***
- Principles of a Home Based, Patient Centric Post-Acute Care System***
- Incentivizing Quality and Improving Access to Care: AFAM-Imperium ACO Enablement Company/ HH CON Criteria Proposal***
- Improving Access to Care: Presumptive Homecare Medicaid Eligibility Proposal***

Background

AFAM, and its predecessor company Caretenders, were founded by myself and several others in Louisville, Kentucky in 1976. I was born and raised in Louisville and both my parents and I and extended family have been active in the religious, cultural, charitable and business life of the city and state for over 60 years. The purpose of the company initially was to address a perceived need in the community for senior in home services. From modest beginnings and with only 7 employees in a small office in Louisville, the company evolved to become a major, national provider of skilled home health and personal care services. AFAM is a publicly held company on the NASDAQ exchange and is proud of its stated mission of "Excellence Through Senior Advocacy".

We now have over 26 offices in Kentucky and 1300 employees including our home office in Louisville. We strive each day through our employees to provide cost effective, quality care to seniors in need of pre and post-acute homecare services. **It is our judgment home healthcare has a bright future and will play a key role as an extender of the Medicare Trust Fund and state Medicaid dollars by providing skilled and personal care services in a patient's home which is the lowest cost venue for care in relation to institutional options.**

Principles of a Home Based, Patient Centric Post-Acute Care System

Home health services therefore should be enhanced through the development of policies which focus on the patient and his or her primary care physician and physician extenders working in concert as patient advocates. This work should emphasize the management of patients through routine interventions while patients live in their own homes so as to prevent the development or worsening of chronic conditions that may otherwise result in costly institutional admissions. **Instead of focusing on systems that reduce hospital readmissions, cost effective homecare intervention can greatly reduce hospital admissions in the first place.** The key features of an enhanced homecare program are:

- Shifting policy and payment models away from institution centric to a patient centric program in which primary care physicians work with seniors to be sure their preferences are recognized and they are served in the lowest cost setting. Access can be improved, family caregivers aided and hospital admissions lessened with presumptive Medicaid eligibility determinations for homecare.

-Payment systems should move from paying for cost to paying for value with an increased emphasis on institutional admission avoidance as opposed to simply reducing readmissions.

-Value Based purchasing models and shared savings programs including use of the ACO regulatory framework should be further developed to allow homecare systems to partner with physician led ACO's to reduce spend and improve patient care.

-Program integrity initiatives should be implemented to address abusive billing practices among isolated sets of homecare providers and maintain the Kentucky CON system for HH to avoid rampant fraud, uncontrolled expenditures and lack of care in rural areas.

Incentivizing Quality and Improving Access to Care: AFAM-Imperium ACO Enablement Company/ HH CON Criteria Proposal

The Special Memorandum suggested the exempting of services for which CON is no longer necessary within the context of "modern healthcare trends" including innovations within the Affordable Care Act ("ACA"). AFAM strongly opposes the elimination of CON as it relates to homecare and believes access to care in areas of need can be

addressed by other means. States such as Tennessee that eliminated homecare CON years ago regretted the decision and have reinstated it. In that state the number of homecare providers ballooned to over 700 from about 170 in a few short years when home care CON was eliminated in the early 90's and access in rural areas suffered as providers tended to congregate in urban settings. (Source: Jeff Ockerman, Tennessee Health Policy Director, jeff.ockerman@tn.gov)

Further, the incidence of fraud in the provision of HH services in states without CON is demonstrably exorbitant and rampant. See a PDF (below) of the March 2013 MedPAC report on Home Healthcare noting pages 200 and 207 for specific references to and material about HH fraud problems in states such as Texas and Florida that do not have CON. While this references principally Medicare fraud, these states experience significant Medicaid fraud problems as well. Also see:

2. A link, following this sentence, to the January MedPAC home healthcare presentation in which SLIDE 9 specifically calculated the savings to be nearly \$1 billion with a reasonable limit on homecare episodes in the 25 counties in states without CON with clearly excessive billings as determined by MedPAC. <http://www.medpac.gov/transcripts/HHA%20Public%200113.pdf>

3. A link to the recent report of the Institute of Medicine last 6 pages of which specifically highlights the homecare excessive billing problems in Texas and Miami Dade. <http://www.iom.edu/Reports/2013/Geographic-Variation-in-Health-Care-Spending-and-Promotion-of-High-Care-Value-Interim-Report.aspx>

One critical innovation within the ACA was establishment of the Accountable Care Organization ("ACO") framework and its shared savings program. Last year at a cost of \$5.8 million, AFAM acquired a controlling interest in Imperium Health Management, LLC ("Imperium") an entity that provides health management services to 4 physician led ACO's, 2 of which operate in Kentucky. The service territories in Kentucky of these 2 ACOs include the counties of Warren, Hardin, Jefferson, Bullitt, Hart, Marion, Allen, Butler, Edmonton, and Warren. AFAM is the only HH agency in Kentucky that has partnered with physician led ACO's.

We are convinced home health plays a key role in containing costs and that by linking home health care through the physician ACO vehicle it can deliver even greater savings to the healthcare system. Our intent with this proposal is to link the ACO model to HH services in already identified areas of need in Kentucky. The Deloitte Report for example in its HH section indicates Warren County as a priority county, in fact one of the few counties demonstrating critical need for HH services. AFAM through Imperium, while not licensed thru CON to operate in this county, provides services to an existing physician led ACO in this very county. Our proposal would open this county and others where ACO's operate to these services in a way we are convinced can meet this need in a most cost effective fashion.

Just recently, our ACO with a services area that includes Warren was recognized by CMS as having achieved better patient outcomes and savings below benchmark under the ACD Shared Savings Program. Accordingly, we would propose the Kentucky State Health Plan be amended as follows:

Notwithstanding the above criteria or any other provision to the contrary herein, an application by a federally qualified, physician led Accountable Care Organization ("ACO") under the Medicare Shared Savings Program or by an affiliated home health agency of such ACO, to establish home health services in a county in which it is not currently authorized to operate, but in which such ACO does operate, shall be found consistent with this Plan.

Improving Access to Care: Presumptive Homecare Medicaid Eligibility Proposal

Kentucky is at a critical juncture in its need to address the care demands of a growing elder population. Significant numbers of Kentuckians, many of whom are dual Medicaid/Medicare eligible, have multiple chronic conditions which we are convinced can often be cared for effectively in the home as opposed to more costly institutional care. **This position is strongly supported by the Deloitte Report issued last year by the Cabinet which specifically concluded Kentucky needs to “expand its rebalancing efforts” to transition away from an emphasis on costly facility care by providing greater incentives for home and community based services.** It seems time is of the essence in the need to address the critical care needs of our elder population by moving toward more home care. Recently, **the AARP, in releasing a major national study on elder care, ranked Kentucky last, 51 out of 51, in its care for the elder population and placed it 46th in terms of the percentage of its Medicaid dollars used for home and community based services.**

Among the states at the TOP of the AARP list for better elder services most have some form of presumptive homecare Medicaid eligibility or easy access to homecare state law provisions. Such states include New Hampshire, Washington State, Vermont and New York as well as Ohio. These laws provide a fast track to Medicaid eligibility with a shortened financial and functional disability assessment tool often providing for the completion of this process within 10 days of discharge. Some states have implemented these provisions by waiver or regulation but there is a growing trend to do so by statute as has been done in New Hampshire and New York State.

Typically these systems have a hard date at 45 or 60 days post presumptive eligibility determination for a final approval for payment with payments to providers beginning however at 10 days after presumptive determination. Error rates have been low at 2% or less per a study by the Kaiser Foundation and states such as Connecticut when they studied this projected about a 25% diversion rate from institutions to homecare.

Set forth following this letter are existing Kentucky statutory provisions already favoring home and community based services. Next is a proposed Kentucky homecare presumptive eligibility statute followed by the text of the New York State statute which includes presumptive eligibility for most all post-acute sectors? Lastly you will see an

interesting excerpt from some analytics done by Connecticut on the fiscal and patient value aspects of presumptive eligibility. It should be noted the AARP has testified on behalf of this initiative in other states most recently in Connecticut earlier this year.

Thank you for this opportunity to respond to the Special Memorandum of the Cabinet. We trust this material will be useful to you as you consider modernization of Kentucky's CON structure and urge you to feel free to contact me or our VP of Government Relations Denis Fleming anytime at 502-891-1000 should you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "William B. Yarmuth". The signature is written in a cursive style with a long, sweeping underline that extends to the right.

William B. Yarmuth
Chairman & CEO

Cc: Secretary Audrey Haynes
Emily Parento, Executive Director Office of Health Policy

Presumptive Homecare Eligibility Assessment Legislation

AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR THE KENTUCKY HOMECARE PROGRAM FOR THE ELDERLY

205.203 Authorization to provide in-home services to the aging -- Collection of fees.

(1)

(2)

(3)

(4) (5)

The secretary of the Cabinet for Health and Family Services may provide, in accordance with the contract between CMS, HHS and the Commonwealth, for in-home services to the aging to include, but not necessarily limited to: homemaker services; home-help therapy services; day-care services; home-delivered meal services; transportation services; foster care services; and health services.

Recipients of state-funded services pursuant to this section and persons who are determined to be functionally eligible for community-based services who have an application for medical assistance pending, or are determined presumptively eligible for Medicaid pursuant to (6) of this section, shall have the cost of home health and community-based services covered by the program, provided they comply with all medical assistance application requirements.

The cabinet is authorized to collect fees for services rendered pursuant to this section in accordance with a fee schedule adopted by the secretary for health and family services. The fee schedule shall take into consideration the ability of the patient or client to pay for such services. Fees shall not be collected from any person who is "needy aged" as defined by KRS 205.010.

The secretary may utilize and promote available or potential community resources for the delivery of services to the aging and shall, when he deems appropriate, contract for services with local, community, private agencies, and individuals, including relatives of

patients and clients, when such services would not otherwise be available without cost.

The services to the aging authorized under this section are in addition and supplementary to any services to which the aging may be entitled under any other federal, state, or local governmental law, regulation, or program.

The services to the aging authorized under this section shall be designed to meet the needs of the minority elderly as identified by the Cabinet for Health and Family Services pursuant to KRS 205.201.

(6) Not later than July 15, 2015, the Cabinet for Health and Family Services shall establish a system under which the state shall fund services under the Kentucky home-care program for the elderly for a period of up to ninety days for applicants who require a skilled level of nursing care in a home health setting and who are determined to be presumptively eligible for Medicaid coverage. Such system shall include, but not be limited to: (1) The development of a preliminary screening tool by the Department of Aging to be used by representatives of the access agency selected pursuant to subsection (b) of this section to determine whether an applicant is functionally able to live at home or in a community setting and is likely to be financially eligible for Medicaid; (2) authorization by the Commissioner for such access agency representatives to initiate home-care services not later than five days after such functional eligibility determination for applicants deemed likely to be eligible for Medicaid; (3) a presumptive financial Medicaid eligibility determination for such applicants by the department not later than four days after the functional eligibility determination; (4) a process whereby during the period of presumed Medicaid eligibility but prior to a final determination of such eligibility, payment shall be made to a certified home health agency for home health services provided under the medical assistance program pursuant to this section, and (5) a written agreement to be signed by such applicant attesting to the accuracy of financial and other information such applicant provides and acknowledging that (A) state-funded services shall be provided not later than ninety days from the date on which the applicant applies for Medicaid coverage, and (B) such applicant shall complete a Medicaid

application on the date such applicant is screened for functional eligibility or not later than ten days from such screening. The Department shall make a final determination as to Medicaid eligibility for presumptive eligibility applicants not later than forty-five days after the date of receipt of a completed Medicaid application from such applicant. In instances where an individual is presumed eligible for Medicaid is subsequently determined to be ineligible, the cost for services provided to such individual shall be paid nonetheless. Provided, however, if upon audit the Cabinet determines there are subsequent determinations of ineligibility for Medicaid in at least 10% of the cases in which presumptive eligibility has been granted in a local social services district the Cabinet shall establish procedures for recoupment and reimbursement of such payments.

(f) To the extent permissible under federal law, the Cabinet for Health and Family Services shall retroactively apply a final determination of Medicaid eligibility for presumptive Medicaid eligibility applicants for the time-period January 1, 2015-the effective date of the statute. State costs during the presumptive eligibility period shall be offset by federal Medicaid reimbursements and savings realized for institutional care that would have been necessary but for the presumptive eligibility system.

N.Y. SOS. LAW § 364-i : NY Code - Section 364-I: Medical assistance presumptive eligibility program

Search N.Y. SOS. LAW § 364-i : NY Code - Section 364-I: Medical assistance presumptive eligibility program

1. An individual, upon application for medical assistance, shall be presumed eligible for such assistance for a period of sixty days from the date of transfer from a general hospital, as defined in section twenty-eight hundred one of the public health law to a certified home health agency or long term home health care program, as defined in section thirty-six hundred two of the public health law, or to a hospice as defined in section four thousand two of the public health law, or to a residential health care facility as defined in section twenty-eight hundred one of the public health law, if the local department of social services determines that the applicant meets each of the following criteria: (a) the applicant is receiving acute care in such hospital; (b) a physician certifies that such applicant no longer requires acute hospital care, but still requires medical care which can be provided by a certified home health agency, long term home health care program, hospice or residential health care facility; (c) the applicant or his representative states that the applicant does not have insurance coverage for the required medical care and that such care cannot be afforded; (d) it reasonably appears that the applicant is otherwise eligible to receive medical assistance; (e) it reasonably appears that the amount expended by the state and the local social services district for medical assistance in a certified home health agency, long term home health care program, hospice or residential health care facility, during the period of presumed eligibility, would be less than the amount the state and the local social services district would expend for continued acute hospital care for such person; and (f) such other determinative criteria as the commissioner shall provide by rule or regulation. If a person has been determined to be presumptively eligible for medical assistance, pursuant to this subdivision, and is subsequently determined to be ineligible for such assistance, the commissioner, on behalf of the state and the local social services district shall have the authority to recoup from the individual the sums expended for such assistance during the period of presumed eligibility.

2. Payment for up to sixty days of care for services provided under the medical assistance program shall be made for an applicant presumed eligible for medical assistance pursuant to subdivision one of this section provided, however, that such payment shall not exceed sixty-five percent of the rate payable under this title for services provided by a certified home health agency, long term home health care program, hospice or residential health care facility. Notwithstanding any other provision of law, no federal financial participation shall be claimed for services provided to a person while presumed eligible for medical assistance under this program until such person has been determined to be eligible for medical assistance by the local social services district. During the period of presumed medical assistance eligibility, payment for services provided persons presumed eligible under this program shall be made from state funds. Upon the final determination of eligibility by the local social services district, payment shall be made for the balance of the cost of such care and services provided to such applicant for such period of eligibility and a retroactive adjustment shall be made by the department to appropriately reflect federal financial participation and the local share of costs for the services provided during the period of presumptive eligibility. Such federal and local financial participation shall be the same as that which would have occurred if a final determination of eligibility for medical assistance had been made prior to the provision of the services provided during the period of presumptive eligibility. In instances where an individual who is presumed eligible for medical assistance is subsequently determined to be ineligible, the cost for

services provided to such individual shall be reimbursed in accordance with the provisions of section three hundred sixty-eight-a of this article. Provided, however, if upon audit the department determines that there are subsequent determinations of ineligibility for medical assistance in at least fifteen percent of the cases in which presumptive eligibility has been granted in a local social services district, payments for services provided to all persons presumed eligible and subsequently determined ineligible for medical assistance shall be divided equally by the state and the district. 3. On or before March thirty-first, nineteen hundred ninety-seven, the department shall submit to the governor and legislature an evaluation of the program, including the program's effects on access, quality and cost of care, and any recommendations for future modifications to improve the program. 4. (a) Notwithstanding any inconsistent provision of law to the contrary, a child shall be presumed to be eligible for medical assistance under this title beginning on the date that a qualified entity, as defined in paragraph (c) of this subdivision, determine, on the basis of preliminary information, that the net household income of the child does not exceed the applicable level for eligibility as provided for pursuant to paragraph (u) of subdivision four of section three hundred sixty-six of this title. (b) Such presumptive eligibility shall continue through the earlier of the day on which eligibility is determined pursuant to this title, or in the case of a child on whose behalf an application is not filed by the last day of the month following the month during which the qualified entity makes a preliminary determination, the last day of the month following the month in which the qualified entity makes a determination in paragraph (a) of this subdivision. (c) For the purposes of this subdivision, and consistent with the applicable provisions of section 1920A of the federal social security act, "qualified entity" means an entity determined by the department of health to be capable of making presumptive eligibility determinations. (d) Notwithstanding any inconsistent provision of law to the contrary, care, services and supplies, as set forth in section three hundred sixty-five-a of this title, that are furnished to a child during a presumptive eligibility period by an entity that is eligible for payments under this title shall be deemed to be medical assistance for purposes of payment and state and federal reimbursement. (e) Presumptive eligibility pursuant to this subdivision shall be implemented effective December first, two thousand seven contingent upon a determination by the commissioner of health that all necessary systems and processes are in place to enroll children appropriately in accordance with the requirements set forth in this title; provided, however, presumptive eligibility pursuant to this subdivision shall be implemented no later than April first, two thousand eight. 5. Persons in need of treatment for breast, cervical, colon or prostate cancer; presumptive eligibility. (a) An individual shall be presumed to be eligible for medical assistance under this title beginning on the date that a qualified entity, as defined in paragraph (c) of this subdivision, determines, on the basis of preliminary information, that the individual meets the requirements of paragraph (v) or (v-1) of subdivision four of section three hundred sixty-six of this title. (b) Such presumptive eligibility shall continue through the earlier of the day on which a determination is made with respect to the eligibility of such individual for services, or in the case of such an individual who does not file an application by the last day of the month following the month during which the qualified entity makes the determination of presumptive eligibility, such last day. (c) For the purposes of this subdivision, "qualified entity" means an entity that provides medical assistance approved under this title, and is determined by the department of health to be capable of making determinations of presumptive eligibility under this subdivision. (d) Care, services and supplies, as set forth in section three hundred sixty-five-a of this title, that are furnished to an individual during a presumptive eligibility period under this subdivision by an entity that is eligible for payments under this title shall be deemed to be medical assistance for purposes of payment and state reimbursement.