RGVSG Proposed Legislative Changes To The PAS Program

Submitted to State Representative Richard Raymond and State Senator Juan J. Hinojosa for proposed legislation by the Rio Grande Valley Solutions Group (RGVSG).

The RGVSG is dedicated to improving the quality of life and the quality of care for Texas residents receiving Personal Care Services through the state's Medicaid program. The program has experienced a significant level of fraud, waste and abuse. The RGVSG proposes several legislative and/or regulatory changes that will improve the delivery of services and reduce the incidence of fraud, waste and abuse. Additionally, the changes seek to reduce program costs by reducing the number of emergency room visits, hospitalizations and rehospitalizations. The changes are also geared toward reducing some inefficiencies in how the state, the Managed Care Organizations (MCO) and the provider agencies operate and work together.

Proposed Changes

1. Transfers from one provider agency to another or from one MCO to another should only be allowed to occur when the quality of service or dissatisfaction of the services provided is the reason for the transfer. HHSC and the MCOs should develop a state-wide protocol that assures that the MCO makes a home visit and confirms that the move is being initiated by the member and not by anyone else (attendant, marketer, family member, etc.). The protocol should also include acceptable reasons for transfer (poor service from the attendant/agency, attendant failing to show up for work, etc.). Once a transfer has been requested by a member, the MCO must provide at least 30 days for the agency to address any service issues the client, family and/or attendant may have prior to the transfer.

    - Reasoning: Unscrupulous attendants, family members and marketers often convince members to change agencies for personal gain or fraudulently call claiming that they are the member. Attendants convince, cajole, or intimidate members into transferring to avoid disciplinary efforts by the provider agency for cause or for additional pay.
    - Reasoning: Currently, transfers are granted by the MCOs without any investigation or determination of why the transfer is requested. This allows for frequent interruptions of the continuum of care, often leaving members in danger. The 30day period will allow provider agencies to fix any service problems.

2. The HHSC and MCOs should create a star ratings system for provider agencies based on measurable standards (e.g. EVV compliance; auto-linking rates; emergency room visit and hospitalization rates; training provided; a

fraud, waste and abuse certification; active compliance plan on fraud, waste and abuse; number of supervisory visits; and substantiated complaints; - etc.). The ratings should be provided to members when selecting a provider agency. The ratings should include ranges of at least superior, acceptable and unacceptable. Agencies rated less than acceptable should be provided a maximum of three months to improve to acceptable levels. If they cannot improve to acceptable levels, they will be barred from further participation in the Medicaid program. The owners of disbarred agencies will also be barred from forming a new agency for a period of at least one year. A similar star ratings system should be implemented for the MCOs.

- Reasoning: Members have no way of judging the effectiveness and quality of service by a provider agency. The rating system gives members an informed choice.
- Reasoning: This provides a way for the MCOs and the state to eliminate provider agencies that are providing poor – even dangerous – health care services to the members and defrauding the Medicaid program.

3. The Agency's Rate Enhancement participation level should be tied to the agency star ratings. Agencies with unacceptable ratings will not be permitted to earn improved enhancement rates.

   - Reasoning: Currently, the rate enhancement (pay increase) is given to all attendants without any expectations of quality of service or work or any way to enforce improvement in quality of service or work.

4. All attendants should be issued a unique identifier number. The number will be used when a person hired as attendants with any provider agency under any MCO. All attendants will be rated on measurable standards (e.g., EVV compliance, auto-linking rates, training, supervisory reviews, etc.). These ratings will be available to any agency seeking to hire the attendant as well as to any member when selecting an attendant. The ratings should include ranges of at least superior, acceptable and unacceptable. Attendants rated less than acceptable should be provided a maximum of three months to improve to acceptable levels. If they cannot improve to acceptable, they will be barred from further participation in the Medicaid program.

   - Reasoning: Currently, poor performing attendants can move from agency to agency without any tracking of their performance. Additionally, some attendants work for multiple agencies at the same time, often clocking in for the same time periods at different agencies, recording in excess of 60 hours per week
   - Reasoning: Members have no way of judging the effectiveness and quality of service by an attendant. The rating system gives members an informed choice.

- Reasoning: This provides a way for the MCOs and the state to eliminate attendants who are providing poor – even dangerous – health care services to the members and defrauding the Medicaid program.

5. The MCOs must do home visits with the member for all annual visits. The MCO must give the provider agency the option to be present at the annual reassessment or other assessments to along with the agency's employee (the attendant) to have input and/or provide additional information that may be needed to appropriately assess the member's needs. The MCO must allow the provider agency to recommend and/or request identified services/items on behalf of the member during the time they are serving the member.

    - Reasoning: The provider agency has the most consistent contact with the member. They often know the member's condition better than anyone else, aside from family.

    - Reasoning: Example: Agency becomes aware of the member falling for the 2nd time. Agency should be allowed to recommend/request that the member would benefit from a shower chair or grab bars in the bathroom if the agency feels that those items would prevent future falls.

6. Members should only be permitted two agency changes per year.

    - Reasoning: Repeated member changes, absent service issues, indicate that the real reasons for the request for changes are outside the scope of the Medicaid program.

7 The MCOs should not be permitted to lock in clients for any period of time.

    - Reasoning: The lock in reduces competition and guarantees the MCOs a secure profit margin without any expectation for improved services, cost reductions, active fraud prevention or other improvements to the Medicaid program.