



**Testimony on House Bill 166**  
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**April 11, 2019**

Chairman Romanchuk, Ranking Member West, and Members of the House Finance Subcommittee on Health and Human Services, thank you for allowing me to provide testimony today on HB166—the state budget. My name is Joe Russell and I am the Executive Director at the Ohio Council for Home Care and Hospice.

**Medicaid Home Health at the Tipping Point**

Ohio is nearing a crisis point in its Medicaid program in which we are dangerously close to losing a significant number of home care providers. We're at the point where we need to seriously consider what the state will do if thousands of vulnerable Ohioans are left without the ability to stay home, and Medicaid spending explodes from the need to use most costly care to serve these individuals.

To avert this crisis the State of Ohio must increase home health reimbursement rates to address Medicaid service gaps, issues surrounding workforce, and better prepare for the coming influx of patients.

Home health rates are the same today as they were in 1998. If you don't remember 1998, it was the year the first Apple iMac was released, the movie Titanic dominated the Oscars, Harrison Ford was the sexiest man alive, DVDs had just been released and there were no smart phones or social media. Back then a two-liter of Coke cost \$0.89, gasoline was \$1.09 a gallon, movie tickets were \$5 and the minimum wage was \$4.25 per hour.

Today, the world is very different and the cost of providing home care for Medicaid recipients far exceeds what Ohio reimburses for those services. Just like businesses in other sectors, home agencies are now faced with making tough decisions about the future of their agencies based on the cost of doing business. The interesting thing is that home agencies are not in jeopardy overall; only their Medicaid business is in jeopardy.

Due to the growing aging population, the number of people that will need services will be doubling in the next twenty years. According to a survey conducted by AARP, nearly 90% of people 65 and over want to age at home. Sadly, without changes to home health reimbursement many people won't have that opportunity.



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The low reimbursement rates themselves are not the only factors contributing to the current crisis. Agencies now have to deal with expensive federal Medicare mandates such as a major shift in the Medicare CoPs (conditions of participation), pre-claim review, and a new payment model called PDGM (patient-driven grouper model). On top of all that, agencies are straddled with having to implement EVV (electronic visit verification) at the state level, which is been more difficult and costly than even we expected.

But as Medicare has gradually increased its rates to lessen the impact of these changes, Medicaid in Ohio has not. Now a critical gap has developed that is making serving Medicaid recipients tremendously difficult. There is a growing crisis with the lack agencies willing to provide Medicaid home health services, with pediatric therapy in a partially vulnerable and dangerous position. This “access gap” will continue to grow as the Medicare population, whose patients are given a larger reimbursement, crowds out Medicaid recipients.

### **State's Priorities in this Budget**

The “as introduced” version of HB166 invests almost \$264 million in FY20 and an another almost \$1.3 billion in FY21 in new money into “Medicaid Health Care Services” line item (ALI 651525)—the line item that reimburses Medicaid providers—and not a single penny of that new money goes towards home care—*not a single penny*.

This committee has heard testimony from several directors that have all said that allowing more people to live in the community needs to be a priority. Not only can community living improve quality of life, but is also less expensive than institutional care, so it makes sense that community living is a priority. Unfortunately, while home and community-based living has been an established priority, the state is not adequately funding the providers for which give people the greatest ability to state home. If the state isn't willing to make HCBS a priority, then how our home care providers supposed to make Medicaid services a priority?

### **Home Health is the Solution**

Ohio must stabilize home health rates to avoid the pending crisis that could leave thousands of Ohioans without care. The OCHCH seeks to address these issues by better aligning the home health services reimbursements—this includes nursing, aide, and therapies—with the rates provided by Medicare.

Paring Medicaid rates with Medicaid is not realistic given the Medicaid rates are so low. However, by making some reasonable increases to the home health rates, as well as

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making a couple policy changes, we can ensure that our home health agencies can and will continue to provide services to this population.

To address these issues, OCHCH proposes the following:

- An increase to home health state plan services (aide, nursing, and therapy);
- An increase to private duty nursing (PDN) and Ohio Home Care Waiver nursing and aide services;
- A unit realignment so the “base rate” is paid after the first unit of service; and
- An elimination of the registered nurse (RN) and licensed practical nurse (LPN) distinction.

Not only will this create sustainable delivery system for Medicaid recipients, by it would also move Ohio closer to a prospective payment model where the state pays for outcomes as opposed to services. The chart below highlights our requests.

**Rate Increase Request**

<b>HH Discipline</b>	<b>Base Rate</b>	<b>Increase</b>	<b>New Rate</b>
Aide	\$23.57 (after 35 minutes)	\$8.55	\$32.12 (after 15 minutes)
Skilled Nursing	\$47.40 (after 35 minutes)	\$19.82	\$67.22 (after 15 minutes)
Occupational Therapy	\$69.94	\$18.26	\$88.20
Physical Therapy	\$69.94	\$18.04	\$87.98
Speech-Language	\$69.94	\$20.82	\$90.76
Private Duty Nursing	\$47.40	\$19.82	\$67.22
OHC Waiver Nursing	\$47.40 (after 35 minutes)	\$19.82	\$67.22 (after 15 minutes)
OHC Waiver Aide	\$23.57 (after 35 minutes)	\$8.55	\$32.12 (after 15 minutes)

The methodology we've used to get these increase is simple. The proposed increases are 20% of the difference between the Medicaid rate and the Medicare rate, what we call the “Medi-gap” Additionally, due to EVV and it's usage of 15-minute units, we are seeking to move away from the 35-minute base rate, which has only been in use for a couple years. No other state uses this mechanism and it's causing issues with billing now that agencies are using EVV. Lastly, we want to move away from the differential rate between the RN and LPN. This differential is allowing the plans to dictate to our agencies who they should use for what services. Unfortunately, that's not the way it works—LPNs always work under LPNs and some agencies don't employ LPNs at all.

This investment would cost the state around \$65 million. We think this is a reasonable request given the amount of new money in this Medicaid budget, as well as the fact that rates are the same as they were in 1998—that's equal to \$3 million over that time span. Lastly, home



care is the only area for which investments actually have the ability to bend the Medicaid cost curve down. For every person on Medicaid that's able to live stay at home, we save the Medicaid program money.

## **MyCare Ohio Issues**

OCHCH seeks to address issues with managed care in home health pertaining to transitions of care, prompt payment, and timely filing with regards to Ohio's Medicaid managed care plans, which is disrupting care and preventing agencies from getting paid.

- OCHCH requests an amendment that would direct the Ohio Department of Medicaid (ODM) to update OAC 5160-26 (*Managed Care Plan*) and OAC 5160-58 (*MyCare Ohio*) as needed to achieve the following:
  1. *Transitions of care*—to support home care providers' federal requirement to initiate care within 48 hours of referral, ODM managed care rules shall prohibit a prior authorization for the first ten-days of service when a home health patient is referred by a physician, a skilled nursing facility, or a hospital. Similarly, hospice patients should *not* be required to have any prior authorization for service because it requires two physicians to certify that a patient may elect hospice care.
  2. *Timely filing*—to ensure positive cash-flow and to reduce administrative burdens for home care providers, ODM managed care rules shall stipulate that Medicaid managed care plans must follow the same guidelines as ODM pertaining to timely filing and recoupment. Two changes needed here:
    1. ODM managed care rules shall limit managed care recoupment of home health agencies for services that have already been rendered and paid up to a maximum of one-year. Additionally, when seeking a recoupment the plan must include any and all details of the recoupment including: (1) patient's name, address, and Medicaid number; (2) the date(s) of services; and (3) the reason for the recoupment.
    2. ODM managed care rules shall prohibit managed care plans from denying home health agency claims for "timely filing" so long as the claim was submitted within one-year of the date of service. This would align with ODM timely filing guidelines.



## Hospice Issue

OCHCH seeks to reduce administrative overhead for hospice agencies, and to ensure critical resources are being directed toward patient care, by eliminate the process of requiring hospice agencies to be used as a pass-through for room and board reimbursement.

- A policy fix is needed to address an issue that is drawing resources away from hospice care, creating major administrative burdens, and restricting hospice patients' choice—known as the “room and board pass-through.”
- For dual-eligible hospice patients, Medicare pays for medical services, medications, supplies, etc. while Medicaid is used to cover the reimbursement for room and board.
- Under current rule [OAC 5160-56-06, (D) Hospice services: reimbursement], licensed hospice programs are treated as a pass-through for room and board reimbursement, even though they do not provide the room and board.
- Sadly, the licensed hospice program is only reimbursed 95% of the room and board rate. This process results in a net reduction in the dollars being used to provide care to hospice patients because the licensed hospice program must come out-of-pocket to pay for the room and board—this doesn't include the cost associated with the administrative complexity to manage this scheme.
- Under current rule [OAC 5160-56-04 (J) Hospice services: provider requirements] facilities must contract with a licensed hospice program to provide those services in a manner that may not violate the Medicaid provider agreement and does not restrict patient choice.
- Sadly, the complexity of the pass-through forces facilities to restrict who they contract with thereby restricting patient choice and arbitrarily driving up the room and board rate—in some cases to 105% of the room and board rate.
- By refusing to contract with licensed hospice programs for not paying at or above the 100% room and board rate, facilities are restricting the choice of hospice patients to choose who can provide that care.
- Not only does this drain valuable resources for hospice patients, it is also impacting the facility's decision-making when it comes time offer their patients hospice care.

To resolve this issue, OCHCH requests two changes:

1. Allow nursing home and other facilities to bill Medicaid directly for room and board;
2. Remove the requirement that hospice programs have to contract for the room and board.

Thank you very much for your attention to these important issues. I would be happy to answer any questions you may have.

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