March 23, 2017

Representative Mark Romanchuk
Chair, House Finance Health and Human Services Subcommittee
77 South High Street, 11th Floor
Columbus, Ohio 43215

Mr. Chairman and Members of the House Finance Health and Human Services subcommittee, thank you for allowing me to address my concerns related to home care in the State Budget. First, I want to recognize and commend the Legislature and Administration for taking steps to lower the cost of Medicaid long term care in Ohio by having the majority of seniors receive their care in the low cost preferred setting, their home.

As one of the largest Home Care providers for the Medicaid program in the State, I am here today to talk primarily about the prior authorization requirements. I am Jenny Sand, Vice President of Strategic Initiatives for Home Care by Black Stone. As part of Almost Family, a national leader in home care, we have offices throughout the entire state and service over 7,000 consumers through the various programs, such as Medicare, Medicaid, Medicaid waivers, and MyCare Ohio. Specific to ODM programs, we provide over 50,000 hours of care a week from over 2,400 home health aides. In short, we are a substantial employer in Ohio providing a valuable service to our seniors and our fellow citizens by providing cost effective long-term care, as well as Medicare-certified, post-acute care. Thus, we have a strong interest in seeing these programs grow and continue, not just for our company but for the future of Ohio.

Our Association, Ohio Council for Home Care and Hospice, is presenting a number of budget amendments to the Committee, all of which we whole-heartedly support. As I mentioned earlier, the main topic that I want to discuss is a requirement for ODM and Managed Care companies to provide home healthcare and hospice companies with prior authorization for our initial assessment. This not only makes sense, but is the right thing to do for the patient, provider and State. Without the proper authorizations, we face challenges with compliance, billing/appeals, and patient care.

Because our company provides Medicare certified home healthcare services and long-term services and supports, such as homemaking and personal care, we have been supporters of the MyCare Ohio program since its inception. Far too often, our patients received LTSS services from us, but post-acute from another provider, leading to duplication, lower quality, and overall increased cost of care. We believe the integrated care and coordination provided by the MyCare Ohio program could potentially solve some of those issues. However, I am here today to tell you that while the goals of Integrated Care are admirable, the current processes have driven up the cost of doing business, and our small margins are dwindling every day. The Managed Care plans are still learning the intricacies of home healthcare, which is causing numerous challenges, and we are seeing home care companies across the state struggle with staying in business.

One such challenge is the requirement for prior authorization. While I understand that there is a level of oversight required, the current authorizations process has been very burdensome and in fact, roadblocks to providing quality care. Some of the delay was addressed through legislation last year, for which we are very grateful. However, one piece that could use further assistance is the requirement that the initial assessment be automatically approved when a patient is discharged from a hospital, skilled nursing or rehabilitation facility when home care

services have been ordered by a physician. Ideally, we would be given five initial visits through the authorization, which would allow us to provide the quality care and oversight to ensure the patient remains at home, and not rehospitalized.

Medicare certified home healthcare agencies are required to follow Conditions of Participation directed by the Centers for Medicare and Medicaid Services (CMS). One of those Conditions is that a home health agency must conduct the initial assessment visit within 48 hours. Thus, by not providing timely authorizations, the insurance companies are putting home care agencies at a compliance risk, where we could be fined or cited by CMS or Ohio Department of Health, who conducts audits for CMS.

Further, the prior authorization process has substantially driven up the cost of doing business. Since the launch of MyCare Ohio, we have created dedicated positions to work through the prior authorization process. Even with these expert staff, we have seen increasing denials for services weeks after providing the care. We provide timely care, which is physician ordered and specific to the patient care plan, and submit authorization on good faith that the insurance plan will approve, the way it has traditionally worked with ODH and CMS. Increasingly, we provide weeks of care, all deemed medically necessary by the physician, covering numerous visits by our nurses and therapists, only to receive denials back weeks later. At that point, we do not have any choice but to discharge the patient or ask them to self-pay, an option that most Medicaid recipients cannot afford, or continue to provide service and hope that our appeal will be favorable, when decided in another 60 or 90 days. This year alone, we have provided thousands of dollars of care without any form of payment for these patients, not to mention the amount of staff hours dedicated to submitting authorizations, answering questions from the plans' authorizations teams, and follow-up on status.

Finally, the lack of authorizations is negatively affecting patient care. One of the reasons why CMS requires us to make an initial assessment so quickly post-discharge is because they recognize that the patient is very vulnerable at that point. The purpose of skilled home healthcare is that the patient still requires short-term care, but their acuity does not require intensive hospital care. Many things can go wrong once home, if not properly managed with clinical oversight. During the first few days at home, the patient is most susceptible for a hospital readmission, which decreases overall patient health and satisfaction, as well as drives up the cost of care to Medicaid. It is imperative that the home care nurse gets to the patient's home as soon as possible to help set up the patient for success and get them to a healthy state as soon as possible.

I urge the members of this committee to consider the requirement of prior authorization of the initial assessment visit. While we agree that MyCare Ohio has good intentions, we have also seen that the processes have not been put in place to fully ensure quality outcomes. Thus, the need for this requirement. I thank you for your consideration.