Before the Health & Human Services Subcommittee
March 23, 2017

Chairman Romanchuk and Ranking Member Sykes and members of the subcommittee, my name is John Stacy and I am the director of advocacy with the Ohio Council for Home Care and Hospice. Our association represents more than 500 home care, palliative and hospice providers across the state.

Thank you for your time and consideration of the following budget issues and suggested amendments:

1. Prior Authorization of Initial Assessment visit by home care and hospice providers
2. Workforce development training and employee recruitment issues
3. Implementation date of the electronic visit verification system for home care providers
4. Consideration of the state Medicaid reimbursement rate methodology by managed care organizations when negotiating rates with providers
5. ODM's proposed restructuring and increases for personal care aide service rates.

1. Prior Authorization of Initial Assessment visit by home care and hospice providers

Medicare certified home health and hospice agencies are guided by the federal Centers for Medicare and Medicaid Services' (CMS) Conditions of Participation (CoPs) which directs how we provide services by requiring providers to conduct the initial assessment within 48 hours of a patient electing to receive hospice care and for home care within 48 hours of referral, the patient's return home, or on the physician-ordered start of care date.

The purpose of the initial assessment visit is to determine the immediate care and support needs of the patient, to ensure timely start of care and to prevent avoidable and costly rehospitalizations. While some hospitalizations may be unavoidable due to advancing patient age, chronic illness, and comorbid conditions, home health agencies, through careful assessment and well-designed interventions, can prevent unnecessary hospitalizations among patients receiving skilled home health care.[i]

If during that initial assessment a medically necessary skilled service is ordered by a physician the agency will provide the service according to the plan of care. HHA have a duty of care to ensure that the patient is receiving the services and supports necessary to remain in their home if that is the best place for their particular condition and needs. If a skilled service such as

wound care, IV therapy, ventilator, and tube feeding is required the agency has a legal obligation to provide that care to the patient and not wait until the authorization is received.

It is our position that the onus is on the physician who ordered the care to demonstrate medical necessity and not for the staff of the Home Health Agency to second guess or substantiate those orders. As such HHA are providing services according to the physician ordered plan of care and hoping that the insurer will retroactively authorize the service. Most often the agency will receive the retroactive authorization, but we have heard from our members of cases where it has been denied due to the standing policy from the insurer of never approving retroactive authorizations. In those cased the HHA is forced to absorb the cost of providing the denied services.

Lastly, while most medical procedures are scheduled 30 to 60 days out allowing adequate time for the prior authorization review process to be completed in a timely manner, hospice and home health providers have much shorter windows to provide care that ensure patients receive the services and supports they need to be discharged from an in-patient facility or enrolled in a hospice program in a timely manner.

Specific Request: We respectfully request that HB49 be amended regarding authorization of initial assessments for home care and hospice services as follows:

- 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.

- The initial assessment be automatically approved when a patient elects hospice care.

- If during an initial assessment a medically necessary skilled service is ordered by a physician, including but not limited to wound care, IV therapy, ventilator, and tube feeding is required to be provided and the home health agency is unable to receive authorization due to it being after normal business hours (i.e. evening, weekends or holidays) the insurance company must approve the retroactive authorization for the provided services.

2. Workforce development training and employee recruitment issues

Tens of Thousands of Ohioan’s have long-term care services and support needs that require not only nursing support but direct care workers as well, to help them perform routine daily activities, such as eating, dressing, and bathing. These caregivers are the backbone of ensuring

Ohioans can remain in their homes with the supports and care they need rather than going to more costly institutional care.

The Ohio Department of Job & Family Services ("ODJFS") has identified home-health services as the second fastest growing industry this decade. However, home health and community based care providers are already suffering from the shortage of available staff for entry-level positions. 72% of home health and community-based care providers reported that they had to limit admissions or reduce services due to a lack of staffing. More than 40% of hospice and home care providers report having no applicants for their open positions.

While there are a number of reasons for this, including low Medicaid reimbursement rates which limit the rate of compensation providers can pay for home-health aide services, we respectfully request that the General Assembly make changes to state workforce development programs to help home health and community-based care providers.

In addition, language in the Ohio Administrative Code 173-32-02.11 (C) (2) (a) (ii) dealing with who can provide personal care services causes problems in hiring workers who have not had a competency test in the past 24-months or if they have a gap in service in that two-year period. We believe that the Department of Aging is misinterpreting Medicare Conditions of Participation (CoPs) as we are clearly not prohibited from hiring that individual, the agency must simply give the aide a new written competency test and a return demonstration test to make sure they are able to fulfill the job responsibilities.

Specific Request: We respectfully request that HB49 be amended regarding workforce recruitment and training for home and community based care providers as follows:

- Add home health and community-based health care providers as a targeted industry for state workforce development programs; and
- Lower the minimum wage threshold of workforce development programs to 125% of the federal minimum wage as opposed to the current 200% many of the programs require.
- Direct ODJFS to review and identify existing programs such as the Temporary Assistance to Needy Families ("TANF") or any other ODJFS grant or funding sources like On the Job Training

("OJT") and The Work Opportunity Tax Credit (WOTC") for occupational training, job core, adult education or career pathway assistance, and make necessary criteria changes to allow for home health provider participation.

- Amend Ohio Administrative Code Chapter 173-32-02.11 (C) (2) (a) (ii) to follow CMS CoPs for Medicare certified providers by striking out as follows:

    OAC 173-39-02.11 (C) (2) (a) (ii) Successfully complete the Medicare competency evaluation program for home health aides set forth in 42 C.F.R. Part 484., ~~as a direct care health care worker without a twenty-four month lapse in employment as a home health aide or nurse aide;~~

3. Implementation date of the electronic visit verification system by the Ohio Department of Medicaid

During the last General Assembly, HB64 established a statewide electronic visit verification (EVV) system for home care providers to combat suspected fraud, waste and abuse. The authorizing language required every home care provider in the state to either use a state provided EVV system or they could, at their own expense, use a third-party EVV system which would collect and submit the home care visit information to the state's EVV system for data aggregation and subsequent integrity checks against billing claims. We support this approach as it allows those providers who currently use EVV for employee and case management functions to maintain their current system as well as allowing those who do not use an EVV system to decide which is best for their personal operations.

HB 64 anticipated that the new EVV system would be operational by July 1, 2016 allowing the state to enjoy an estimated savings of $9 million in FY2017. However, given the complexity of the project there were several revisions of the parameters delaying the selection of the software vendor for the project until August 3, 2016 resulting in a new Go-Live date of November 2017. As of today the state has yet to issue the system specifications for the third-party EVV providers.

Over the subsequent months during stakeholder meetings, we raised concerns about the ongoing delays and the impact that is going to have for data integration by third-party EVV providers. Many of our member's software providers have stated that they will not work on integration solutions until the state issues its final rules for the program as there are too many unknowns. If the state adheres to the November Go-Live date we anticipate that there will be a host of integration issues resulting in

conflicting information between the EVV and MITS systems resulting in claim denials and reimbursement payment problems.

Specific Request: We respectfully request that HB49 be amended regarding electronic visit verification as follows:

- EVV implementation Go-Live Date will be six months following the effective date of the administrative rules to allow time for home care providers to work with their software vendors to implement integration with the state EVV system.

4. Consideration of the state Medicaid reimbursement rate methodology by managed care organizations when negotiating rates with providers

ODM has spent a lot of time and energy creating a new reimbursement rate methodology the state believes to be sufficient for home care services under the Medicaid State Plan. As you may know, the state is required by CMS to document that Medicaid State Plan rates are *"consistent with efficiency, economy and quality of care"* and ensure sufficient beneficiary access to care, as required by the Social Security Act. We are concerned about the state allowing MCO's to institute their own rates below what the state has documented as being required to ensure the efficiency, economy, quality, and access of care.

Several other states, including high senior population states such as Arizona, Florida, and Michigan, require MCO's to provide reimbursement rates equal to or higher than those established by the state.

With the expansion of managed care in Ohio for Medicaid receipts we are concerned that MCO's will focus more on following the lead of Buckeye Health Plan and institute a 15% across the board rate cut for home care providers rather than focus on care management. We believe that Ohio should require that MCO's pay rates at least equal to the state methodology to protect Ohioans from receiving substandard care. In addition we believe that the state should institute a policy to periodically review the rates to determine if they are sufficient to ensure quality care for Medicaid recipients.

Specific Request: We respectfully request that HB49 be amended regarding the state's home care reimbursement rate methodology as follows:

- ODM's Medicaid Rate Methodology should be required to be considered by an MCO when negotiating rates with providers.

- We recommend that the Medicaid Rate Methodology be reviewed biannually to coincide with each state budget cycle.

5,. ODM's proposed restructuring and increases for personal care aide service rates.

Lastly, we would like to voice our support of the proposed **restructuring and increases for personal care aide service rates.** Beginning in July 2018, ODM will establish a single unit-based rate for Ohio Home Care and PASSPORT waiver programs and for state home plan home health aide services. The department will also establish a differential rate for non-skilled agencies and certified or otherwise accredited agencies. We are supportive and appreciate the departments continued support of home and community based care as a cost-effective way to provide consumers what they want – to age in a place they call home.

Thank you for your consideration of these budget amendment requests. I would be happy to try to answer any questions you may have.

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[i] Preventing rehospitalization through effective home health nursing care. Vasquez MS, Home Healthcare Nurse. 2008 Feb; 26(2):75-81.