Testimony on Substitute House Bill 33
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May 11, 2023

Chairman Romanchuk, Vice Chairman Wilson, Ranking Member Ingram, and members of the Senate Health Committee, thank you for allowing me to provide testimony today on Substitute HB33—the state budget. My name is Brent Tow, President/CEO for CHP Homecare and Hospice. I've worked for CHP for over 20 years. I'm testifying today to ask for your assistance to fix an unintended consequence of a regulation that is having a significant negative impact on access to Medicaid home care services.

Ohio's Medicaid home care program is at a crisis point as home care providers are no longer able to continue subsidizing these services. We're at the point where thousands of vulnerable Ohioans are going without care. We know from experience that people will forgo care to stay home until they have an emergent need and are forced into a care environment that is much more expensive and is not their home.

Ohio Medicaid home care program is plagued by rates that are so low that they do not cover the cost of care. But in addition to those low rates, there are a number of regulatory burdens, or red-tape, that are preventing business like mine from providing services to people who are on Medicaid.

In a nutshell, at the end of 2016 Medicaid began offering reimbursement for the 60-day recertification visit at the expense of decreasing the hourly rate for non-supervisory visits. At the same time they also separated LPN per hour rates from RN per hour rates. So if a CHP patient had a block of 6 hours a day over the course of a month, before the rate increase in November of 2021 with our LPN making the visits, we were receiving $2,574 less. The 6% increase we received in November of 2021 was quickly cancelled out due to rapidly rising inflation and the pay rates we had to offer to keep or attract new aides.

Below you'll find some of the data I presented to my Board last year detailing why after 32 years, we could no longer afford to provide Medicaid services. The programs are not sustainable.

Compensation Comparison

<u>Reimbursement Before 2016</u>

$54.95 for non-supervisory nursing per hour (RN **<u>or</u>** LPN)
$0 for 60-day patient recertification
$0 for 60-day aide supervision (plan to schedule with normal visit)

<u>Reimbursement After 2016 & before November 2021</u>

$47.40 for non-supervisory **RN** nursing per hour.
$40.65 for non-supervisory **LPN** nursing per hour.
$37.08 for 60-day patient recertification (plan for at least <u>36-min</u> patient care first then do recertification)
$0 for 60-day aide supervision
Example: 6-hour block of non-supervisory visits for 30-days now **$2,574** less per patient.

<u>Reimbursement After November 2021</u>

$50.29 for non-supervisory RN per hour.
$43.13 for non-supervisory LPN per hour.
$37.08 for 60-day patient recertification
$0 for 60-day aide supervision
Example: 6-hour block of non-supervisory visits for 30-days now **$2,128** less per that same patient.

It's important to understand that these rates changed because of a policy change that began paying different rates to RNs and LPNs. However there's been a significant unintended consequence of this policy decision, MCOs and ODM is dictating to providers what type of provider they should use for certain patients without consideration of patients' needs. The incentive is clear, the more LPNs are used (and paid) the more money is saved.

In addition to providers being forced into using certain providers even with concerns of patient safety, making matters more concerning is that providers will be paid the LPN rate even if they don't employ LPNs and even when and RN is used. My agency and other believe this is wrong and needs to be fixed.

The solution to the RN and LPN issue is a simple policy fix. To address this, I'm asking for your support of an amendment that will simply prohibit the MCOs and care managers from dictating to agencies what type of providers to use and prohibit them from paying the LPN rate if an RN was used. The amendment does three things:

1. Prohibit a requirement for agencies to use only licensed practical nurses when providing some or all home health services;

2. Prohibits payment to be made at licensed practical nurse rates if/when a registered nurse provides the services;

3. Prohibit the establishment of a payment rate, policy, or procedure that prevents a home health services provider from making decisions about a patient's clinical care that are in the patient's best interest.

Nobody looks at Medicaid and thinks it should be a money maker. It's a community service and we're fine with that but we have to at least cover the costs of providing care. While we have made some tough decisions and might have to make more, we would be willing to return to being a bigger Medicaid provider if the state pays for the services. Otherwise the problem will continue.

Thank you for considering investing in home care and to allow vulnerable people to get the care they need. Thank you for allowing me to testify. I'm happy to answer any questions you might have at this time. Thank you.