

Oral Testimony Provided By Chani Feldman with Maxim Healthcare on July 18, 2017, at 2:30 PM

My name is Chani Feldman and I am a registered nurse. My experience as a nurse began at Children's National Medical Center in Washington DC where I worked in the Neonatal Intensive Care Unit caring for the extremely medically fragile babies that were transported for care there. I made the move to home healthcare 10 years ago and I became very passionate about allowing kids and adults to remain in their homes and communities. As you are well aware, keeping these individuals at home represents the highest quality of care for them as they are lovingly cared for by their families as well as being the lowest cost type of care possible.

Maxim Healthcare is a nationwide company that employs over 65,000 caregivers across 41 states in over 250 office locations. In 2016, Maxim provided care to just over 54,000 individuals across the country.

We have six offices in Indiana that provide care to over 750 patients and employ over 1200 caregivers. In addition to healthcare staffing, our primary focus is on the medically fragile population of kids and adults that receive extended hourly care. Without this care being provided by states, these patients would ultimately reside in facilities. Sometimes resembling mini-ICUs in the homes, Maxim's caregivers require the highest level of training that a home healthcare company can provide, from care of feeding tubes, trachs, and ventilators to wound care and disease management.

We appreciate the opportunity to provide perspective on this business to care for Hoosiers in the community setting. The burning question is how to fix the problem of individuals not able to get care in their homes. There are a few major areas of improvement that would really make a difference in this industry, and would make Indiana a model for Home and Community Based Services: rates, workforce development, and regulatory fixes.

Rates:

The current reimbursement rate is not sustainable as an attractive option for caregivers. Demand continues to go up and the supply of caregivers continues to remain the same or go down. Because of this, we are left with open shifts that simply can't be filled because we are not able to compete with other healthcare settings. We often can't compete with fast food restaurants and retail store wages. That is quite troublesome. While it sounds hard to believe an extra \$.50 or \$1.00 can be the difference between filling a shift and working at McDonalds, this happens daily. Rates need to be attractive to allow agencies to recruit, train, and retain excellent caregivers.

The pattern we have seen over the past 6 or 7 years show reimbursement rates going down. The rate methodology has proven to not be an appropriate way to determine how providers will be reimbursed. The yearly uncertainty that comes from not knowing if the rate will stay the same or go down moves this industry in the wrong direction.

We can't just snap a finger and have a robust workforce. It takes time to develop this type of healthcare worker. Agencies are increasingly hesitant to make these investments because of the unpredictability. When we talk about rebalancing and moving more individuals to home and community based settings, the biggest factor for agencies to be on board with this is for rates to be established that are appropriate for the services they are providing. Once that is accomplished, small increases are quite standard in the Healthcare Staffing Industry because of the demand and the fact that the cost of living goes up each year. In order for us to be competitive for those same nurses and home health aides, we need to be able to pay them and stay competitive.

As healthcare is moving toward paying for value, it is time for our industry to start taking steps in that direction. Simply looking at open shifts and patients not able to receive care that they are authorized for is a great way for FSSA to start examining quality in this industry.

Avoidance of higher cost events and settings is another way. Care needs to be taken though into understanding the different populations of homecare services. Many recipients of homecare will never improve. Measuring quality with metrics for the intermittent Medicare population is not the answer. Looking at how agencies keep these individuals stable in the home and avoiding high costs events such as ED visits and hospital admissions are other ways to measure success and quality.

Workforce development:

We want to suggest a way to address workforce development for home and community based services that is not specific to rates, but rather, training. As a nurse, I can speak to the fact that providing healthcare to people in the community is a mere blip on the screen in nursing school. Because this is not seen as a career path option, agencies will often hire caregivers who will give us a year or two of their time, but only use this as springboard for other opportunities. As healthcare gets more expensive and states are desperately looking to reduce costs by giving more people opportunities to stay at home, we need to make this career path attractive. Pay is just one aspect, but training and professional development are also important. Maxim is currently partnering with a nursing school that gives their students an opportunity to do a community rotation. Making this course of study a full semester, like med-surg and psych nursing currently are, makes this a real option after graduation. Incentivizing agencies to form these partnerships would be key, as currently this is done on our own time.

Regulatory:

There are a few simple regulatory fixes that will quickly make a huge difference in the current population of homecare, specifically with Aged and Disabled Waiver Respite Nursing.

Often times, Respite Nursing is requested and used intermittently on weekend shifts, evening shifts, or as needed. Maxim often receives these referrals in rural towns making it difficult to staff with such a limited pool of nurses who are frequently deterred by the many miles they would need to drive to work. A way to address this issue would be either a mileage reimbursement or a rate differential. The other challenge with Respite nursing is that we have to offer RNs a higher wage to

pick up these shifts and can only bill at the LPN rate. Bringing the rates up to the Traditional Medicaid Fee Schedule where there is a different rate for an RN and an LPN would make a huge difference.

Another barrier we face daily is the fact that through traditional home health fee for service, care can only be provided in the home, the school, or the place of employment. This frequently presents a problem with doctor's appointments. For example, when a patient on a ventilator needs to go to the doctor, he or she will need a nurse to be there to provide care which doesn't stop for appointments. Currently, the agency needs to get special approval for this through the PA process. Removing this barrier eases a large administrative burden.

For respite nursing, the place of care it is even more stringent. Services can only be provided in the home. Not being able to provide care outside the home seems to be an antiquated rule and one that isn't in touch with current needs. To focus on the social health of an individual, we need to be able to accompany these individuals in certain settings outside the home. There are many situations in which this would be of benefit to the consumer and would be safe to provide, such as outpatient therapy, going to church, and other outings in the community. We strongly believe that the recipients would lead happier and healthier lives if we could accompany them to these types of community activities they would otherwise not be able to attend without these services. Certainly, this seems to be the goal as home and community based services are expanded to more recipients with the goal of keeping costs down.

Thank you so much for the opportunity to address this group. We look forward to working with the State on this.