House Bill XYZ

Testimony of Harris T. Capps,
Parent and Guardian of Matt, my son with IDD
Before the House Finance Subcommittee on Health and Human Services
March 22, 2016

Chairman Romanchuk, Ranking Member Sykes, and members of the Committee:

Before starting my allotted time: In an attempt to be helpful, I want to make you aware of what I believe is a ***noteworthy*** **wording error** In HB 49, line 96281 - 96284… The phrase says: "… a pilot project authorized by the Director may be continued or implemented in a manner ***inconsistent*** with one or more provisions of either chapter or one or more rules adopted under either chapter".

My name is Harris Capps and I am a Parent and Guardian for my son Matthew who has Intellectual and Developmental Disabilities (IDD) and resides in a wonderful Intermediate Care Facility (ICF), Mount Aloysius, located in New Lexington, Ohio (16 miles east of Lancaster). I am also a parent advocate. For example, I am on VOR's National Issues Oversight Committee, and have served as a State Representative for VOR, and was co-founder of Ohio's Disability Advocacy Alliance (DAA) organization. Today, I am providing my personal testimony, not that of an organization. I thank you for the opportunity to discuss the submitted DODD budget and policy set forth in HB 49.

Request an addition to HB 49, line# 96290 - to include VOR among other associations, as a planning entity interested in the issue of developmental disabilities. Providing this organization a seat at the table will help ensure issues affecting all sides are included. Many ICF stakeholders are still not convinced this is the case.

Whether we like it or not, at some point, when assessing the ICF reimbursement rates, comparisons must be made to funding for Home and Community Based Services (HCBS) provided under waivers, for example, to residents of small group homes and in-home care. There are important policy, observations and conclusions that are necessary to these deliberations. Because there are different cost reimbursement approaches for HCBS care versus ICF care, state and federal funding sources (Ohio DODD and Federal Medicaid) seem to frame comparisons on funding improvements for ICFs as either being too difficult because the funding follows a "different process", or because ICF populations are being reduced, implying they don't want to sink money into a passé approach for client care.

a) The Olmstead Supreme Court decision provides for freedom of choice in resident care, and ***warns*** against the usage of this Decision to limit individual rights. In fact, the current odorous law suit against Ohio by the Disability Rights Organization (DRO) is a very direct outgrowth of the intentional misinterpretation of The Olmstead Decision.

b) There is considerable opportunity for HCBS providers to profit from the fostered downfall of Intermediate care Facilities. With that assertion made, federal agencies under Medicaid (e.g., The Agency for Community Living (ACL)) have issued policy and guidelines that continue to threaten the continued existence of ICFs. These agencies often use draconian reimbursement policies to punish state government for not "towing the line" to move away from sustainable support for ICFs in favor of HCBS.

c) For years HCBS, small group homes have made the argument that they are cheaper. However, with the exception of studies done by the national organization, "VOR" (formerly named, "Voice for the retarded) other HCBS-friendly cost assessments were comparing "apples-to-oranges", in that they did not account for the extra care required for more severely disabled ICF residents. Moreover, there has been national recognition by the press that the aging of the HCBS population was experiencing considerable unexpected funding shortfalls due to unanticipated health issues for these residents.

> ***In recent budget testimony*** *by* ***DODD, Mr. J. Martin****, he proposes "****(HCBS)*** Increases (to) waiver reimbursement to cover complex care needs. Individuals who are dependent in all areas of daily living require a workforce that is stable and well trained to meet their everyday needs and maximize their quality of life. The Executive Budget incentivizes providers to serve these complex individuals. This provision costs $10.8 million ($4.1 million state share) in 2018 and $12.9 million ($4.9 million state share) in 2019".

d) It is obvious that the "rush to judgment" against ICFs was very much pre-mature and indefensible. Neither complex needs nor economies of scale entered the deliberations. Yet, continual improvements to benefits and wages continue to be laid at the feet of HCBS workers.

> I***n recent budget testimony*** by ***DODD, Mr. J. Martin***, he proposes **HCBS incentives**:
> "(This Budget) increases wages for direct support staff. DODD depends on direct service staff to provide support to individuals in the developmental disabilities system. Providers face increasing challenges to recruit and retain staff. The **longevity of staff is critical** to providing quality services, enabling individuals to work, live, and fully engage in their communities. Direct support staff with two years of experience and up to 60 hours of training will be eligible to receive up to a six percent wage increase. This provision costs $12.9 million ($4.9 million state share) in 2019".

YET, these proposed budget items for HCBS care that are identical to the same requirements at an ICF are NOT addressed. This appears as *institutional benign neglect*.

Direct Support Professional (DSP) issue: ICFs have a work force crisis. Providers across the state are experiencing 10% to 20% vacant DSP staff positions and overtime and 40%+ turnover. ICFs are burning out the current workforce, which causes errors and further turnover. These employees are vital to the success of serving our population yet we continue to downplay their importance in the payment rate structures. In the current, as well as the proposed reimbursement formulas, the Direct Care portion of the rates leaves 30% - 40% of all of the facilities with un-reimbursed cost over the ceiling.

The "current" budget language addresses this on pages 3136 and 3137, lines 96453 through 96482. As it "currently reads, the "average rate" in the system would increase from $290.10 (current average) to $297.35 per day. This increase is tied to the condition that the proposed new reimbursement system is fully implemented for FY 2019 rate setting. The 2.5% is not tied to direct service or other employee pay rates. In addition, the language limits rate increases and decreases to +3.5% to -3.5% for each provider compared to the rate in effect as of 6/30/2018.

It further states that even after this calculation, if the average calculated rate for all ICF's is greater or less than the cap, each provider rate would be further adjusted up/or down by same % to get to the cap. There are still many moving/undecided pieces and parts to the new reimbursement methodology that have not been determined as of yet because the information has yet to be gathered and analyzed. What is further troubling is DODD wants to "freeze" rates from FY2017 to FY2018 for each provider, which would mean there would be many "winners" and "losers" based on happenstance, not actual cost and resident need.

During the last major Budget cycle with hearings in early 2015, **HCBS** wages were increased effective July 1st at a rate of 6.5%. ICF wages were increased by 2.5%, but did not take effect until a year later (July 1st, 2016). The same is happening this budget cycle. HCBS gets a greater increase, while ICFs get the same old 2.5% delayed increase. DODD does not want to provide the ICF 2.5% increase until the new cost reimbursement system is in place. This delay is unnecessary and has a punitive effect on ICFs. DODD should acquire necessary **ICF** funds for a 3.5% increase effective July 1st, 2017, followed by an additional increase under the new cost reimbursement system of at least 3%.

In that DODD is requesting added funds to incentivize workers (para "d" above), request similar funding be made available to ICFs. Similar incentives for HCBS do not have to come out of wage increases. Funding for the same incentives should not have to be taken from ICF employee wages. This would be a further disincentive. The incentives between the ICFs and HCBS should be equivalent, or weighted in favor of ICFs for caring more a higher percentage of complex needs. This should be written into HB 49.

Lastly, it may seem inappropriate to compare ICF funding to the funding being provided to persons who break the law… but ICF weaknesses in funding demand a certain amount of this advocacy for our most innocent and most vulnerable citizens.

Primarily because of the current opioid epidemic, *Director Tracy J. Plouck's Testimony before the House Health and Human Services Subcommittee Ohio Department of Mental Health and Addiction Services FY 16-17 Budget House Bill 49 March 2, 2017stated, "*All told, the Executive Branch has, with support from the Ohio General Assembly, invested more than $939 million toward drug abuse prevention, treatment, recovery supports, life saving measures and interdiction in FY 16 alone".