Georgie Elson
Senate Medicaid Committee
Interested Party Testimony, HB 96
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Thank you for the opportunity to testify today, Chairman Romanchuk, Vice Chair Huffman and Members of the Senate Medicaid Committee. My name is Georgie Elson, I am an Advocate, a MyCare Ohio Waiver Recipient, and I serve on many advocacy groups. I also am a board member of Disability Rights Ohio. I am only speaking for myself. I have multiple disabilities including Autism, TBI, Ehlers Danlos Syndrome, and many of its related comorbidities. I use a reclining power chair; am limited in how long I can sit upright; experience countless daily subluxations & dislocations; and receive daily IV fluids & medications through a central line.

Direct Care Workforce Task Force: During the last budget cycle, I came to testify twice on the dire need to have Medicaid's reimbursement rates increased for Direct Care Workers - including Waiver Nursing. To begin, I want to sincerely thank the legislature for listening, learning, and taking a role in making those requests a reality for the disability community and direct care workers. The increase has made significant impacts on some people's lives. Despite that, solving Ohio's Care Crisis will require bringing people together to come up with multiple solutions. That is why I believe the creation of a Direct Care Workforce Taskforce is still needed. To increase its effectiveness, it is essential that this task force brings all the relevant players to the table – especially individuals with disabilities who know, utilize, and live within these systems every day. This task force should include individuals who utilize each of the different waiver systems that Ohio has to offer, and other important stakeholders not limited to the following – members of the House of Representatives, members of the Senate, a direct care worker, family members, agency home care providers and others.

COL Adjustment for Direct Care Workers: Another concerning issue facing our community is the lack of a Cost-of-Living Adjustment for direct care wages. I don't want us to end up in the same situation that we have just begun clawing our way out of – where wages remained stagnant and non-competitive for several years. As the cost of living continues to rise at a higher rate than wages, the need for such a solution only becomes more evident. This simple solution will help secure the direct care workforce and make it much more likely that providers will be able to remain as caregivers in this field; Helping to ensure that they will be able to continue providing the care that many need to survive.

Medicaid Trigger Language: Another major concern that I want to address today, is in regard to the trigger language included in the Governor's version of the current budget. For anyone listening who may be unfamiliar, the trigger language specifies that if the federal government reduces the amount of funding to our state Medicaid Expansion population to less than 90%, which is the current federal match, then the Medicaid Expansion in Ohio will abruptly end. This will kick 700,000 of our fellow Ohioans off of their current Medicaid health insurance. With the current language, even if the federal match drops by 1%, the program will end.

I would like to see the restrictive trigger language that is specific to the Medicaid Expansion population be removed in the House version of the budget. This should not be an automatic decision. Legislators should be able to make those decisions in the future, once they know more about what these Medicaid cuts will look like. If the cuts to the Expansion population is small, I think the state should consider opportunities to fund it.

Minimizing harm to Medicaid, both federally and at the state level, is important. Medicaid is not only a popular program with constituents, but most importantly it is a life saving program. 26% of Ohio's population rely on Medicaid as of 2024. That's 3 million Ohioans. (1) Ending the expansion, will reduce Ohio's Medicaid population by 23%. This means that nearly a quarter of Ohio Medicaid recipients will have their Medicaid coverage abruptly stopped.

It's also important to recognize that most individuals in the expansion program do have a job. It just doesn't come with health insurance or pay well enough to secure health care through the marketplace. There are many professions and employers that do not offer health insurance at all. One of many examples of that situation is seen in Ohio's Direct Care Workforce. Many direct care workers actually rely on Medicaid and fall within the Expansion population. We already have a Care Crisis in this state. Ending the Expansion will force direct care workers into another difficult situation. Do they keep their job without access to healthcare? Do they leave it – no matter how much they love their job and clients – in hopes of finding a role with employer sponsored health insurance coverage? Will they even be able to find one? These difficult choices will impact the disability community and further reduce access to care for those that need it most.

Medicaid cuts do not only cause harm to participants in the program, their families, and the people they may care for; Medicaid cuts also cause harm to the economy and to hospitals who rely on reimbursement for services to help them stay afloat. Many rural area hospitals already struggle and are at risk of closing their doors, further compounding the issue of healthcare deserts in the state. "A February 2025 report by the health care advisory firm Chartis found that 46% of rural hospitals are already forced to spend more to support patients than they receive in private and public payments and reimbursements, putting many at dire risk of shuttering. States that did not expand Medicaid coverage in recent years were hit the hardest, which proves that those Medicaid dollars are needed to sustain clinics and hospitals. (3)" For some facilities, budget cuts will lead to massive layoffs, resulting in longer wait times and reduced access to care for everyone across the state. (3) "Healthcare Workers will lose their livelihoods – and patients will lose their lives. "(3)

Additionally, "hundreds of studies have found that Medicaid expansion has improved access to care and the health of the people who gained coverage, while reducing mortality and bolstering state economies, among other positive outcomes."

<u>Medicaid Work Requirements:</u> Along those same lines, I would also like to briefly comment on the work requirements for Medicaid that are also on the table. Work requirements are being considered "despite the fact that the majority of Medicaid Enrollees already work, are disabled,

are caregivers for a loved one, or are in school. Further, “The extra paperwork requirements will lead to those who are eligible being removed from the program as well and it’s very costly to implement. (2) For example, “When Arkansas implemented Medicaid work requirements in 2018, despite the majority of enrollees already working, about 18,000 people lost coverage. The policy was poorly understood, and enrollees had trouble reporting their work activity. What's more, the employment of low-income adults didn't grow. “(2) It seems clear to me that work requirements don’t work and are not worth the cost or harm that they can cause states.

Self-Direction for Waivers: I want to take a moment to also sing the praises of a positive program that’s been created for those receiving Home and Community Based Services – Self Direction. The new Self Direction program rolled out on the various Medicaid waivers has been a positive for the following reasons:

- It was created by Medicaid with much collaboration from disabled advocates, family members of those with disabilities, and other important stakeholders. This has led to a program that is more responsive to the needs of those utilizing it. It has also been a very positive example of how much better programs can be with the constant collaboration of those who will utilize it.

- It has allowed those who normally would not be seeking a career as a Medicaid home care provider, to provide services for their friend, family member, or loved one.

- It has led to a faster enrollment process with less hoops to jump through for new providers, directly decreasing the barriers to entering the field.

- It gives the disabled individual more control over their care. We have more control over our providers, their hours, and ultimately our life.

Response to Previous Testimony on Self Direction: To be frank, I heard testimony under the House Medicaid Committee last week from a panel which included an agency owner. Those testimonies said some things about Self Direction that simply are not fair, or in some cases, are not even true. One comment made was that the same person/people control the Self Direction process all the way through – from the referral, to the service hours, to the claims, and that they “receive additional funds from the consumer.” As someone who has gone through the enrollment process with Self Direction, I can assure you that is not true. I did not have to pay extra funds for Self Direction, and the enrollment process is controlled by various parties and individuals. The consumer asks the Care Manager for a referral. The referral is sent to PPL. The Care Manager helps with the budget. There are negotiations and an agreement with the provider about pay. PPL helps with the paperwork and orientation. Everyone has a separate role and there are lots of steps and responsibilities on the consumers end to get something like this set up. So, it’s not just like a care manager says, “now you're going to do self direction” and that’s it. There are several steps with different players that consumers must be involved in, and consent to, along the way.

This individual also testified that the Self Direction program is taking away providers from home care agencies and moving them to self direction, without increasing the capacity of providers in the field. I know that to be false because I use all three options in my care, which include, a Self-Directed Provider, an Independent Provider registered through the Department of Medicaid, and two Agency Providers. My brother would not be a provider without Self Direction, so he IS an addition to the number of providers available in the system. Additionally, the program is still quite new, and the kinks are still being worked out, therefore it is too soon to make such claims. The option to be an Independent Provider, could just as easily entice Agency Providers to leave for that option as well. There are pros and cons to providing care under **each** of the three options.

If an agency is in fact losing providers to Self Direction, I think they should reflect about why that is, and it most likely comes back to the pay. The reimbursement rates for care services were increased during the last budget cycle, including for agencies. However, there is nothing that stipulates that those rate increases be passed down to agency employees in the form of wages, so even though agencies *likely* got paid more money, often their employees have not, and are not, getting those increases. (I have a provider in my home under an agency who is still payed around $13/14 hour, while my other providers are paid $22 for the same work.) **This is not all on the agencies at all.** A very important piece of information to this is that Managed Care Organizations (MCOs) such as Buckeye, CareSource etc are **legally allowed to pay providers LESS than the standard Medicaid reimbursement rates** that were increased last year. This is true for both Independent Providers and Agency Providers. I learned this from the same panel testimony I've referenced throughout. When it comes to agencies, a MCO will say "We'll provide you 85% of Medicaids Reimbursement rate." Agencies only have two options, to accept what they are offered, or to cancel their contract with that MCO and loose all their clients. In other words, it's not as simple as mandating that the agencies pass down a certain percentage of Medicaid's Reimbursement rates, as I erroneously testified previously, because **the agencies also are not getting the full Medicaid reimbursement rates to be able to pass them down.** What we really need, is to **stop the MCOs from being able to shortchange all providers by paying their providers less.** Any changes we try to make to increase reimbursement rates will be undermined by MCOs deciding they don't want to pay those any way. This is a major concern as MyCare is being expanded in our state.

In conclusion, please consider adding a built in Cost-of-Living adjustment for Direct Care Workers and creating a Direct Care Workforce Crisis Task Force to monitor and improve Ohio's Care Crisis into the house version of the budget. I ask for removal of the Medicaid Expansion trigger language which would abruptly terminate healthcare coverage for hundreds of thousands of your constituent and reconsideration of the plan to implement work requirements. Please consider the issue of MCOs paying less than Medicaid's reimbursement rates. And finally, I request that the legislature works to protect Ohio's Medicaid program to improve the health of our fellow Ohioans.

Thank you again for the opportunity to testify today on HB 96 Chairperson Stewart, and members of the House Finance Committee. I will do my best to answer any questions.

1. https://www.healthpolicyohio.org/files/publications/medicaidbasics2025.pdf

2. https://www.upi.com/Voices/2025/03/03/medicaid-cuts-Trump-Republicans/9341741013448/

3. https://www.usnews.com/opinion/articles/2025-02-26/medicare-medicaid-healthcare-budget-cuts-house-republicans