Ohio Consumer Voice for Integrated Care
Voice for Ohioans who qualify for Medicare and Medicaid

Testimony of Ohio Consumer Voice for Integrated Care
Senate Finance Committee on HB 64
By John Arnold, Project Manager, UHCAN Ohio
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Chairman Oelslager, Ranking member Skindell, my name is John Arnold. I am the Manager at UHCAN Ohio for a coalition we coordinate, Ohio's Consumer Voice for Integrated Care. OCVIC is a coalition of consumers and advocacy organizations who have come together to assure that the best interests of Ohio's Medicaid and Medicare participants are considered in MyCare Ohio. We are part of a national initiative, Voices for Better Health,[1] which is working to establish the consumer voice of older adults and others with disabilities in new Medicare/Medicaid demonstrations that would provide better coordinated, higher quality care. I appreciate the opportunity to appear before this committee to offer the perspective of organized consumers and advocates on "MyCare Ohio."

Since January 2014, I have conducted question and answer sessions with an estimated 10,500 enrollees in independent living communities, public housing, assisted living and other settings. Many enrollees, both older and younger adults with disabilities, are active on OCVIC's Facebook page and participate in OCVIC's regional monthly phone calls with enrollees to discuss their experiences. OCVIC continues to have regular on-going discussions with enrollees in various diverse settings.

OCVIC believes in the promise of MyCare Ohio – better care coordination across settings, better care and better quality of life for dually eligible Ohioans who have received fragmented, often poor care, from two systems that were not designed to work together. However, last year's massive enrollment of dually eligible people into Medicaid managed care plans – a unique step among integrated care demonstrations across the US – generated disruptions of services, fear and confusion among many enrollees, some of whom were put at great risk by the upheaval. The reason is simple: Ohio tried to enroll way too many of the most complex Medicaid recipients in new plans, instead of starting small, following the other states' best models. We hope the chaotic start-up of MyCare's Medicaid plans will encourage lawmakers to proceed cautiously in integrating behavioral health services into Medicaid managed care, with appropriate timelines and guardrails in place to protect people with complex needs.

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[1] Voices for Better Health is a project of Community Catalyst, a national organization building consumer input in health reform http://www.communitycatalyst.org/initiatives-and-issues/initiatives/voices-for-better-health.

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Many, but not all, start-up issues have been addressed in MyCare Ohio. The managed care plans, Area Agencies on Aging, and other providers have worked tirelessly. However, problems continue and MyCare Ohio is falling considerably short of its potential to improve health and wellbeing of enrollees, coordinate acute and long-term care, and achieve future savings in Medicaid. There is still time to learn from past experience and engage in course-correction.

Independent Evaluation of MyCare Ohio: From our coalition's extensive communications with MyCare Ohio enrollees and providers, we know that many people have experienced problems, and continue to do so, from processes and systems that don't work. But we have no idea how many enrollees have suffered harm – especially serious harm. As important, no one knows how many enrollees have *benefited* from MyCare Ohio and, if so, in what ways. We need to know NOW how MyCare Ohio is working and falling short, so that stakeholders – the state, managed care plans, providers and consumers - can make mid-course corrections and improve it. Thus, we are requesting language to be added to HB 64 that would require the Department of Medicaid to contract with an Ohio university with expertise in gerontology and long-term care issues to examine the processes that have been used by the state and the managed care organizations and to determine how those processes have affected the MyCare participants. This would allow stakeholders and decision makers to adjust the program in real time and to address any problems revealed in the evaluation to assure that the desired care coordination outcomes are being achieved prior to determining the future of the program. The formal federal evaluation will not be completed until the end of the demonstration and does not cover the same ground.

Independent Providers:

We believe that persons with disabilities, regardless of age, should have a choice in who provides their most intimate care – such things as dressing, feeding, bathing and toileting. In Sub-Committee you heard from an individual using these services why access to Independent Providers – individuals they select - are critical to maintaining their health and quality of life. That's why OCVIC, consumers, and other advocates for people using home care were horrified when HB 64 proposed eliminating the current program using IPs who provide home care for thousands of individuals in and outside of MyCare, without setting out an alternative way that consumers could retain their providers of choice.

We asked OHT to remove the original language and create a workgroup with broad stakeholder participation to develop an option for long term services and supports in the timeframe necessary to address the state's concerns about the current arrangement, in which IPs submit Medicaid claims. OHT drafted language to create a workgroup and process for self-direction, one way to address this issue, which has not been included in the bill. Although MyCare Ohio requires that enrollees have access to self-direction, the program is not fully operational or accessible and is limited to MyCare enrollees. OCVIC and the plans have agreed to work on making sure that self-direction is a viable

option for MyCare enrollees, allowing them to retain their IPs, but we are concerned about the rest of the population needing these services.

Language in the current version of HB 64 calls for the legislature to resolve the IP issue by December 2015, but includes no workgroup, timeline or process with broad stakeholder participation. We are requesting – and will work to draft - language to be added to the bill that would protect the choice of individuals to use independent providers for their long term services and supports and preserve a living wage for those providers. We are requesting that the Senate create this workgroup, with broad stakeholder participation, to work out the complex details and policy choices involved and obtaining necessary federal waivers to do so.

Furthermore, if a federal appeals court upholds the new home care rule based on the Fair Labor Standards Act, additional funds will be required to preserve the ability to use Independent Providers in the immediate future while the workgroup determines the best approach. We would like to see funds set aside in the budget to make sure that people needing these services continue to receive the hours they need and that independent providers continue to be paid an adequate wage to continue working as IPs. OCVIC believes the state has the ability to estimate the cost and/or amounts for the set aside funds.[2]

Because OCVIC recognizes the vital role of Independent Providers in the lives of individuals who use them, we oppose any reduction in pay that will result from implementation of the proposed rule. The independent provider is highly skilled at providing personal care to individuals with very particular needs and preferences. Cutting their pay may force independent providers to seek other employment, compromising continuity of care and safety for many Ohioans with disabilities. Cutting their pay jeopardizes this work force, which will undermine not only the safety, but the right of people with disabilities to live in the setting of their choice and maximize their mobility – central tenets of the US Supreme Court Olmstead decision.

Vital Supports for Older Adults

We believe that older adults should be able to live in safety and dignity, without fear of abuse, neglect and exploitation. OCVIC wishes to voice support for vital adult services which are growing in importance as our aging and disabled populations grow. The first is to address the inadequate funding levels for Adult Protective Services, and we urge you to increase the APS funding to $20 million per

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[2] The details and timing of adding a consumer self-direction option to every Medicaid Waiver are complicated and critical. Many self-direction models exist, requiring choices. For IPs to remain a viable option for those who cannot function as an employer without assistance, investing in a fiscal agent will be necessary. Others may require a "surrogate" to assist with carrying out employment functions such as time sheets.

year in this biennium. The second is to allocate additional funds for preventing senior hunger, which jeopardizes the health of those with food insecurity. We endorse the request of our colleagues at Advocates for Ohio's Future in their funding requests for these pressing needs.

We are hopeful that, with these recommendations, MyCare consumers will experience a smoother transition to receiving their acute care and long term services and supports from Managed Care Organizations; that enrollees will have better health outcomes; and that Medicaid budget growth will be constrained. We believe that prior to making the decision whether to take MyCare statewide at the end of the three-year demonstration we must make investments now to allow the demonstration to succeed.

Thank you for considering OCVIC's input. I'm happy to answer any questions you may have.

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