Testimony presented before the Ohio House Finance Committee

Pamela E. Zipperer-Davis, MHA, FACHE, FACMPE, President, CareStar, Inc.

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- ✓ **CareStar, Inc., 5566 Cheviot Road, Cincinnati, OH 45247 (Corporate Headquarters)**
- ✓ **CareStar, Inc., 2760 Airport Drive, Suite 130, Columbus, OH 43219**
- ✓ **CareStar, Inc., 4141 Rockside Road, Suite 150, Seven Hills, OH 44132**
- ✓ **CareStar, Inc., 422 Main Street, Suite 202, Zanesville, OH 43702**

Chairman Smith, Vice Chairman Ryan, and Ranking Member Cera and the esteemed members of the sub-committee, thank you for allowing Dr. Barnes and I to speak to you today about HB 49. My name is Pamela Zipperer-Davis, and I am the President of CareStar, Inc., a case management organization with four offices throughout the great State of Ohio, serving Ohio beneficiaries in all 88 counties in the State of Ohio. CareStar's mission is, "improving communities by improving lives." We take this very seriously and are an integral part of the communities we serve, and know that the communities are healthier because of our services.

CareStar is the only entity that serves all 88 counties with the Ohio Home Care Program in the State of Ohio. We have continuously served the Ohio Home Care population since 1998. We started as a provider in two of the four regions in 1998. Then, became the sole provider from 2004 through July, 2013. A second provider was added in July, 2013 with each of the four regions having a second provider in 2015. CareStar currently provides assessment and case management services to 2,686 individuals in the Ohio Home Care Waiver Program (OHC). At one point, CareStar served as many as 14,000 individuals in the OHC Program. CareStar has a 93.9% patient satisfaction rating.

CareStar has been in business since 1988, is an S Corporation and an ESOP (Employee Stock Ownership Program). We employ 330 individuals, and preceptor interns and co-ops from many universities in nursing, social work, technology, health care administration and other programs. We are a stable and proud employer in the State of Ohio. Through employee donations, we offer nursing scholarships to three separate institutions of higher learning annually.

The Ohio Home Care program is a Waiver program that enrolls individuals who have been assessed and require waiver supports to enable them to remain in their home rather than receive facility-based care. These individuals have long-term, chronic and complex health conditions and disabilities. CareStar's Assessment Specialists and Case Managers conduct thorough face-to-face assessments to determine level of care, program eligibility and to ensure that the individuals' needs can be safely met in a community setting. The assessments and person-centered service plan development include the individual served, legal guardian, service providers and informal support persons the individual or guardian chooses. The assessments identify the strengths, weaknesses, preferences and needs of individuals, which serve as a resource in developing person-centered service plans. On an on-going

basis, assessments are completed to address the Individual's care needs and conditions. Assessments are completed by registered nurses and licensed social workers at three different stages as noted below:

Initial assessments to determine level of care and eligibility when an applicant requests enrollment on an Ohio Department of Medicaid (ODM) administered waiver.
Annual assessments for an individual's redetermination of level of care, program eligibility and service and support needs.
Event-based assessments for an individual on a program when he/she experiences a significant change of condition.

In addition to serving individuals in the Ohio Home Care Program, we serve thousands of other individuals that have chronic and complex health conditions. These individuals can have commercial insurance, Medicare, Medicaid, be a member of the MyCare Ohio Program or part of a Medicaid Waiver Program. In addition, CareStar Information Systems, Inc., a subsidiary of CareStar, Inc., has developed and provides the software to the Ohio Department of Medicaid for case management in the Home Care Program. This software has been licensed by the Department of Medicaid since 2005. The original application was developed by CareStar, at its own cost, as a case management agency, because software was not available through the Ohio Department of Medicaid or any other agency. We developed the software to manage and take care of the population we serve.

CareStar has a strong and passionate interest in seeing the waiver programs grow throughout the State of Ohio with decreased costs, improved consumer satisfaction and improved outcomes. We can collectively achieve this with other case management agencies, the AAAs, the Ohio Department of Medicaid, advocacy groups, hospitals, nursing facilities, physicians and other key stakeholders involved with this program.

We would like to call to your attention some of our concerns with the long-term services and support, LTSS, programs moving to managed care, MLTSS, in 2018.

As you know, the MyCare Program is making the transition to managed care and those results have not truly been documented. There is minimal data shared amount key stakeholders. The MyCare transition is still in its infancy and individuals are confused as the systems are complex. Care is delayed for many reasons. The transition has not gone as smoothly as many thought it would. We are currently in year three of a five-year transition, and more time is needed.

The 1915i, or Specialized Recovery Service (SRS) Program, began to move into managed care as of December, 2016. Like MyCare Ohio, that transition has not gone smoothly. Contracts for the case management agencies (CMA) with the managed care plans were not standardized, and there is still a great deal of confusion. Most managed care plans do not know how to contract case management agencies. They are used to contracting providers and CMAs are not providers under the Ohio definition of a provider. Every managed care plan presented different language, different program requirements, etc. The variance among the managed care plans has added an administrative burden, increased staffing in the case management agencies and delayed needed services.

Billing software has had to be acquired or billing must be outsourced to a third-party. Rather than the billing being directly between the CMA and the Department of Medicaid, case management agencies must bill all managed care plans. Some managed care plans have affiliated companies that handle the

behavioral health programs. Therefore, the 1915i requires that the case management agency not only work with the managed care plan, but also their subcontracted behavioral health entity. This adds an additional layer of rules, pre-authorizations, provider manuals, etc. CMAs have increased liability due to the lack of consistency and expediency with the managed care plans.

We continue with the programs that have been moved into managed care, MyCare and 1915i, to experience delays in individuals receiving services due to incorrect eligibility lists, prior authorization requirements and the complexity of claims management and payment. The two years remaining in the five-year transition of MyCare is still needed to assess the advantages or disadvantages of having moved My Care into managed care. This process should not be short changed until satisfaction surveys, costs, and most importantly, medical and social outcomes are widely known. The core business and competence of the managed care plans is not Medicaid Waiver programs, and their systems do not allow for the proper management of the individuals.

Some of the issues CareStar has experienced with the five managed care plans responsible for the 1915i Program are as follows. One of the plans denied 100% of the initial claims for dates-of-service in January, 2017. The denial reason was that T1016 was not a recognized CPT code in their fee schedule. CareStar had to use additional staff to appeal the denials, and to date, the payment has not been received, causing a cash flow delay of at least 60 days. A second plan denied 100% of all claims initially for the same reason noted above. Dates-of-service date back to January, 2017. Unfortunately, the resolution with this managed care plan is still pending. In good faith, CareStar continues to provide services to individuals while issues are resolved.

The third managed care plan denied 100% of all claims with dates-of-service dating back to January, 2017. The denial reason was that no pre-authorization was obtained for case management services even though the individual was referred to CareStar by the managed care plan. This situation is still not resolved and payment is still pending. For dates of service dating back to January, 2017, the lack of understanding among the managed care plan with loading the contracts, paying this type of service, eligibility of individuals, needed services and contracting case management agencies has led to significant delays.

While there has been great testimony regarding the AAAs providing these services, CareStar, as an independent case management agency, also provides these services. We are owned and managed under one company throughout the entire State of Ohio allowing for consistent and maximum coordination, communication and resolution of any issues that arise.

We agree with some of the assertions made by the Ohio Department of Medicaid in the PowerPoint testimony presented to this subcommittee on March 8, 2017 by Director Barbara Sears. If you look to page 15 of that PowerPoint, the following bullets are noted.

- In 2016, CMS recognized Ohio for leading the nation in HCBS spending relative to total Medicaid spending.
- The Home Choice Program ranks first nationally in transitioning individuals with mental illness, and is ranked second in overall transitions.
- More than 9,400 Ohioans enjoy new found independence through HOME Choice.

Once again, with CareStar being the only single entity that provides services throughout the entire 88 counties of the State of Ohio, we are very proud to be part of these accomplishments along with the Ohio Department of Medicaid. In House Bill 49, the managed care plans are not required to use case management agencies. This would put CareStar effectively out of business in the State of Ohio. While there is a great push for the AAAs to provide services through a mandate, there is no discussion of allowing a case management agency, such as CareStar, to continue providing services which CareStar has very efficiently and effectively done since 1998. With all the challenges that are before this committee, the taxpayers of Ohio and the rest of state leadership, why would we fix something that is not broken?

LTSS is a specialized area as noted by many others that have testified before you. While some note that states like Texas have recognized decreased costs, there is insufficient data as to the quality and outcomes that are being achieved. Further, there is insufficient data on the individuals' satisfaction and understanding of their programs. CareStar has created a solid company comprised mostly of licensed social workers and registered nurses that care for these individuals as well as individuals in programs like the Multiple Sclerosis Society and other disability programs. This is our core business, and we are excellent at the services we provide. We have experience with pregnant moms, infants, adults and geriatric populations. As part of a managed care population, the OHC individuals are a small group of individuals and are not part of the core business of a managed care plan, even a Medicaid managed care plan.

As a health care executive that has worked in hospitals and ambulatory settings and was a managed care executive, I understand the complexities of managing a very diverse population with diverse medical, behavioral health, social, financial and other needs. The populations will get lost when lumped in with hundreds of thousands of other members. The social needs, including such things as, home modifications are profound among this population. CareStar successfully administers home modification and assistive adaptive devices for 7% of our census each month enrolled in OHC. This is a need that will continue, and if poorly administered, will have a significant negative impact for the LTSS population. In the State of Ohio over the last 20 years, we have watched plans enter the state to provide Medicaid benefits, leave the state and discontinue providing Medicaid benefits and enter again to restart the cycle. The Ohio Home Care Program has been stable for the 19 years in which CareStar has provided services. Why destabilize a program that is nationally recognized?

I would like to close by thanking this committee for your attention and the opportunity to testify before you today. I would respectfully request that you not support the provisions contained in HB49 that would transition the LTSS program to managed care.