Ohio Consumer Voice for Integrated Care
Testimony to Senate Medicaid Committee,
The Hon. David Burke, Chairman
Panel on MyCare Ohio

By Cathy J. Levine, Executive Director, UHCAN Ohio

May 20, 2015

Chairman Burke, Ranking member Cafaro, my name is Cathy Levine. I am the Executive Director of UHCAN Ohio and am here today representing 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."

OCVIC's manager, John Arnold, who is here today, has conducted question and answer sessions with an estimated 10,500 enrollees since January 2014, in independent living communities, public housing, assisted living and other settings. Many enrollees, both older and younger adults with disabilities, are active on our Facebook page and participate in John's regional monthly phone calls with enrollees to discuss their experiences. He alone is in regular touch with 1150 enrollees. Other coalition members are also connected to enrollees in other 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 nation's best models.

Many, but not all, start-up issues have been addressed. The managed care plans, area agencies on aging, and other providers have worked tirelessly. How do we move forward to realize the potential benefits of MyCare?

[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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Independent Evaluation of MyCare Ohio: From our coalition's extensive communications with MyCare Ohio enrollees, we know that many people have experienced problems. But we have no idea how many enrollees have suffered harm – especially serious harm. More importantly, no one knows how many enrollees have *benefited* from MyCare Ohio and, if so, in what ways. We need to know how MyCare Ohio is working and falling short, so that we can work with the plans and state to 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 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.

Long-Term-Care Ombudsman:
We would like to see Ohio expand funding to improve the capacity of the Office of the State Long Term Care Ombudsman. Under MyCare, the Long Term Care Ombudsman responsibilities were expanded to include acting as the ombudsman for MyCare consumers -- the designated advocate for MyCare enrollees and families can go for help to obtain necessary and appropriate care and to monitor patterns of problems. Although there were limited federal dollars made available for this purpose, those funds have not covered the full costs of this important role and the state has been unable to place a dedicated MyCare Ombudsman in all of the MyCare regions. Recently additional federal funds of $205,000.00 became available that are paying for an additional Ombudsman in the Northeast Region and outreach materials.

The Ombudsman is crucial as the designated advocate for MyCare enrollees, but enrollees are not even aware that the Ombudsman is available nor do they know the right place to call. Due to funding and staffing constraints, the Ombudsman role in MyCare has been limited to responding to complaints – complaints they don't necessarily receive as enrollees are unaware of their existence. They are unable to make themselves known to home and community residents, as they have done so well in nursing homes. In order to allow the Ombudsman the ability to cover all of the MyCare regions adequately and to make it possible for them to be proactive in monitoring MyCare enrollees, OCVIC is recommending funds be added for their MyCare related work to the Office of the Ombudsman budget for SFY2016 and SFY 2017.

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. We have two people here today to tell you why IPs are critical to maintaining their health and

quality of life. Therefore, OCVIC and other advocates for people using home care were horrified when HB 64 proposed eliminating the current program using Independent Providers who provide home care for thousands of individuals in and outside of MyCare, without setting out a clear path for transitioning people choosing independent providers to self-direction. Consumer self-direction puts the individual in charge of his or her own care, instead of being "over-medicalized" by health care providers who tend to want to "cure" them, We asked OHT to remove the original language and replace it with language creating a workgroup with broad stakeholder participation to develop a consumer directed 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.

We are pleased that OHT has drafted a proposed amendment along the lines we requested, but we still harbor grave concerns. If a federal appeals court upholds the new home care rule based on the Fair Labor Standards Act, requirements for self-direction will have a higher price tag than before. We want guarantees that funds are set aside in the budget to make sure that people choosing self-direction receive the hours they need and independent providers get paid an adequate wage to continue working as IPs. Furthermore, 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.

OHT verbally promised to engage a workgroup affiliated with the Ohio Olmstead Task Force, and we support allowing that process to work to design a self-direction option that meets the needs of people with disabilities.

OCVIC coalition members are hopeful that with these important funding additions 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 allowing me to participate in this panel and I look forward to your questions.

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