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## Testimony at Public Hearing on Ohio ICDS Proposal to CMS

I am here as a long term advocate for the elderly. I am also the past chairman of the Ohio Advisory Council on Aging (2010-2011). My remarks will concentrate on the older population, but are just as true for the disabled and others covered under this proposal.

We all want the best coordinated care system with a close eye on the cost, especially as the elderly population continues to grow in Ohio. Let me speak first about the financial aspects of this proposal. Whether we like it or not, money dictates a lot of what affects service delivery. One of the stated goals is to save Medicaid costs for Ohio.

The way this program is structured, cost savings may not materialize. With for profit managed care companies securing contracts what you have is another pair of hands in the medical money pot. The first goal of MCO's is to make a profit. Potential savings would go first to the MCO's. We found in the 90's in Medicare when the profits weren't huge enough for the HMO's, they left the system.

Another cost factor is that the state would be sharing the capitation risk with the MCO's. So if the MCO doesn't feel their risk is being covered or their profit isn't high enough the state of Ohio will be obliged to give them a higher capitation rate. According to the Affordable Care Act, MCO's must spend 80% of their income on benefits. That leaves 20% for overhead and profit. Compare this with AAA's administrative costs of less than 10%.

Now let's look at the affect on the consumer- the most vulnerable of the elderly population. Ohio's 12 AAA's currently operate the third largest waiver in the U.S. Since its inception, PASSPORT has grown from serving 4200 persons to 30,000. Ohio has gone from a ratio 90% nursing home vs. community based care to a 58/42% ratio with a consumer satisfaction rate of 99%. The number would be even more dramatic if there hadn't been times when PASSPORT's intake was closed by the state. The average cost of PASSPORT is 1/3 the coast of nursing home care. The goal of getting to parity with other well performing states was well within reach under a planned Unified Long Term Care System.

For the consumer the service was seamless, with assessment, care management, caregiver support and monitoring of service providers. Under the proposed system, assessment and care management will go to different MCO's. The phasing in of the new systems will be very confusing and disruptive and could mean many more would end up in nursing homes because of the complexity.

It is too bad that all the experience of the AAA's was not considered in designing the new approach. We hope it is not too late to include this valuable resource in a meaningful way. Just as people with mental problems need experts in their field, and the disabled need experts in their field, so do the elderly need their experts. We can't afford to have these MCO's use this demonstration project as their learning tool.

Our greatest concern is that more dollars will go to the MCO's and as they cut back and deny services, as so many HMO's have done, it will be our vulnerable seniors who will suffer. Many will needlessly end up in nursing homes, instead of in the community, where they prefer to be and where the cost is so much less.

Lets remember bigger isn't necessarily better. Programs designed to meet different needs of different cohorts are possible within a structure that still addresses the urgent need for better coordination in our health care system.

Public Testimony-State Demonstration

Integrated Care Delivery System for Medicare –Medicaid Enrollees

Submitted 3/20/2012 by Deborah Nebel, Director of Public Policy

Linking Employment, Abilities and Potential (LEAP), Cleveland, Ohio.

Good afternoon, and thank you for this public forum designed to hear the concerns and recommendations of stakeholders, especially those of consumers and their advocates on this major health care reform initiative. My name is Deborah Nebel, and I am the Director of Public Policy for LEAP, a non-residential Center for Independent Living working primarily with adults with all disabilities, regardless of age. I also chair the Ohio Olmstead Task Force's Legislative Committee (OOTF), a grassroots coalition of disability advocacy organizations and consumers. Last week, you heard from two OOTF members, Pat Luchkowsky (Easter Seals) and Larke Recchie (Association of Area Agencies) and were introduced to OOTF's comments and recommendations which I support wholeheartedly. Today I have also included a copy of the Advocacy Principles we have adopted to serve as the core values by which we believe this proposal should be evaluated. Today I would like to focus on one of those principles—"Individual at the Center" of any service delivery system and what that means especially for persons with disabilities.

While we applaud the proposal's inclusion of "person centered care" as a good starting point; we believe that the proposal lacks key details on consumer-directed care. Our experience has taught us that person centered care is not the same as consumer directed or person directed care and we are concerned that the proposed delivery system will reflect too heavily on a medical and not a social or independent living model in which the individual is at the center of the system at both the macro and micro levels.

Specifically we are concerned about the following and believe the proposal needs to include or strengthen the subsequent areas:

- The needs and experiences to date of all persons who are receiving Medicare and Medicaid services through Ohio's Medicaid program should be reflected in

the core design, including both the positive and correcting the negative aspects of the current system. (Macro level)- For example-Care Coordination or Care Management should not serve primarily a gatekeeper function but rather build upon the desires and capacity for the individual for self-directed care. I.e. Services that enable the individual to live within the community of their own choosing. Persons should have informed choice as to the services that they receive. The Federal Cash and Counseling model which has not been utilized in Ohio and the Aging Choices Waiver should be incorporated into the overall design.

Meaningful Communications must also be a hallmark of any system design. And consumers and their advocates must have meaningful input into the design, procurement process, and ongoing input in the governance, policy, and direction of the chosen delivery systems.

- Acknowledge that while the aging population and the under 60 adult population with disabilities have similarities; there also are distinct differences. For those over 60, the care management component of PASSPORT obviously provides the support and responsiveness needed by an aging population and they have been successfully able to divert persons from unnecessary nursing home placements and remain living in the community for as long as possible. This service should be retained in the new model. On the other hand, persons under 60, if they cannot manage their own services need "care management" to serve more of a coordinating, networking, advocacy role. This population will often benefit from independent living skills training that enable them to manage their care and services and to receive the supports they need to live independently in the community. The Co-Op PCA model that LEAP helped start and that is being continued through the ODJFS Co-Op project should be considered. Centers for Independent Living and other providers with an independent living philosophy should be considered to provide care management/peer support services as needed by the individual.

- Individual Care Plans/Service Packages must be developed with the individual's participation and the care team should include team members of their own choosing. (Micro level)

The individual must approve and consent to the care plan, and should be able to decline services with informed consent.

Individuals should have the ability to hire independent providers for their Home and Community Based Services.

- Current proposal does not guarantee participants access to key long term care services and supports. While the proposal does state that persons will receive the "same services" that they receive currently the long list of services in the proposal use permissive language so consumers and their advocates are left wondering as to the administration's intent. It is also not lost on the advocacy community that cuts in the last budget to home and community based providers, especially independent providers, and to the PASSPORT program have further eroded Ohio's home and community based alternatives to institutional care.
- Ohio needs to make a commitment to add the services available under the Community First Choice Option to the Medicaid Services available under this integrated care service delivery model.

This option is available under the ACA under 1915 (k) and provides an enhanced 6% FMAP to participating states. Eligibility is set at 150% of FPL or states can use existing waiver standards and a person must have an NF LOC.

The attendant services available under this option would enhance what is available for the individual care plan. Personal care assistance includes assistance with ADLs and IADLs, other health related hands on care, cuing, and supervision. It also can help an individual acquire or maintain skills necessary for self-management, and consumer directed services. In addition it can provide non-medical services to help individuals transition back to the community including: first month's rent.

Thank you for this opportunity to testify and I look forward to working with the state on the implementation of this important health care reform effort.

Good afternoon, it's indeed a pleasure being with you this afternoon. Let's begin with a bit of history, I'm 81 years old, a veteran of the Korean Conflict, but today I want to talk about my wife, who was diagnosed with AZ in 2000, and I remain her primary care giver today. Incidentally, I needed to get a caregiver to stay with her while I am here. Her name is Thelma. She raised six children, active in community stuff (President of the woman's Board at Children's Hospital), started and worked her own interior design business, 25 years as a member of First Community Choir etc

Now; Thelma has twelve years on the slippery slope of deteriorated capabilities.

Our finances and our capabilities to care for Mom have also slowly deteriorated.

They tell me that 65% of spousal caregivers die before their loved one.

After about five years of doing my best, I reached out for help and found it at PASSPORT. I was introduced to the program and what a Godsend, We received some prepared meals to begin with and now we also have Daycare and some home health care services. I frankly have no idea where we would be at if not for the kind of help we have received. Lindsey Soma-Ungvari has become a close friend of mine as well as Thelma and is helpful, understanding and available.

I understand that services handled by Lindsey will continue but it seems that we are fixing something that's certainly not broken. A review of the concept leads me to question a few issues and wonder how this new reorganization can possibly make the process any better.

Let take a quick look at some of these proposals:

1. House bill 153 will authorize changes that will affect how long term care services are delivered in Ohio. Why because as a "consumer" I don't see what's wrong!
2. It will create a single HCBS. I can hardly wait!
3. This bill will improve "consumer" access to the system. I for one find the system very accessible.
4. I cannot imagine how a "consumer" will be given the chance to choose their provider.
5. "Consumer gets to choose their own manager. That looks like trouble to me.
6. Single waiver will:
  - a. Comprehensive new functional assessment
  - b. The State will separate the assessment and care management. Why
  - c. "Person centered planning
  - d. Two case management entities. Does that mean I need to be in contact with an entity far away and someone I do not know? That idea rules out my neighborhood management. What will happen to my friend Bonnie and her backup Kim who are available even when things unexpectedly happen and a close by flexible home health care company can handle that situation with dispatch?
  - e. Case management, 24/7 is unrealistic when operated by the State whereas if I call my home health care people at any time for anything they are ready and willing.

- f. Provider enrollment and reimbursement. Once again the State will establish rules and regulations along with an oversight...Is the FBI taking over?

The "alphabet" organizations, the continued reference to "politically Correct" language frightens me. I've been around a long time and I feel that the more the State gets involved the more the system costs and the further it is away from the "consumer"

Thank you

Donald Ross

TESTIMONY ON THE  
PROPOSAL TO THE CENTER FOR MEDICARE  
AND MEDICAID INNOVATION for  
STATE DEMONSTRATION TO INTEGRATE CARE FOR MEDICARE-MEDICAID  
ENROLLEES  
March 20, 2012

Good afternoon. My name is Alan Cochrun and I am the executive director of the Access Center for Independent Living in Dayton, one of Ohio's 11 centers for independent living. Centers for independent living provide non-residential, consumer directed services which *must* include advocacy, information and referral, independent living skills, peer support and transition to the community for individuals who no longer wish to reside in institutional settings such as nursing facilities and ICF/MRs.

Last week Ohio Olmstead Task Force Chair Shelley Papenfuse and I spent over an hour with HOME Choice Project Director Kim Donica discussing some of the issues that Transition coordinators are encountering in implementing HOME Choice, a program that upholds the Ohio Constitution's Inalienable Rights section. Aside from some administrative difficulties, most of the issues that we discussed are triggered by a lack of knowledge on the part of all parties involved. What is available to individuals enrolled in HOME Choice, what the process is, what the roles of each party are and even some issues around the basic philosophies of HOME Choice could be found at the root of most of the problems discussed.

The related Ohio Waivers are not new and HOME Choice was implemented back in November of 2008, so that's not new either. In fact, HOME Choice was designed to enhance *existing* waiver/state plan services. Yet, a lack of knowledge about HOME Choice and the services available to enrollees continues to hinder not only the transition process itself, but in many cases impacts the very success of many transitions.

It concerns me that Ohio's proposal to CMS included only a quick reference to education in the Executive Summary stating that the ICDS plans will include outreach and education functions; a reference to the Patient Centered Medical Home Education Pilot Project; and another in the NASHP Workplan. The word *training* (or even simply train) is only mentioned in Figure 4 under Additional Community Support Services; a *trained* health care professional under 24 hour in-person coverage; an Affordable Care Act citation under Ohio Minority Health; and Cultural Competency Training under the State Health Equity Work Plan.

A comprehensive training and education plan is as crucial to the success and implementation of this demonstration project as *any* other plan included in this proposal. A training plan that includes cross training on each role of the ICDS plan. A training plan that educates ICDS enrollees in not only what their enrollment options (which I *trust* includes services available and not just which health plans there are to choose from in their geographic area) are, but whose job it is to do what. A training plan that includes purveying what *participant-directed* truly means, in contrast to what *participant-centered* means. Most

importantly, a training plan that responds to the fear I personally heard in the voices of each and every person that spoke at the Focus Group I attended.

I cannot help but notice that the 7 geographical areas also happen to be areas of Ohio that are covered by at least one of Ohio's centers for independent living. We *are* who we serve – people with disabilities. Among the services we provide is the development of Independent Living Plans. These plans address the needs of an individual to live more successfully in the community. These plans reach beyond mere medical or functional needs, but more often than not include achieving successful outcomes in locating and obtaining the services needed to function and live their lives to the fullest extent possible. It is my hope that as Ohio moves forward in this demonstration project that it will consider this valuable asset and the resources they may bring to all parties in this effort, especially in the area of Participant-Directed Services. I have attached to my testimony a document that discusses Community-Based Organizations in the Dual-Eligibles Initiative from Massachusetts that you may wish to consider as you develop a more concrete plan for implementation.

Under **Provider Choice** on page 21 there is mention of *personal care attendants*. I am excited to see this provider type included in the proposal and I encourage you to look at the Ohio Rehabilitation Services' PCA program. Aside from financial woes it continues to be a successful program, and best of all it epitomizes the concept of *participant-directed services*.

I am, however, concerned about "allowed to have freedom of choice of providers within the networks" in the same section of this proposal will be defined. My concern not only refers to how my last suggestion might be implemented with this *within the networks* clause, but more specifically how it will impact the nursing and home health services options currently available to Ohio waiver beneficiaries. "Providers within the networks" implies, and hence my concern, that current delivery of services to participants who have long standing, well-working relationships with trusted, providers knowledgeable about the specific needs and procedures associated with the participant's health care *may* be disrupted. The unintended consequences of this may, but more likely will, disrupt the participants' lives, their jobs, and perhaps in a worst-case scenario – their health and safety. Providers who have worked with individuals for many years are vital to a participant's life in the community and are difficult, if not impossible to replace regardless of the length of time included in a "transition period." Providers in the mental health field, the brain injury field as well as ABD populations currently providing reliable and trusted services to individuals cannot be collateral damage as part of any policy change implemented by the great State of Ohio.

In closing I offer you a quote from William Penn, founder of the Province of Pennsylvania:

*"Right is right, even if everyone is against it, and wrong is wrong, even if everyone is for it."*

This can be taken many different ways. More frustrating, perhaps, is that they *all* apply.

Respectfully,

Alan R. Cochrun  
Executive Director  
The Access Center for Independent Living  
*...a member of the Ohio Abilities Network*



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## **Community-Based Organizations in the Dual-Eligibles Initiative**

### **What is a Community-Based Organization (CBO)?**

Community-based organizations (CBOs) are defined as organizations independent of any ICO or MassHealth or Medicare provider organizations, with expertise in LTSS. Generally, over 50% of the CBO's governing body shall come from the population it serves. The CBOs discussed in this document may include, but are not limited to: Independent Living Centers (ILCs), Recovery Learning Communities (RLCs), Deaf and Hard of Hearing Independent Living Services programs (DHILS), ASAPs, and chapters of The Arc. EOHHS, in consultation with other stakeholders, will further identify the characteristics of such CBOs, and the qualifications and duties of such LTSS Coordinators.

### **Coordinating Long-Term Services and Supports**

Long-term supports and services (LTSS) are to be coordinated by community-based organizations. ICOs will contract with CBOs to provide staff trained specifically to serve as independent LTSS Coordinators. The LTSS Coordinator is independent in that he or she is not directly employed by an ICO, PCMH, or other provider organization, to help ensure that coordination is "conflict-free."<sup>1</sup> However, he or she is expected to act in cooperation with the rest of the care team, and at the direction of the beneficiary. There will be one coordinator per care team, and ideally that coordinator will come from a CBO whose expertise is most reflective of a consumer's particular needs, including CBOs with

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<sup>1</sup> Community-based organizations which provide only referral, training, and assessment services shall not be considered "provider organizations" for the purpose of determining eligibility to provide independent LTSS Coordinator services.

whom the individual had a relationship prior to enrollment into the ICO. (For instance, a consumer with deep and persistent mental illness may wish to choose a coordinator affiliated with an RLC.)

The independent long-term service coordinator is a full member of the beneficiary's care team, serving at the discretion of the beneficiary. The consumer may decline to have an LTSS coordinator and seek other people to serve in this role or not have someone fulfill this role, while retaining the option to have this position filled at any time as needed.

The coordinator will assess the long-term support service needs of beneficiaries, working in coordination with the beneficiary and the rest of his or her care team to develop an appropriate service and care plan for community-based services, equipment and other home and community needs. This shall include both covered community-based services and other available community resources, as appropriate to the beneficiary's needs. If, after initial assessment, an individual has no LTSS needs, the LTSS Coordinator need not continue as member of team; however, an LTSS Coordinator shall be added to the team at any time at the request of the individual and in the event of any contemplated nursing facility, psychiatric hospital or other institutional admission.

Once LTSS needs have been identified, the coordinator will also assist in referrals and procurement of services, including those from other organizations as appropriate. If the LTSS requires medical expertise, the LTSS coordinator shall work with the necessary medical professional(s) and the beneficiary to ensure the beneficiary receives the appropriate LTSS.

EOHHS, in consultation with other stakeholders, will identify further qualifications and duties of LTSS Coordinators.

*Example 1: A care team has decided a beneficiary requires an air conditioner to reduce the incidences of heat exhaustion suffered by the beneficiary in the summer months. The LTSS service coordinator on the care team shall be required to assess the air-conditioner options in collaboration with the beneficiary and appropriate parties (i.e. building management). These*

*options shall be presented to the rest of the care team for final determination of the product to be purchased.*

*Example 2: A care team has decided that a beneficiary who previously had no LTSS needs (and thus had no active LTSS coordinator) now requires peer respite. A member of the care team shall be designated to contact the appropriate CBO contracted LTSS service coordinator, who will then re-join the team. The LTSS service coordinator shall be responsible for taking the necessary steps for the beneficiary to enter the peer respite.*

### **Ensuring Culturally-Competent, Barrier-Free Care**

In addition to using an independent LTSS Coordinator from a CBO, an ICO or EOHHS shall contract with designated CBOs, as determined by EOHHS, to ensure that it provides culturally-competent care suited to a diverse population of people with disabilities. Culturally competent care includes, but is not limited to, the ability to demonstrate compliance with the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS), Massachusetts CLAS standards, and the Americans with Disabilities Act.

An ICO, in order to demonstrate CLAS compliance, must contract with a CBO to complete a CLAS assessment every 3 years, or more frequently as appropriate, and to monitor the implementation of any recommendations resulting from the assessment process. ICOs must also contract with CBOs to provide ongoing training for staff at all levels on issues of cultural competence pertaining specifically to people with disabilities. These trainings shall include information about the intersections of disability, health status, and social determinants of health (such as race, ethnicity, socioeconomic status, gender, sexual orientation, and geographic location). Staff attendance at such trainings shall be required in order to demonstrate ongoing CLAS compliance.

*Example: An ICO requires staff to receive quarterly training on cultural competency in provision of care to people with disabilities. One quarter, the training is on unique attributes of Deaf culture. The next quarter, training may be on different views of mental illness within different ethnic minority populations.*

In order to demonstrate compliance with the ADA, an ICO must contract with a designated CBO to complete an ADA assessment tool required by the Department of Public Health. Previous completion of any assessment tools shall not be understood as fulfilling the ADA obligation. The ICO ADA coordinator will work with the CBO ADA trainer to assess compliance with the ADA, develop a transition plan and create a training program that meets the needs of the ICO. Trainings should be geared to address concerns specific to any ICO target populations or beneficiaries.

*Example: An ICO in Franklin Massachusetts contracts with an ILC in Worcester to conduct an ADA assessment. As part of the assessment the ILC discovers that the examination rooms in a provider's office are not accessible. The ILC will work with the provider to develop a transition plan that includes programmatic access. The ILC will work with the provider and track progress of the transition plan.*

### **Overseeing Service Provision**

Oversight of the dual-eligibles initiative shall be provided through a collaborative arrangement between EOHHS, ICOs, and those CBOs identified by EOHHS to fulfill this role. The consumer oversight entity formed by this arrangement shall be independent of any ICO or LTSS provider, and shall not be subject to legislative appropriation. It shall be an independent advocate for members of the program to provide quality assurance, performance monitoring, and ombudsman services to ICO members.

The responsibilities of the entity may include, but not be limited to: reviewing transition plans to ensure ICOs meet requirements of the Americans with Disabilities Act and CLAS standards; reviewing quality and performance data; reviewing eligibility and enrollment coverage policies; and reviewing medical necessity criteria and protocols.

The oversight entity shall also provide trained staff to assist consumers who have concerns or questions regarding the program. As part of this consumer-assistance role, the oversight-entity staff members may serve consumers who are going through the complaint process, in the role of third-party advocates. (The consumer may also elect to choose an advocate outside of the oversight structure.) The oversight organization shall receive notification of all complaints filed, tracking and reviewing them to assess any patterns or practices by ICOs that negatively impact the provision of care and services to consumers.

*Example 1: A dual eligible is denied access to personal care attendant services by an ICO, despite the service being recommended by the care team. The dual eligible shall have the option of getting support from the oversight entity in the form of direct advocacy. This advocacy may include, but is not limited to, providing direct assistance to the dual eligible in the internal ICO grievance procedure and/or filing a complaint against the ICO.*

*Example 2: The oversight entity will track ADA compliance of ICOs at the statewide level, reporting back progress to the Assistant Secretary for Disability and other stakeholders, for the purpose of determining strategies for improving ADA access by ICOs as needed, rewarding ICOs achieving compliance, and developing best practices that go beyond mere letter-of-the-law ADA compliance.*

### **Geographic Considerations**

To ensure the highest quality of services and conflict free case management, ICOs shall not be limited to contracting with CBOs by geographic regions. An ICO may contract with a variety of CBOs, without geographic limitations, in order to ensure its beneficiaries receive expert LTSS coordination particular to their primary needs, and in order to receive training and assessment to comply with CLAS and ADA obligations.

*Example: An ICO in a rural region of the state may not be geographically proximate to an ILC or be proximate to an ILC seeking contracts with an ICO, making it necessary for the ICO to contract with an ILC from another region.*

March 20, 2012

I am here today as an advocate for the Central Ohio Area Agency on Aging and its administration of the PASSPORT Program; just as the Agency and the PASSPORT Program have been advocates for individuals like my Mother.

My Mother is 96 years old and a consumer of the PASSPORT Program. My 88 year old Father is her primary care giver. When my family and I realized that in order to continue to keep my Mother in her home she would require additional assistance, we reached out to the Central Ohio Area Agency on Aging. From the very first time I contacted the Agency and learned of the PASSPORT program, my questions and concerns were met with compassion and an understanding of the importance of providing a safe home environment for people like my Mother. Today we have established a relationship with the Agency and the PASSPORT Program that far exceeded our initial expectations. We have a PASSPORT Case Manager that frequents the home and is always available to help us as we encounter the need for changes in assistance and care for my Mother. Through these visits, the PASSPORT Case Manager has been able to personally meet with my parents, assess their needs and help resolve any issues. I believe that to the PASSPORT Case Manager, my Mother is not merely a Case Number, but an individual that is to be treated with dignity and respect with the goal to keep her in her own home for as long as possible.

As I understand it, beginning in 2013 there will be changes to the way services, such as those my Mother receives today, will be delivered and accessed under the proposed Integrated Care Delivery System. I am also under the belief that there will be no loss of these services. However, my concern is that if the State of Ohio proceeds with a change to managed care without the inclusion of Central Ohio Area Agency on Aging managing the PASSPORT Program, our state's elderly and others in need will lose a valuable ally and advocate for their well being. I am also very concerned that there will be no "hands-on" Case Manager that will meet regularly with my Mother and others like her and assist in addressing their needs. I fear that personal knowledge and compassion concerning the consumer's best interest will be lost. I know that there is a cost associated to every service and that business decisions are often made on that basis alone. However, it is extremely difficult to associate a cost to a relationship between a PASSPORT Case Manager and the PASSPORT Consumer. This type of relationship affords the best opportunity to meet a consumer's needs. It is not a one size fits all process.

To conclude, I ask that serious consideration is given to retain the Ohio Area Agencies on Aging as the administrators of the PASSPORT Program and that PASSPORT Case Managers remain available to meet regularly with PASSPORT consumers. The Ohio Area Agencies on Aging have built a solid foundation for PASSPORT consumers and that foundation should remain. Their ability to seamlessly handle the PASSPORT Program is, I believe, the best Ohio has to offer to its citizens. To exclude their role would be a disservice to all they have served so well over the years.

Respectfully submitted,

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Testimony of Cathy Levine, Executive Director, UHCAN Ohio on Ohio Medicaid's  
Draft Proposal to  
Integrate Medicare and Medicaid Benefits  
Open hearing for Consumers, Family Caregivers, and Advocates  
March 20, 2012

My name is Cathy Levine. I am executive director of UHCAN Ohio, a consumer health advocacy organization that is working to implement health care reform and to make sure that diverse consumer interests have a voice in health care reform. Since 2010, we have coordinated the Ohio Campaign for Better Care, to make sure that health care reform fixes health care for older adults with multiple chronic conditions – who too often receive fragmented, uncoordinated health care with bad outcomes - and builds a strong voice of older adults and family caregivers.

Thank you for your serious efforts to replace fragmented, uncoordinated, and often unsafe care for older adults and people with disabilities with integrated, and better quality care and for your ongoing efforts to elicit stakeholder input into your draft proposal. We appreciate your inclusion of consumers in governance of the ICDS and quarterly member meetings to increase enrollee involvement.

UHCAN Ohio shares the administration's view that developing new models of integrated benefits for people who are dually eligible is a high priority for Ohio – and the nation. However, because you are proposing major changes in both medical care and long term services and supports (LTSS) for people with complex needs, the stakes are high for consumers and their families. Your current proposal is, unfortunately, lacking in essential design details that must be included in order to protect consumers.

Furthermore, although you have engaged stakeholders in general discussions over the past year, you have not allowed sufficient time for serious, regular conversations with consumers and advocates on the details of the specific proposal issued on February 27, 2012. By comparison, in Massachusetts, after their draft proposal was issued on December 2011, a 30-day comment period ended on January 10, 2012. Officials then took an additional *five weeks* to incorporate comments – as opposed to the *six days* Ohio has allotted between the close of comments – March 27, 2012 – and submission to CMS on April 2, 2012 to incorporate comments. Massachusetts officials met *weekly* with advocates – and sometimes more frequently - to fully understand their concerns and recommendations. The proposal that Massachusetts submitted to CMS on February 16, 2012, incorporates many of the advocates' design



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recommendations, many of which are also included in the recommendations you have received from the Ohio Olmstead Task Force and UHCAN Ohio.

On March 2, 2012, UHCAN Ohio co-hosted, with Ohio Olmstead Task Force, a one-day strategy session, facilitated by Community Catalyst and the Boston Center for Independent Living, experts on consumers' interests in developing improved models of care. Out of that "boot camp" came a set of principles and specific recommendations for strengthening the Ohio proposal. You have received our principles and recommendations. The Olmstead Task Force and UHCAN Ohio – joined by Ohio Consumers for Health Coverage, the coalition of diverse consumer interests that I co-chair -- urge you to adopt these recommendations and to work with advocates on specific proposal language so that we can get the details right.

And now for something completely different: The Olmstead members divided up our recommendations for the purposes of testifying and I won the privilege of speaking about Financing and Paying for Integrated Care.

Getting the financing right – typically left for providers and payers to decide – is a matter of life and death to consumers. OHT has chosen to pursue the capitated financing mechanism offered by CMS, with the goal of maximizing opportunities for changing how we pay for health care to promote better patient care, better outcomes, and lower costs. Many consumer advocates believe that a capitated model provides flexibility to spend money where it is needed – on home visits, wheel chair repairs, adequately funded personal assistance, bed sore prevention, and other services that keep people healthy. But the details have to be spelled out so that the money goes to better care.

Unfortunately, the OHT proposal is vague on critical details of how financing – and risk adjustment – will be determined.

To get the financing right for very diverse populations with complex – and widely varying – needs, this initiative will have to use *risk adjustment* and use it *effectively*. Effective risk adjustment will help to ensure that integrated care organizations are appropriately compensated for the risk of their enrollees and will encourage innovative care among providers who care for dually eligible individuals with high levels of need.

Without adequate risk adjustment, an ICDS may receive windfall profits, thus defeating a central goal of the demonstration project (better care at *lower cost*). And, while we are just as concerned as other stakeholders about reining in health care costs, the bigger concern for consumers is an

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*UHCAN Ohio is a statewide nonprofit organization working for high quality, accessible, affordable health care for all Ohioans.*



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*Undercompensated* ICDS: one without adequate resources to provide for the medical and long-term services and supports needed by the most complex beneficiaries and those needed to achieve person-directed care. Based on recent provider rate cuts, we are extremely concerned that the ICDS will not have adequate funding or a requirement to reimburse providers adequately to ensure that enrollees get the personal care they need to live independently.

Getting payment right requires taking a number of key steps. These are adapted from a recent report from *the Massachusetts Medicaid Policy Institute*.

1. **Establish rating categories** based on the type and severity of diagnoses among dual eligibles (this helps to capture some of the variation in risk among enrollees).
2. **Select – and then refine -- a single risk adjustment system** on the basis of several criteria, including accuracy, transparency, and the experience of payers
3. **Develop a method to predict long term support service needs.** This should include looking at prior expenditures, but should also include information from a **comprehensive assessment of an individual’s functional status, prevention needs and other factors.** Critical among these is non-medical factors, or **social determinants** – home and community resources that can help or undermine efforts to achieve and maintain good health, and which often determine racial, ethnic and economic health disparities.
4. **Use risk sharing strategies** to minimize losses and gains and encourage innovation. Please note: The Ohio proposal mentions the “possibility” of using risk-sharing strategies, such as stop loss and risk corridors. Given that this is a new program without data on actual program experience, Ohio must commit to using these additional strategies to ensure that ICDSs are adequately compensated and to protect consumers from unintended harm.
5. **Update the risk adjustment** for ICDSs frequently

We would like to see Ohio commit to incorporating each of these steps into its proposal to CMS.

We would expect that OHT would be able to provide an estimate of savings from moving to this new delivery system, along with the underlying financial assumptions, prior to CMS approving the project. For example, the public should understand what the state knows about the target population, their current rates of preventable hospitalizations, institutionalizations, and emergency room visits and how much the state believes it will need to invest upfront in increased primary care and community-based LTSS in order to not only meet quality metrics, but also to achieve the long-term projected savings.



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We want to see complete transparency around savings and to see savings that accrue to Ohio reinvested in community-based services and supports.

In light of outstanding concerns, we strongly urge Ohio to adopt a voluntary “opt-in” enrollment policy, instead of limited “opt-out,” at least in the early years of the program. Given the admittedly uncharted waters of rate setting and risk adjustment, coupled with the lack of track record for these new ICDSs, consumers should have the ability to volunteer – or not – for these new systems, until the bugs are worked out.

I have an additional recommendation that was not discussed with other partners. Ohio’s PACE program enjoys strong satisfaction from enrollees and it is my understanding that Ohio is considering expanding PACE to other counties. The proposal states that people currently in PACE will be allowed to remain there, but is silent as to future enrollment of new people in PACE. If the State requires all dually-eligible individuals (except those excluded in the proposal) to enroll in managed care programs, then they should include as an option for these individuals the ability to select PACE if they qualify (55 yrs of age and older, meet level of care criteria, live in the county of the PACE program, and are safe in their home setting at the time of enrollment). New York State has done this and it has been very positive. Independent assessment to determine that patients meet the level of care criteria should be incorporated.

Thank you again, and I would be happy to answer any questions you may have.



## **Advocacy Principles for Dual Eligible Integration Policy Initiatives**

The principles below apply broadly to individuals of all ages who are dually eligible for Medicare and Medicaid, including people with disabilities and chronic conditions. The term “community-based long term supportive services” (CBLTSS) encompasses the full gamut of medical and functional assistance services needed by individuals to live safely, live well, and with maximum independence in their communities throughout their lifetimes.

### **CHOICE**

Individuals have the right to choose where, how, and from whom they receive health care. The opportunity to live independently in an apartment or home, to be employed, to be engaged in the community with family and friends, to pursue personal activities, and to set one’s own schedule is not to be determined by an individual’s physical or mental health status or functional capacity.

### **COMMUNITY-BASED LONG TERM SUPPORTS AND SERVICES**

Individuals have a right to community-based long term supportive services (CBLTSS) that are readily available, consumer-directed to the maximum extent, and of sufficient scope to support independent living in the community. Policy initiatives must address how they will enhance the development and availability of CBLTSS, while also preserving the best features of a state’s existing CBLTSS systems.

### **DO NO HARM**

Individuals cannot be forced to bear such possible consequences as the short or long-term interruption of needed provider relations, reduced or lost services and benefits, CBLTSS coverage that is inadequate in both scope and levels, and the constant fear of unknown disruptions to critical healthcare services as states attempt to integrate highly complex and historically discrete Medicaid and Medicare funding and service streams. Existing Medicare and state Medicaid packages must not be weakened in the name of achieving unproven future benefits.

### **INDIVIDUAL AT CENTER**

The individual’s needs and experiences are core to every aspect of policy initiative design, from stakeholder outreach and process to integrated service delivery, from beneficiary assessment to establishing provider reimbursement rates, from implementation to monitoring and enforcement. In particular, care coordination strategies and CBLTSS must consistently inform and build upon individuals’ desires and capacity for self-directed care and independent living within their chosen communities.

#### **1. MEANINGFUL COMMUNICATION AND INPUT**

Individuals have a right to effective communication of all outreach information, general enrollee and beneficiary communications, and individual notices concerning

either their health or policy initiatives and procedures that could affect their health care services. This principle applies whether information is intended for distribution by mail, in person, electronically, or through any other technological process. Stakeholder processes are not complete without beneficiary input and feedback. Once enrolled in new programs, beneficiaries must have meaningful avenues to provide ongoing input into program governance, policy and direction.

## 2. PRESERVING ESTABLISHED PROVIDER RELATIONS

Individuals have a right to continue to see the experienced providers with whom they have established relationships. Various options for preserving individual continuity of care with providers must be made available at several levels and during key periods of time, such as during enrollment, during an extended transition period, and throughout treatment for a complex chronic or temporary condition.

## 3. NON-DISCRIMINATION

Individuals have a right to receive non-discriminatory and effective healthcare that fully complies with applicable federal and state law, which includes physical and programmatic accessibility, cultural and linguistic capacity, and appropriate specialist expertise in all aspects and levels of service delivery.

## 4. CONSUMER PROTECTION

Individuals have a right to consumer protections including strong state and federal administrative complaint mechanisms and recourse to state and federal anti-discrimination law without the need for administrative exhaustion, as well as requirements directed at such critical components as network adequacy, cultural and linguistic competence, stakeholder input, strong oversight and enforcement mechanisms, and the continual collection and development of real time and beneficiary-oriented data measures that track successful health outcomes and the maintenance of independent living in the community.

## 5. FINANCING AND PAYMENT

Initiative financing and payment structures must be transparent and cannot give providers an incentive for denying or minimizing the services and care needed by individuals, or give states the opportunity to use federal financing to supplement a state's Medicaid budget. The accrual of short and long-term savings from integration must be reinvested in the expansion of CBLTSS and a broad range of alternative services that further independent living in the community.

## 6. ENROLLMENT

Individuals must be allowed to actively opt in to new initiatives rather than being passively or mandatorily enrolled.

*Information contained herein is based on a document developed by Boston Center for Independent Living, Inc., National Council on Independent Living (NCIL), Community Catalyst, Disability Rights Education & Defense Fund (DREDF) and Tri-County Independent Living Center.*

OHIO OLMSTEAD TASK FORCE & UHCAN OHIO  
 COMMENTS AND PROPOSED RECOMMENDATIONS TO OHT PROPOSAL  
 ON MEDICARE-MEDICAID INTEGRATED CARE MODEL (ICDS)  
 3-8-12

<b>SPECIFIC CONCERNS</b> (BASED ON ADVOCACY PRINCIPLES FOR DUAL ELIGIBLE INTEGRATION POLICY INITIATIVES)	<b>SPECIFIC ASKS</b> (PROPOSED CHANGES)
<b>CHOICE; DO NO HARM; PRESERVE EXISTING PROVIDER RELATIONS</b>	
<p>Not strong on continuity of care, e.g.</p> <ul style="list-style-type: none"> <li>• How do members maintain relationships with current providers? Including the ability to retain and hire independent providers.</li> <li>• Only two choices of ICDSs</li> <li>• How will the ICDS provide LTSS such as personal assistance, to allow people to live in the community</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Require a transition period</li> <li>• Require ICDS to have an open network in order to bring in members' current providers</li> <li>• Require ICDS to allow for Single Case Agreements so that out-of-network providers can be paid and relationships can be maintained</li> <li>• Ensure reasonable provider rates. The significant cuts (20%+) to <b>independent providers</b> and the rules that apply the cuts to the first hour of service must be examined for impact on persons with disabilities who require more than one visit a day to live independently. Rates or (%) should be restored.</li> <li>• Contract with an independent community provider to serve as a consumer navigator. Within the targeted populations, Peer Counselors could be utilized (behavioral health, person with disabilities). Navigator would need up to date access to plan data and quality indicators to assist persons who are dual eligible to make an informed choice of ICDS. (outcome data)</li> </ul>

<b>COMMUNITY BASED LONG TERM CARE SERVICES AND SUPPORTS</b>	
<ul style="list-style-type: none"> <li>• Too much emphasis on medical model</li> <li>• Provision of all needed services is optional ("may" instead of "shall" in proposal)</li> <li>• LTC services and supports should be governed by an independent living model so that people get the services they need to live as independently as possible in the place of their own choosing.</li> <li>• Certain HCBS and behavioral benefits are listed only as "may be included"</li> </ul>	<ul style="list-style-type: none"> <li>• Guarantee members <u>all</u> waiver and state plan services (change "may" to "shall" in proposal)</li> <li>• Add additional services that promote consumer choice and access to LTSS</li> <li>• Develop incentives for ICDS to reward increased use of HCBS</li> <li>• Add Personal Care Assistance (non medical) and other services to Ohio's Medicaid program by applying for the Community First Choice Program available to the state's through the ACA.</li> <li>• The need for Independent Living Services must be included in the assessment (doesn't usually appear in a traditional medical assessment)</li> <li>• Details are needed on the how LTC</li> </ul>

	<p>Services and Supports will detailed in this proposal will interact with the Medicaid Health Home Proposal (Behavioral Health).</p>
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<b>NON-DISCRIMINATION</b>	
<p>Many providers are unable to provide effective health care for people with disabilities, limited English proficiency, or cultural differences.</p>	<ul style="list-style-type: none"> <li>• Provider networks need to be non-discriminatory and provide effective health care that complies with applicable law— physical and programmatic accessibility (offices, equipment), provide ways and methods of communication to meet the needs of individual consumers, cultural linguistic capacity (ASL) and appropriate Specialist expertise in all aspects and levels of service delivery.</li> <li>• A robust and comprehensive provider network that meets the needs of this population should be part of the criteria for contracting with a specific ICDS.</li> </ul>

<b>INFORMED CHOICE; MEANINGFUL COMMUNICATION AND INPUT</b>	
<p>Choice is meaningful only when it is <u>informed choice</u>  Concerns that prospective members will not know:</p> <ul style="list-style-type: none"> <li>• what an ICDS is, much less which one to enroll in</li> <li>• that the ICDS is managed care</li> </ul> <p>Concerns that plan is being rushed through</p>	<ul style="list-style-type: none"> <li>• Establish a navigator service, with independent navigators</li> <li>• Delay submitting proposal until details are worked out with stakeholders, particularly beneficiaries and their advocates</li> </ul>

<b>ENROLLMENT</b>	
<p>Needs much more detail on front door determination of eligibility and level of care (will it be similar to or less than the Passport program?)</p> <p>Ohioans who are dual eligible will be passively enrolled into systems that lack the capacity/experience to serve their complex needs, esp. the LTSS needs of persons with significant functional disabilities</p> <ul style="list-style-type: none"> <li>• Since opt out is only allowed for the Medicare services, will those that opt-out end up back in siloed systems? (I wasn't sure if the result described, siloed systems, is because opt out is only allowed for Medicare. Can someone clarify?)</li> </ul>	<ul style="list-style-type: none"> <li>• Presumptive Eligibility</li> <li>• Voluntary, opt-in</li> <li>• However, if passively enrolled, members need to be able to opt out of both Medicare <u>and</u> Medicaid</li> <li>• Develop an incentive program for Medicare enrollees to stay in the program</li> </ul>

**INDIVIDUAL AT CENTER: CONSUMER DIRECTED CARE**

<p>Proposal lacks key details on consumer-directed care; does not guarantee duals access to key LTSS Patient-Centered care is not the same as consumer-directed care.</p>	<ul style="list-style-type: none"> <li>• State should take up the Community First Choice option to ensure personal attendant services (key to consumer directed care)</li> <li>• Members should have option of consumer directed services (Choices Waiver in Aging)</li> <li>• Each member must have an individual care plan developed with his/her participation and with team members they choose; member should approve plan.</li> <li>• Persons participating in ICDS should have the ability to hire independent providers for their HCBS</li> </ul>
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<b>EVALUATION, QUALITY MEASURES, AND TRANSPARENCY</b>	
<p>The proposal contains very little detail</p>	<ul style="list-style-type: none"> <li>• Need to provide details on evaluation measures that incorporate metrics specific to duals population (and sub-populations)</li> <li>• Consumer advocates need to have input into the procurement process (criteria).</li> <li>• Proposal should have specific requirements around transparency of finances and quality measures.</li> </ul>

<b>FINANCING AND PAYMENT</b>	
<p>No details on risk adjustment No detail about expected savings or where they will go</p>	<ul style="list-style-type: none"> <li>• Financing and payment-risk adjustment must be done correctly so that persons in the ICDS are not denied necessary long term services and supports.</li> <li>• Profit (or non-profit "surplus") should be transparent; excess should be recaptured and reinvested in services</li> <li>• State should be required to reinvest savings in community-based care services and supports.</li> </ul>

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TO WHOM IT MAY CONCERN;

GREETINGS. I AM AWARE THAT MY SERVICES WILL CONTINUE, AND NOT BE ILIMINATED, BUT WILL CHANGE HOW I RECEIVE MY SERVICES AT THIS TIME. I REALLY NEED TO KNOW MORE ABOUT HOW THE WAIVER WILL WORK FOR PASSPORT CLIENTS, BOTH CURRENT AND FUTURE, AND SPECIFICALLY WHAT IT WILL MEAN FOR MYSELF OR MY FAMILY.

WILL I KEEP MY CASE MANAGER? WHO WILL BE PROVIDING MY SERVICES? WHO WILL BE WORKING WITH ME AND APPROVING MY SERVICES THAT I MAY NEED? HOW RESPONSIVE WOULD A NEW SYSTEM BE TO MY CHANGING NEEDS.

I CAN TELL YOU WHAT WORKS FOR ME AT THIS TIME. MEDICAL, TRANSPORTATION, MEALS, AND KEEPING OUR CURRENT AIDES ON STAFF. I ALSO FEEL THE "NEW DEAL" NEEDS TO BE RESTRUCTURED TO FIT THE ILLS OF TODAYS SOCIETY. SPECIFICALLY WHEN IT COMES TO TODAYS RISING COST OF HEALTH CARE.

WE ARE THE FORGOTTEN PARENTS, GRANDPARENTS, NEIGHBORS, ETC. IF CHANGE IS NEEDED, IT SHOULD BE FOR THE BETTER FOR ALL PEOPLE. IF THIS PLAN FURTHER PROMOTES ANY SUFFERING FOR THE CHILDREN OF THIS NATIONS GREATEST GENERATION, (BABY BOOMER'S). THE LAST THING ANY RETIRING GENERATION NEEDS IS MOR SUFFERING.

WHO DO YOU WORK FOR? BECAUSE AT GROUND LEVEL, IT DOES NOT APPEAR THAT YOU WORK FOR "WE THE PEOPLE." SENIORS ARE FIGHTING A LOOSING BATTLE ON MANY FRONTS EVERY DAY OF OUR LIVES. SO AT A VERY TENDER AGE IN OUR LIVES WE HAVE IN THE PAST, AND ARE CURRENTLY BEING ~~TH~~ THROWN TO THE WOLVES.

THANK YOU,

SIGNATURES

NAME

*Calvin Campbell*  
*Elizabeth Ashford*  
*Wald a Ctrip*  
*Linda Todd*  
*Eva Brooks*  
*Mary Jean Jefferson*

NAME

*Jacqueline Morton*  
*Charlene O. Thomas*  
*Gracie M. Springfield*  
*Sande Reynolds*  
*Paul Smith*  
*Valerie J. Brown*

My name is Carol Mollett and I am my mother, Roma Blazer's, representative. Currently, my mother's in-home care is managed through Passport and the Choices program. My sister, Kathryn Blazer, is her caretaker.

I am responding to a letter informing us that the Choices program may be eliminated in favor of a managed care company. Even though the letter states that my mother will still receive her services, it does not say how they will be administered. Does this mean that my sister may no longer be her caretaker? Who would be providing her services, if not my sister? Would some stranger be coming into her home for four hours a day to take care of her? Would she be able to keep the case manager she currently has? Who would be working with me and approving any new services she might need? How responsive would a new system be to her changing needs? I think these are pretty important questions that should be answered. It seems to me that this new "Managed Care Company" idea has come out of nowhere. Whose idea is it and why do they feel we need to change a system that is working? Also, why are they moving so fast that we hardly have time to respond or get our questions answered? It appears as if they do not want to answer our questions. As you can imagine, my sister and I are deeply concerned. To us this is not just about a number among many; this is about our mother, and the care she will receive in her last years.

My mother is 94 years old, partially paralyzed, incontinent, and has had 3 strokes. She is in a wheelchair and cannot be left alone; She needs continuous 24 hour care. My sister provides 24 hour care, but receives compensation for 4 hours. How much more cost efficient could a system be? If my mother were in a nursing home, the cost of her care would skyrocket. In order to take care of our mother, Kathryn cannot work out of the home and the pay that she receives is an important part of their income. Thanks to the Choices Program my mother is able to stay in her own home and be taken care of by her daughter. She is able to have her dog, eat home cooked meals, and engage in conversation with someone who can understand her and can respond appropriately, and most important, she feels safe and loved. A wonderful situation compared to a nursing home. In fact, I am sure it has contributed to her long life. Choices has been a blessing to us and continues to be because it allows my sister to stay at home and care for our mother. How could this possibly be improved upon and why would you want to change something that works so well? Also, I can't say enough about our case worker, Kristen Greer, whenever my mother has needed anything; Kristen has seen to it that we received it in a timely manner. She makes regular visits to see my mother to evaluate her and make sure she is okay and to check with her in case she needs anything. She also calls me to check in and ask how my mother is doing and I not only rely on her, but greatly appreciate her. In other words, my sister and I trust the Choices Program and the people who run it completely.

I hope you will take into consideration how we feel and express our concerns. Also, it would be nice to have some answers to the questions that I posed above, not just a blank statement that she will still receive her services.



# Campaign for Better Care

Building better care at lower cost for older and chronically ill adults

When we meet the challenge of making our health care system work for older and chronically ill adults...  
It will work for  
everyone.

That is the aim of the Ohio Campaign for Better Care, a movement of twenty-five organizations representing hundreds of thousands of Ohioans that strives to ensure that the needs of older adult patients and their family caregivers are front and center in the delivery of health care in Ohio.

Older adults and people with chronic conditions make the **heaviest use** of health care with the **poorest outcomes**, the **greatest challenges**, and at the **highest cost**. Obviously, the needs of older adults with chronic illness bear immediately upon the question of payment reform in the health care delivery system.

The Ohio Campaign for Better Care goes beyond the statistics about chronic illness to put a human face on the issue, to improve the health care system so that it delivers high quality, comprehensive, and coordinated care to older adults with chronic conditions and their family caregivers, and to mobilize and engage patients and families to fight for the care they want and need, bringing the voice of the consumer to policy debates over health care reform and how to implement any new legislation.

Payment reform will affect all participants in health care, including payers, providers, and insurers. Consumers, especially those with multiple chronic conditions and other health needs, worry that payment reform will negatively impact access to needed services. For these reasons, we encourage discussions of payment reform models to incorporate the following principles to ensure that the health and rights of consumers are protected.

## 1. Transparency

Measures of care and incentives built into the payment system must be open, transparent, and understandable by patients. An open process must be built through which there is full disclosure, capacity for public review, and explanation of all payment criteria.

## 2. Protect Vulnerable Consumers

Payment policies should take into account the higher costs of patients whose needs are affected by high medical utilization, socio-economic status, language and other social/cultural factors. Patients with high medical utilization should be protected by global payments.

## 3. Consumer Voice

Consumers are the heart of the health care system, and their voice must be strong and lasting in the governance of payment reform structures. Consumers should be represented at all levels of governmental implementation, including in the governance of ACO's or other intermediaries.

#### **4. Savings Shared With Consumers**

Legislations should provide explicit methods to assure savings created by payment reform are passed on to consumers.

#### **5. Patient Choice and Care Accessibility**

The payment system should ensure patient choice of primary care and other providers such as specialists, nurse practitioners and mental health professionals. Patients must have access to caregivers with linguistic and cultural capacity to provide effective care. Payment systems must promote patients' continuity of care with their providers. Patients must have access to medically necessary out-of-network care.

#### **6. Quality Improvement**

Any gain-sharing payments made to an ACO must be based on improved outcomes.

#### **7. Evaluation and Monitoring**

Legislation must include public, independent, meaningful and frequent monitoring and evaluation of the payment system focusing on quality of care, including outcomes, patient satisfaction and quality of life.

#### **8. Patient Empowerment**

Because they have been shown to lead to better health outcomes, reduced disparities, and better satisfaction with one's health care, as well as reduced costs, models such as chronic disease self-management, ideal medical practice, and shared decision-making must be supported by the payment system.

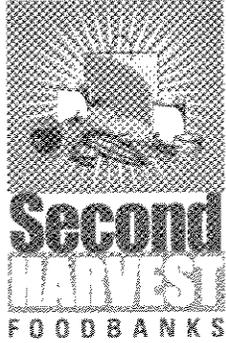
#### **9. Promote Public and Community Health**

Commitment to fund public and community health initiatives must accompany payment reform. Any ACO must be inclusive of community based providers such as health departments, community health clinics, mental health providers and homeless shelters, and new resources should be added.

#### **10. Patient –Centered Primary Care**

Payment reform legislation should align incentives so that patient-centered primary care is the center of our health care system. The payment system should support teams that can deliver culturally-competent, coordinated preventive and primary care that focuses on the patient's physical and behavioral health.

OHIO ASSOCIATION OF



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Office of Ohio Health Plans  
Integrated Care Delivery System Public Hearing  
March 20, 2012

Good afternoon, and thank you for the opportunity to speak to you today to share our recommendations for Ohio's Integrated Care Delivery System Demonstration (ICDS) program.

I first want to thank Governor Kasich and his leadership team for their vision and commitment to eliminate barriers, improve program performance, and modernize and integrate health and human services eligibility systems. These visionary efforts will help to reduce red tape and bring services to our most vulnerable citizens.

The emphasis that Ohio's ICDS program places on "preventing and reducing the harm caused by high-cost, prevalent conditions," such as diet-related diseases like diabetes, cardiovascular disease, or hypertension could effectively save the state hundreds of millions, if not billions, in health care costs, if adequate resources and policy changes are directed toward relieving Ohio's high hunger rates.

**Who We Are**

My name is Nora Balduff and I serve as the director of Child and Senior Nutrition for the Ohio Association of Second Harvest Foodbanks (OASHF), Ohio's largest charitable response to hunger. We represent Ohio's 12 Feeding America foodbanks, providing food, funding, training and technical assistance to more than 3,300 food pantries, soup kitchens, homeless shelters, and supplemental food providers.

**Who We Serve**

The need for emergency food continues to surpass record levels. From October to December 2011, 2.3 million Ohioans visited our member food pantries alone, an increase of more than 200,000 over the previous quarter. One in seven were adults over the age of 60. In 2010, one third of the households we served had a member in poor health.<sup>i</sup> The average income for a household standing in our food lines is \$910.00 a month.<sup>ii</sup>

Of the seniors we served, 75 percent reported trouble accessing a stable source of food, while 34.8 percent reported they had skipped a meal, cut back on the

From over 30,000 paper plates completed by emergency food assistance recipients in 2011:

*"I stand in line with the snow falling on my head. I'm 69 years old. These are my golden years?"*  
--Anonymous

*"I need food to live. Food stamps is not enough to last a month. I'm 82 on Social Security. It's not enough. I can't work."*  
--Martha H.

*"I was laid off my job. My husband is on Medicare and a diabetic. When we hit the donut hole, we have a choice: food or insulin. Food pantry keeps us going."*  
--V. Bloom



Ohio's Largest Charitable Response to Hunger  
- 2011 ServeOhio Award Recipient-

size of meals, or otherwise suffered from very low food insecurity.<sup>iii</sup> Ohio now ranks tenth in the nation for adults aged 50-59 suffering from food insecurity, and the recession's effects on income, depletion of resources, retirement savings, and investments threaten to increase the rates of both hunger and diet-related diseases in the future.<sup>iv</sup>

### **The Cost of Hunger**

Food is medicine. Hunger, food insecurity rates and health outcomes are directly linked.

A conservative estimate by the Center for American Progress, "Hunger in America: the Suffering We All Pay For," found that because hunger continues to exist, it cost Ohio \$6.97 billion dollars in 2010 in health care costs, lost educational achievement and worker productivity, and private charity. Most (78 percent) of the hunger bill was as a result of increased illness and health related outcomes.<sup>v</sup>

Food insecurity is an established health hazard and impairs the ability of Ohio's older adults to live safely, independently, and cost-effectively in their homes.<sup>vi</sup> Living with food insecurity dramatically increases rates of disability, diabetes, depression, and Activities of Daily Living limitations.<sup>vii</sup> Preventing food insecurity is demonstrably effective as a "vaccine" for a lifetime of poor health, hospitalizations, developmental delays, and anemia, among other damaging outcomes.<sup>viii</sup>

As a Hartford Scholar, placed at the Central Ohio Area Agency on Aging for my Master's degree, I visited with PASSPORT consumers in their homes. I can tell you how they, their families, and the home health care aides who care for them rely on the emergency food assistance network to put food on the table. Many of the older adults served by these programs participate in the Commodity Supplemental Food Program, a federally-funded box of prescribed commodities designed to provide critical protein, calcium, iron, Vitamins A and C and low-salt, low-sugar supplemental foods. Operated through a partnership with Ohio's foodbanks and the Ohio Department of Job & Family Services, Ohio's foodbanks have distributed over 21,500 monthly boxes, providing an average 35 meals per month, to very low-income older Ohioans. Federal limits on program funding and rapidly rising food costs have resulted in long waiting lists across the state and, as soon as next month, will result in the removal of 1,064 program participants, due to federal funding restrictions.

Our network is overwhelmed. Our supplies of food are diminished. We work hard to leverage public investment in relieving hunger but private charity cannot close the gap. That gap between access to enough healthy food and the risk of hunger is costing us now and will cost us more in the future, as our state ages and as the health of our children, our workforce and our older adults is affected.

From the paper plate project:

*"My grandparents wouldn't survive without the help from foodbanks like this one. He is a Korean War Vet and doesn't have enough money to buy prescriptions and food to eat."*  
--Anonymous

*"I need this food just to keep me alive. I'm a ninety year old woman and a widow at that. Now you do the math. Thanks."*  
--Nellie J.

*"We receive food stamps and Medicaid and have been forced to pay a \$260.00 spend down so that now we don't go to the doctor and can't afford prescriptions."*  
--Anonymous

*"I make \$7.50 an hour—home health. The Food Bank helps supplement my meals."*  
--Anonymous

While the ICDS program proposes including community support services such as home delivered meals, more must be done to adequately and cost-effectively prevent the diet-related diseases that will otherwise cripple all efforts to cut costs while providing effective care.

We must invest in increasing the amount of fresh, healthy food available to Ohioans young and old. Directing resources and policy changes toward preventing hunger will be far, far more cost-effective than the treatment of chronic, diet-related disease.

## Recommendations

In recognition of the health care cost savings that can be achieved, the sustained record demand for services, and rising fuel and food costs, OASHF recommends:

- Investing \$4.5 million of Medicaid GRF over the 2013 SFY budget to provide additional fresh fruits, vegetables, and lean protein items through the Ohio Food Purchase and Agricultural Clearance Program.
- Piloting the auto-enrollment of eligible older Ohioans from multiple state-administered programs into the health support and benefit programs they are eligible for, like the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps), Medicare Savings Programs, the Medicare Part D Extra Help program or the Low Income Home Energy Assistance Program.
- Including food insecurity screenings within all publicly funded programs that serve older adults, their caregivers, and their dependents to identify, reach, and enroll those who are potentially eligible into all of the health support and benefit programs for which they may be eligible.
- Expanding and integrating proven programs, like The Ohio Benefit Bank™, into service delivery.

Thank you again for the opportunity to speak today on behalf of the hundreds of thousands of older adults we serve. We stand ready to work with the Office of Health Transformation and Office of Ohio Health Plans to bring about sustained solutions that cost-effectively address our health care crisis while meeting the real needs of the people we all serve.

Nora Balduff, MSW, LSW  
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From the paper plate project:

*"My husband and I are both retired and on fixed incomes. We are struggling to keep our home and at time it is hard for us to keep food on our table. Without the help of all the West Ohio Food Banks around Lima we would have to buy cat food for ourselves."*  
--Anonymous

<sup>i</sup> Hunger in Ohio, 2010. Mathematica Policy Research, Inc.

<sup>ii</sup> Ibid.

<sup>iii</sup> Ibid.

<sup>iv</sup> Ziliak, J., Gundersen, C. August 2011. Food Insecurity Among Older Adults. AARP Foundation. Retrieved from [http://drivetoendhunger.org/downloads/AARP\\_Hunger\\_Report.pdf](http://drivetoendhunger.org/downloads/AARP_Hunger_Report.pdf)

<sup>v</sup> Shepard, D., Setren, E., Cooper, D. (October 2011). *Hunger in America: Suffering We All Pay For*. [http://www.americanprogress.org/issues/2011/10/pdf/hunger\\_paper.pdf](http://www.americanprogress.org/issues/2011/10/pdf/hunger_paper.pdf)

<sup>vi</sup> Lee JS, Fischer JG, and Johnson MA. *J Nutr Elder* 29(2): 116-149, 2010; Torres-Gil. *Nutrition Review* 54:S7-8, 1996; Ziliak JP et al. *The causes, consequences, and future of senior hunger in America*, 2008.

<sup>vii</sup> Ziliak, J., Gundersen, C. August 2011. Food Insecurity Among Older Adults. AARP Foundation. Retrieved from [http://drivetoendhunger.org/downloads/AARP\\_Hunger\\_Report.pdf](http://drivetoendhunger.org/downloads/AARP_Hunger_Report.pdf)

<sup>viii</sup> Ettinger de Cuba, S., Weiss, I., Pasquariello, J., Schiffmiller, A., Frank, D., MD, Coleman, S., Breen, A., Cook, J., MD. Children's Health Watch. *The SNAP Vaccine: Boosting Children's Health*. Retrieved from [http://www.childrenshealthwatch.org/upload/resource/snapvaccine\\_report\\_feb12.jpg.pdf](http://www.childrenshealthwatch.org/upload/resource/snapvaccine_report_feb12.jpg.pdf)

**Testimony at Open Hearing for Consumers, Family  
Caregivers and Advocates**  
**STATE DEMONSTRATION TO INTEGRATE CARE FOR  
MEDICARE-MEDICAID ENROLLEES**

Director McCarthy, members of the Integrated Care Delivery System Management Team and members of the Office of Health Transformation: My name is Maria Matzik and I am an employee of the Access Center for Independent Living in Dayton, a consumer of the Ohio Home Care Waiver Program as well as a being dual eligible, and most importantly a proud member of the disability community.

I currently sit on many committees: The Medical Care Advisory Committee, the Single Waiver Committee, the Front Door (Level of Care Committee), and the CareSource Integrated Care Advisory Council. I have had a couple of meetings with you, Director McCarthy, in the past to gain an understanding of the direction that Ohio is going with health care. I come before you today to say that I am greatly concerned in the direction that you have chosen and the amount of questions that are still remaining.

From the Demonstration Proposal you say:

***Ohio has formally sought internal and external stakeholder input into the design of an ICDS program beginning in January 2011. Over the past year, the State has conducted numerous activities to solicit this input and has given serious consideration to stakeholders' concerns and expectations in making key decisions about the program design. These activities include:***

- ***Presentation of a concept paper to the State's Unified Long Term Care Systems Advisory Workgroup;***
- ***Development of a beneficiary questionnaire and summary of responses; and***
- ***A series of public meetings and statewide conference call***

***In late December, State staff met with advocates for consumers and family caregivers to formulate a strategy to obtain input directly from individuals and other interested stakeholders in their communities. Based on recommendations from that meeting, during January and February 2012 state staff participated in five regional meetings in Athens, Cleveland, Columbus, Dayton, and Toledo.***

I would like to point out a few things:

- You say that the input was ***given serious consideration to stakeholders' concerns and expectations in making key decisions about the program design.*** The input from most forums and the conference call was **against** a managed care model. During the focus group in Dayton, which I co-coordinated, when participants expressed a fear for a managed care model they were told that the state has not yet made a decision on this. I find it difficult to believe that from February 3<sup>rd</sup> to February 28<sup>th</sup> you made that decision. Individuals could not give informed input because they had no idea what it really was that they were commenting on.

- Individuals giving input had the concept paper for a foundation. Most had no idea what the concept paper was. When the concept paper was released it said nothing. When questions were posed to State Officials they were not answered. How is this informed input?
- You state that *in late December* a decision was made about holding 5 public meetings to gather consumer input. This decision was made because Mrs. Butler pointed out, during a Unified Long Term Care Committee meeting, that the input of consumer's had been overlooked. I don't believe that the state would have organized the focus groups or conference call had it not been for that meeting. And, since it was an afterthought the rush to organize them so quickly caused little time for some sites to reach out to *ALL* stakeholders.
- You state that "*advocates for consumers and family caregivers*" were involved in this meeting, but what about *THE* consumers? Why were they not involved?
- And in regards to the *beneficiary questionnaire* it was altered and reposted without knowledge or input from the consumers and disability advocates. The information removed was questions that were crucial to gaining a snap shot of consumer direction and independent living.

You state in the proposal that:

***The delivery of services to the ABD population through a managed care model is not new in the Ohio Medicaid program.***

- Individuals who are receiving services in a Medicaid 1915(c) Home- and Community-Based Services Waiver are new to managed care. As I stated earlier I sit on the CareSource Integrated Care Committee and they have no concept of consumer direction. Disability is an entirely new concept.

You state in the proposal that:

***Ohio's Long-Term Services and Supports System remains out of balance, tilted heavily towards institutional service settings. Ohio lags behind most other states in its rebalancing efforts. Medicaid spending per capita for nursing home care in Ohio still ranks in the top quintile of all states, and the relative proportion of Medicaid spending for institutional care versus community-based care is well above the national average.***

- First, in your packets I have provided you with an outline about the Community First Choice Act and comments from ADAPT which explains in detail the CFC Option. I know that you, Director McCarthy, have been given information on this in the past. The Patient Protection and Affordable Care Act of 2010 established a new State plan option to provide home and community-based attendant services and supports. Section 2401 of the Affordable Care Act, entitled "Community First Choice Option," adds a new section 1915(k) of the Social Security Act (the Act) that allows States, at their option, to provide home and community-based attendant services and supports under their State plan. This option, available October 1, 2011, allows States to receive a 6 percentage point increase in Federal matching payments for expenditures related to this option. The section 1915(k) benefit does not diminish the State's ability to provide any of the existing Medicaid home and community-based services. States opting to offer the Community First Choice Option under section 1915(k) of the Act can continue to provide the full array of home and community-based services under section 1915(c) waivers, section 1115 demonstration

programs, mandatory State plan home health benefits, and the State plan personal care services benefit. Community First Choice provides States the option to offer a broad service package that includes assistance with ADLs, IADLs, and health-related tasks, while also incorporating transition costs and supports that increase independence or substitute for human assistance.

- Second, Director McCarthy when you and I met last year on Friday April 22<sup>nd</sup> we had a great conversation about the direction of the state's health care. You told me that you were an idealist and that you want us to think outside of the box. I do not see that in this proposal. I see a lot of wordage that is consistent with the status quo. I thought that we would have the opportunity to discuss things like non-licensed individuals being part of the mix of providers. That, as we discussed in the past, would be a huge cost savings and would open up another avenue for consumer choice. At the very least I would have liked to have seen Independent Providers mentioned in the proposal. I am concerned that the managed care agencies will contract only with agencies. The cost savings may not be apparent when viewing Independent Providers vs. Agencies, but the quality of outcomes and satisfaction to the consumers has to be taken into account. Furthermore, I ask that an extensive review be conducted as to the effect of the providers pay cut and the delay in reimbursement to providers when MITS went live. I know several individuals who lost providers due to both.

You state in the proposal that:

***In the specifications included in the state's Request for Applications, the state will request that prospective ICDS health plans adopt a care management model that fundamentally transforms the manner in which health care is provided to persons who are dually eligible for Medicare and Medicaid, particularly those with high functional needs. Prior demonstrations of integrated care models for Medicare-Medicaid enrollees have shown that increased investments in primary and preventive services can produce high returns on investment in terms of reduced utilization of tertiary care, including inpatient hospital services and extended nursing home stays. This transformation in care management includes extensive use of home visits, high use of physician substitutes such as physician assistants and nurse practitioners.***

- Next in your packets you will find an example of New York's Independence Care System model. I saw this and thought, "Now that's thinking outside of the box!" For a decade now, Independence Care System (ICS) has operated a nonprofit Medicaid Managed Long-Term Care (MLTC) plan in New York City whose motto is: "People with Physical Disabilities Welcome Here." The services provided, which make up the ICS Disability and Chronic Care Coordination model includes:
  - **Person-centered care coordination**
  - **Enhanced care management**
  - **Home care services** - including both agency home care providers and Consumer Directed Personal Assistance. Consumer Directed Care enables ICS members to select their own caregivers, who have broader latitude to help than agency caregivers—a crucial factor for the independence of members with very high needs (e.g., catheterization, suctioning).

- 12-24 hours of personal care
- Behavioral health program
- Expert wheelchair fitting, purchase, maintenance and repair
- Specialists in pressure ulcer prevention and intervention
- Social/educational/artistic activities to combat isolation
- Transportation services

The ICS program of services has resulted in improved health care outcomes, including prevention of potentially avoidable medical complications, reduced emergency room visits, fewer and shorter hospitalizations, and success at keeping individuals out of nursing homes and living independent lives, in the language of the landmark Supreme Court *Olmstead* decision, in the “least restrictive environment.”

You state in the proposal that:

***The state will also be looking to purchase care management models that are culturally sensitive to the Medicare-Medicaid enrollees they serve. Medicare-Medicaid Enrollees are, by definition, low income. Many have significant disabilities or frailties related to advanced age, but they share a common desire to be treated with dignity and respect by the health care system. Culturally sensitive care management models, which make sincere efforts to build provider networks that reflect the cultural characteristics of their members, will be rated more highly in the plan selection process. The state will also be looking for models that recruit providers capable of communicating with members in their own primary language.***

- Disability is a culture and it is important to remember that our needs are very different from our seniors with disabilities. Being Deaf is being part of a culture. Sign language interpreters will be a crucial need.

You state in the proposal that:

***A requirement to conduct periodic home visits with members so that individuals can be observed and assessed in their own home environment. Individuals with more significant health and functional needs will be required to be visited more frequently than individuals in relatively good health and with no functional impairments.***

- What is meant by “relatively good health and with no functional impairments”?
- I would challenge “you”, Director McCarthy and members of this review team, to come and spend time in our world before making such drastic changes – not relying on multi-million dollar analysis, but get to know us and what our lives are like before making decision that will impact us forever.

You state in the proposal that:

***A common or centralized record, provided by the ICDS, for each beneficiary, whose care is coordinated by the ICDS, that is accessible to all health care practitioners involved in managing the beneficiary’s care, so that all encounters with the beneficiary by any practitioner can be shared across the ICDS***

- What about being accessible to the beneficiary? Will we have access to our records?

You state in the proposal that:

***While Ohio intends to provide specifications for the “architectural framework” of the care management model for ICDS members in its Request for Applications, the state also recognizes that the organizations bidding for ICDS health plan contracts will also bring to the table their own care management models for effectively managing care for Medicare-Medicaid Enrollees.***

- The enrollees (a small diverse group) should be at the table.

You state in the proposal that:

***Improving the overall quality of care by making health care more patient-centered, reliable, accessible, and safe, by eliminating preventable health-care acquired conditions and errors.***

- At what point did we enter into such a medical model? This should refer to “Consumers” and “Consumer Directed” not “patient-centered”. We do not want a medical model service where the individual plays a role as patient, as has often been the case in traditional home care. We want a model where services are based on the independent living model where the individual has the maximum control possible.
- I understand that Medicare uses an acute care medical model. Federal law prohibits Medicare from paying for services other than those considered necessary for the diagnosis or treatment of illness or injury or restoration of function. It also requires that a beneficiary “be confined to the home” or homebound in order to receive home health benefits and that the home care have a clear end point. That said, how will this Dual Eligible Demonstration Waiver allow for us, some who have had functional limitations from a very young age, to thrive. We seek to have everything that you have employment, education, worship, play sports, volunteer, create art, raise families, social opportunities, intimate relationships, etc. Our needs are not exclusively medical and in a lot of instances with individuals with physical disabilities it’s just our life and very normal. You sensationalize it by making it something that it’s not, a “condition”, an “illness”, “the most vulnerable of society”. We are not side shows, but a part of a contributing society.

You state in the proposal that:

***Individuals will be required to choose one of the two ICDS plans in a region. Thus, if the SNP is not one of the ICDS plans, the individual will be disenrolled from the SNP and given the choice of one of the ICDS plans.***

- What if the plans don’t have what an individual needs?

You state in the proposal that:

***Although Medicare-Medicaid Enrollees will be required to receive services within the designated networks of each ICDS plan, beneficiaries will be allowed to have freedom of choice of providers within the networks, including choice of LTSS providers such as personal care attendants. During the stakeholder engagement process, consumers identified “Participant-Directed” services as a valued LTSS benefit. ICDS plans will be required to provide Participant-Directed services as a service option within their LTSS benefit package. This service allows ICDS members to select their own LTSS providers within an established individualized budget, including the option to pay family members as personal care attendants. ODJFS is considering the option of contracting with a single fiscal agent to manage this***

*benefit for all participating ICDS plans, to reduce the administrative costs related to this service option.*

- We are concerned about the choice over our direct care providers that we currently have, particularly the use of Independent Providers vs. agencies. Will this fiscal agent allow us to do that?
- Participant directed allows for choice and assures that the ultimate decision regarding services and supports is indeed the individual. Individuals (or their representatives) should be empowered to decide who comes in their homes, assists them with finances, assist them with cares that would mortify you to need assistance with, have access and knowledge about the most personal part of your life, etc. by *selecting* the providers. Individuals (or their representatives) should be empowered to *manage* their services by determining the schedule for when they receive services and addressing performance issues of providers, and if an individual (or representative) decides that they do not want a provider working for them anymore, that individual should be empowered to *dismiss* the provider.

In conclusion, I would like to express my hope for a program that has the potential to provide remarkable services, but a concern for the speed in which this is being proposed. I personally ask you, Director McCarthy, to not lose sight of the need for opportunity, equality and continuity in the service package for Ohions. I ask that you look at this as an opportunity for our brothers and sisters to thrive and succeed as a contributing part of our society.

Thank you!

Respectfully,

Maria A. Matzik, B.S.  
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## State Demonstration to Integrate Care for Medicare-Medicaid Enrollees

Public Hearing March 20, 2012

Good Afternoon Director Moody, Director McCarthy, Dual Leader Harry Saxe and other Ohio Governmental employees.

My name is Mary Butler. I am employed by the Ohio Statewide Independent Living Council (OSILC) as Systems Change Coordinator and I am a charter member of Ohio Olmstead Task Force, serving as the first Co-Chair, Chair for more than 5 years and as vice-chair for the remaining 6 years. OOTF began its 11<sup>th</sup> year in February.

OOTF membership has participated in workgroups that ODJFS has held, not only for Dual Eligibles but for Health Homes, Single Waiver programs and beyond. This is a huge undertaking and I want to compliment both Directors for the knowledge they have procured before working with the people who will have their lives changed by some of what we are talking about doing. We want to thank you for using the data obtained by the Lewin Group through regional meetings held around the state and two statewide Conference Calls as well as numerous private meetings.

People made it very clear that they like PASSPORT and Choices. The disability community feels it is extremely important to keep the Choices Program in place and to allow it to expand beyond the 60+ age group into the younger adult group. This program is definitely "consumer directed." Some people, like myself, are very interested in what the State has to offer and is willing to learn even more so that we all can make informed choices of what is going to affect the way we live the rest of our lives.

ODJFS's HOME Choice Program has been using Area Agencies on Aging, Centers for Independent Living, Ohio Brain Injury Associations, and other non-profit agencies for the Transition of people from nursing facilities to home and community based services and supports. Those organizations are known as Community-Based Organizations (CBOs). Those CBOs are invested in the disability/aging community and will do a superior job for ODJFS and for the people they serve. Other CBOs include, but are not limited to: Mental Health Organizations, Deaf and Hard of Hearing Centers, The Arc, Blind Centers and some in connection with other stakeholders. When an entity, such as those, have the independent living philosophy, the correct training and focus for long-term supports and services coordinators, participants tend to be very satisfied. The coordinators can assist in helping the person make an informed choice by providing true choices. MA has legislation covering this aspect that we could review

The Administration has been saying that they are making home and community services and supports available to everyone who wants them, rather than put them automatically into a nursing home. I want to believe what is being said is true, but do

not understand the 3% cut in agency workers in the community and the 3% plus a 20% cut in the pay scale of Independent Providers. To add more fuel to the fire, nursing homes (institutions) are getting an increase of about 10% per person in their beds. These employees are taking care of people who need assistance. The only thing different between them is the "where" they do their job! To make this a "level" playing field, where everything is equal (fair), the pay system should be the same for each of them no matter where they perform their duties. The cuts really do need to be corrected in an upcoming budget. As a direct result of this cut, some Independent Providers have left their jobs and others have taken jobs where they make more money.

We really want to see the state apply for the Community First Choice Option authorized under the Affordable Care Act. This option could increase home and community attendant services, so needed to keep people in the community where they have been living with family and friends around them. My mother lived in the community until she died just 2 months short of her 98<sup>th</sup> birthday. So many people, especially in the medical community, stated that she should be in a nursing home because she was too old to live in the community! She did not think that was so and made it very clear how she felt every time we faced one of those medical community people. We need to re-educate people, especially the medical community that people can stay in the community until they take their last breath. All they need is support and services to be able to stay there. If that is their wish, why not provide it? Because my daughter-in-law's parents lived in Canada, I know they provide services and supports to stay in the community as first choice for their residents. People are happier being where they want to live.

In the proposal, you have not addressed how the state is going to provide cultural, racial and some specific services needed to not have people feel they are being discriminated against. Again I can see how having CBOs assisting in this area would be a big help. Independent Providers are another way this can be solved. With independent providers the person with the specific need is the employer. The employee looks at the employer in a totally different way than "a client" of some agency and the agency is the employer. Independent providers are one of the most important parts of services and supports.

Please do listen to my brothers and sisters who are a part of our community. They see things that are equally important to them. Remember that we LIVE this life on a daily basis. Who else would know what is important other than someone who lives every day needing supports and services??? Please pay particular attention, and if you do and you take advantage of and utilize what is being suggested, you can have a state that others will point to as really serving their disability/aging communities.

Thank you.

(440) 864-3495

Thank You!

Hi!

MARCH 20, 2012

To whom it may concern;

My name is Toshia my Aunt Ellen Williams has been blessed by the PassPort program. In her own words she went from living in Prison to living in a mansion here at the Lincoln Lodge Retirement Residence.

We understand the program will still exist in some form... How it will be implemented and the quality is in question?

We are very grateful to have COAAA on our side. The case manager has been very diligent about making sure all of my Aunt's needs are met.

Jeanette Hamilton

Will my Aunt Ellen be able to keep her case manager?  
Who will be providing her services?  
Who will be working with me and my Aunt and approving new services she may need?  
How responsive would a new system be to my Aunt's changing needs?

(nursing home called Bryden Place)