



Testimony of Holly Saelens

AVP, Government Contracts

Molina Healthcare of Ohio

On

Integrating Medicare and Medicaid Benefits

Open Hearing for Providers and Other Stakeholders

Tuesday, March 13, 2012

Thank you for the opportunity to provide input on the Ohio Department of Job and Family Services (ODJFS) State Demonstration proposal to Integrate Care for Medicare and Medicaid Enrollees (MMEs/Dual Eligibles). As a committed partner with the Office of Ohio Health Plans to provide health care coverage for approximately 250,000 CFC and ABD Medicaid consumers in Ohio, we support efforts by the Office of Health Transformation (OHT) to create a system which will not only improve health outcomes but also improve the member's quality of life. Our service area includes 50 of the State's 88 counties. Molina Medicare offers Medicare Advantage Prescription Drug plans, including a Special Needs Plan for individuals' dual eligible for both Medicare and Medicaid within 15 counties in Ohio. Molina currently is the 8th largest SNP plan in the country and provides coverage for 22,000 dual eligibles.

I have provided as part of my testimony information about Molina Healthcare and Molina Healthcare of Ohio for you to review. Molina was founded in 1980 by Dr. C. David Molina, an emergency room doctor who recognized his patients would be better served by regular access to a physician rather than through costly emergency room visits. Our commitment to quality is strong as all nine of Molina's eligible health plans have achieved NCQA accreditation. ~~Four~~ ^{Four} of our health plans have achieved Excellent Health Plan Accreditation, which requires HEDIS results in the highest range of national performance. Molina has a strong commitment to quality and expects each health plan to achieve and continue accreditation.

Comments on the ICDS Model

Molina strongly supports the member centric approach which is very similar to the concepts contained in the Integrated Care Delivery System Model (ICDS). Duals integration programs should not only coordinate but integrate services such as clinical and behavioral health services, long term care supports and services (including home and community based services) administrative and appeal functions and oversight, monitoring and funding.

ODJFS' approach to beneficiary protections is aligned with our model which includes cultural awareness training for vendors, plans and providers, stakeholder and member participation on advisory bodies, contracting with safety net providers, clear, timely, and fair processes for complaints and disenrollment requests, and maintaining a dedicated liaison for individuals and organizations serving the developmentally disabled. I have attached an example of some member stories that illustrate some key concepts such as transition of care and coordination of services that we provide to our current members across the country. These concepts are the strengths of the Molina multi-disciplinary approach to care management and providing community connections for our members.

- Geographic regions: Molina supports the geographic services areas identified as the first phase of the ICDS program and is aligned with our current SNP service regions and support the concept of having a choice of ICDS provider.
- Enrollment: Dual Eligibles should be passively enrolled into the pilot programs with the option to dis-enroll to another plan or into the managed FFS model. We understand that CMS has provided a little leeway in this area of "opt-out" and would suggest that we fully consider the administrative challenges of the proposed approach, but also the impact on member satisfaction.
- Provider Network Standards: Molina devotes significant resources to being responsive to provider partners. We do require all providers to meet certain quality standards through our credentialing review, and will work to provide access to out of network providers for new members who have on-going relationships with providers so long as the providers accept the plan's contract rates or existing fee for services rates; meet applicable professional standards and abide by the plan's utilization management criteria. We also suggest that some flexibility in this approach is reasonable especially if necessary for the member's health. We understand that providers also will be going through the transition to an ICDS and would leverage our "It Matter to Molina" program, a provider input and feedback program that allow providers to share their concerns with us directly. We are also moving aggressively to augment our current IT infrastructure to allow providers to get real time approvals for services as well as have access to a more complete member profile.
- Care Management: We support the team approach to care management and this is aligned with the Molina model of care. We also support the integration of behavioral health services as these providers bring a wealth of experience to serving the populations.
- Expected Outcomes: Measuring quality is important. The development of specific data elements to support a star rating process that recognizes the burden of mental illness, chronic disease and disability in the dual eligible population

would benefit the quality of the data and give a more accurate assessment of the plan's capacity to improve health outcomes. Another option is to monitor member satisfaction by using tools such as CAHPS. This tool is widely used and validated in the health care community

- **Qualified ICDS entities:** As ODJFS considers criteria for selection of ICDS entities; we ask that you consider the applicant's current service and longevity in the Ohio Medicaid program. While we expect many applicants to submit proposals, we do ask for consideration of criteria that ensures that these entities are appropriately licensed, have no current regulatory actions, penalties or citations, be capable of demonstrating administrative and financial capacity to serve the population to manage high cost times and start up costs, and have a licensed Dual Special Needs Plan. This population with their complex needs will not be well served by an inexperienced entity with no understanding of Ohio Medicaid requirements and expectations.

Thank you for the opportunity to provide input on this project. We look forward to working with you in the future.



**Ohio Association of Health Plans
Public Comments on the State's Demonstration
Proposal to Integrate Care for Medicare-Medicaid Enrollees**

Tuesday, March 13

Good morning. My name is Miranda Motter and I am the President & CEO of the Ohio Association of Health Plans (OAHP). On behalf of OAHP member plans, I am pleased to provide public support for the State's Demonstration Proposal to Integrate Care for Medicare-Medicaid Eligibles, which will dramatically improve the care coordination for over 120,000 Ohioans.

OAHP represents 20 member health plans providing health insurance coverage to more than 7.5 million Ohioans. Ohio's health plans include commercial insurers, Medicaid Care Coordination Plans and Medicare Advantage Plans. As the statewide trade association for the health insurance industry, OAHP is a leading organization that actively promotes and advocates for quality health care benefits for all consumers in Ohio.

According to the Ohio Office of Health Transformation, individuals who are dually eligible for Medicare and Medicaid make up only 14 percent of the total Ohio Medicaid enrollment but account for almost 40 percent of the total Medicaid spending.

Despite enormous costs, dually eligible individuals do not always obtain good health outcomes because they are more likely to suffer from complex and multiple chronic conditions and there is poor coordination between the Medicare and Medicaid programs.

Medicare and Medicaid are designed and managed with almost no connection to each other. Today, the long-term care services, prescription drugs and acute health services that are provided to individuals who are eligible for both programs are poorly coordinated. Therefore, patient health does not improve as it should. Moreover, dually-eligible individuals are left on their own to navigate the Medicare program for hospital and physician benefits, a separate program for prescription drug coverage (Medicare Part D), and the State Medicaid program for long term care services and supports.

There is a solution to this system fragmentation and lack of coordination and OAHP applauds the State for proposing a managed care coordinated solution to establish high quality, patient centered-care for this vulnerable population. Coordinated care will enormously improve outcomes and the quality of life for “dual eligible” Ohioans while at the same time lowering Medicaid costs for Ohio taxpayers.

Managed care plans currently provide coordinated care and are at the forefront nationally of implementing systems and programs that have a proven ability of providing better, more coordinated care for beneficiaries, while also helping states control escalating program costs. Managed care is the most prepared to improve the health of patients through coordination, providing administrative functions, managing rigorous quality management programs,

maintaining robust data systems that provide comprehensive information on patient care and conditions, utilizing predictive modeling to identify and prevent adverse health events, and contracting with quality providers.

Managed care has a long history of providing coordinated care in Ohio and improving the health and well-being of over a million Ohioans. Managed care plans have substantial experience in serving Ohio's high-need populations. In 2011, approximately 640,000 Ohio Medicare beneficiaries were enrolled in Medicare Advantage plans. As of July 2011, over 10,000 Ohio dual eligibles were enrolled in special needs plans and as of January 2011, more than 120,000 Ohio Aged, Blind and Disabled Medicaid Beneficiaries were enrolled in managed care plans.

By coordinating care, managed care plans have not only improved the health and well-being of Ohioans, but managed care has helped to slow the growth of Medicaid. The State's Integrated Care Delivery Systems (ICDS) proposal offers significant savings opportunities – due to the large number of dual eligibles served in an unmanaged setting and their extremely high per capita costs. Recent actuarial studies have shown that this type of approach in Ohio could yield over \$6 billion of overall savings across a ten year period.

Care coordination through managed care provides increased accountability to the state. Ohio is able to hold plans accountable – through enforceable contracts – for quality, access, and outcomes. Managed care also can ensure quality care – by contracting with providers who deliver quality services to their patients.

Care coordination through managed care will offer consumers improved health outcomes as the State's approach creates strong incentives to make sure that patients get the right care, in the right place, at the right time. The ICDS program ensures that dual eligibles enrolled in the program have access to the medical and support services they need, and that the services they are provided are of the highest quality possible. This competitive program model guarantees beneficiaries a choice between competing plans in their geographic region. And as a result, Medicare-Medicaid beneficiaries will be able to choose the ICDS plan which best meets their individualized needs.

Successful care coordination through managed care will require partnerships with critical community stakeholders and qualified providers across the state. OAHP member plans are committed to connecting with community partners and providers in new, innovative ways to provide the quality care this vulnerable population needs while ensuring consumer choice and access to care. This ICDS program is designed in a way that will continue to need the expertise and services of various types of community partners in order to make this a success. OAHP member plans stand ready to partner with the State to help improve the quality and care of Ohio's dual eligible population.

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March 13, 2012

My name is Ann Sutton Burke. I am the Director of Aging and Caregiver Services for Jewish Family Service of the Cincinnati Area. We are a provider for the PASSPORT program through Council on Aging of Southwestern Ohio our Area Agency on Aging. We provide Social Work Counseling to low income seniors in their homes. Thank you for taking my comments today.

Our question to you today is why we need a new demonstration program when we already have a system that has demonstrated results? The system of Area Agencies on Aging in Ohio has proven itself year after year in meeting the needs of PASSPORT Clients and I believe they are well positioned to continue this role in the future.

Our clients are the most venerable and often highly compromised. The system in place works for them and for the taxpayer. It does it in a way that has

- Decreased the percentage of older adults receiving care in nursing homers from 90 to 58 percent in the past 20 years.
- Resulted in Ohio spending less on long-term care today in real dollars than 15 years ago.
- Done this without compromising client satisfaction as the most recent results have shown.

As to the fate of providers such as ourselves after reading the State of Ohio Demonstration to Integrate Care for Medicare-Medicaid Enrollees proposal we have more questions than answers. We hope you will look at the system not only from the State down to the plans but from the level where the delivery of care actually happens so from the client up. Thank you.

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March 13, 2012

Harry Saxe, ICDS Project Manager
Office of Ohio Health Plans
50 West Town Street
Columbus, Ohio 43215

Dear Mr. Saxe:

I am submitting my comments today at the Open Hearing for Providers and Other Stakeholders concerning the proposed changes to the delivery of Medicaid and Medicare services by the Office of Health Transformation. I am the Chief Financial Officer of Frontier Community Services. We are a 501C-3 non-profit organization located in Chillicothe, Ohio. We provide services to the developmentally disabled, homemaker/personal care to the elderly in their homes and housing to low to moderate income families and seniors. We provide services to over 110 elderly clients in their homes through Passport, Care Coordination, Alzheimer's Respite and Caregiver Support programs. Frontier employs 260 staff of which 50 staff members are employed providing services to the elderly that includes direct care staff, nurses and administrative personnel.

I believe the proposed changes by the OHT will have a significant impact on the services that Frontier currently provides to the seniors that we serve. In reviewing the ICDS Proposal, the proposal will only be introduced in seven regions of 3-5 counties each. The counties that Frontier serves are in none of these regions. We serve rural counties only. I question why this implementation is not being done in any rural counties. From our experience, providing senior services in rural counties is more expensive given the travel time and travel expense involved serving clients in these areas. The Proposal does not address the transition to rural areas which causes a lot of confusion for many areas of the state. Frontier has an excellent relationship with the Area Agency on Aging District 7, Inc. in providing quality services to our clients in rural areas. I understand the desire and objective of the ICDS program to provide higher quality and more person-centered care at reduced costs, but the current program for the elderly in their homes in rural Ohio, at least for the clients we serve, could not have better quality and person-centered care than is currently being provided. I would encourage you to consider modifying your Proposal for rural areas and keeping the home services with the Area Agency on Aging District 7, Inc. The current system for services by the Area Agency on Aging District 7 and the services provided by Frontier are not broken and that aspect of senior services does not need fixed. Modifying the Proposal to meet different conditions will make the entire Proposal stronger, more client centered and more cost effective.

Frontier is an Equal Opportunity Employer and Provider of Services



Frontier Community Services strives to provide the best quality care to the elderly clients we serve. Frontier's Chief Executive Officer, Gregory J. Arcaro, is not able to be at the hearing today, but will submit written comments. Thank you for the opportunity to provide comments about the proposed changes.

Sincerely,

A handwritten signature in cursive script that reads "Samuel C. Wood". The signature is written in black ink and is positioned above the printed name and title.

Samuel C. Wood,
Chief Financial Officer



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Comments Regarding ODJFS Office of Health Plan's State Demonstration to Integrate Care for Medicare-Medicaid Enrollees

Presented by Ernest Boyd, Executive Director, Ohio Pharmacists Assn

March 13, 2012

The Ohio Pharmacists Association, representing pharmacists in all practices sites in Ohio, strongly supports the state's proposal to the Center for Medicare and Medicaid Innovation to improve the quality of services to the dual-eligible population in Ohio. We believe that these improvements will lead to greater coordination of care throughout the medical system. Although we support all the facets of the proposal, my comments will be limited to the Medication Therapy Management parts of the proposal, which has been proven to greatly improve the outcomes in this highly-vulnerable population, while also reducing overall costs.

WHY MEDICATION THERAPY MANAGEMENT (MTM) IS NEEDED

Medications are the primary way that chronic diseases such as diabetes, heart disease, asthma and others are treated.. However, over 50% of patients take their medications incorrectly, resulting in over 10% of all hospital admissions, 20% of nursing home admissions, and perhaps up to 50% of hospital readmissions in the first 30 days after release. Shockingly, 1 out of 3 prescriptions are never filled, for a variety of reasons. Medicare D began paying pharmacists for MTM services, and have increased the number of patients eligible for these services, due to the positive outcomes that have been obtained through MTM. Pharmacists are beginning to provide these services to private insurance programs as well as Medicare D, and Ohio will be making a great improvement for these patients by bringing Medicaid into the mix. Patients improve their rate of adherence with medications, fill more of the prescriptions as required, and spend less time in emergency rooms and hospitals.

WHAT IS DIFFERENT ABOUT MTM FROM SERVICES CURRENTLY BEING PROVIDED?

Historically, Medicaid and insurers have paid for the provision of only medications, not the service of the pharmacist. The pharmacist, with their minimum 6 years of professional education leading to a Doctor of Pharmacy degree, have been underutilized. The pharmacist is now being recognized as the health care provider with the greatest amount of education on the actions, side effects, and proper use of prescription and nonprescription medications, and that training is now being used to improve patient's outcomes. Pharmacists direct interaction with patients has resulted in them being recognized by the Gallup organization as one of the most trusted professions. That trust, combined with their knowledge of medications, has resulted in patients have a much better outcome through medication therapy management. It has been clearly demonstrated that regular, face-to-face pharmacist visits, using motivational interviewing techniques, changes patient behavior, and improves outcomes

MTM involves an initial meeting with the pharmacist to review all medications, including prescription, OTC, and natural products. Often this group of patients is taking a number of medications from several prescribers. The pharmacist, following review, may call the prescribers, suggesting deletion of duplicative drugs, discuss possible changes to therapy when a different drug has fewer side effects, or talk about other issues having to do with being sure the therapy is the

most appropriate for the patient. Most importantly, the pharmacist will review and discuss each of the drugs, and their proper use, being sure the patient or their caregiver understands the use and importance of the medication. Currently, a large percentage of people stop taking blood pressure, lipid drugs, and others where symptoms are not evident. The patient, through regular meetings with the pharmacist, is coached about taking the drugs regularly.

SUPPORT OF MTM FROM SURGEON GENERAL AND OHIO-BASED ORGANIZATIONS

The Surgeon General of the United States released a report in January titled "Improving Patient and Health System Outcomes through Advanced Pharmacy Practice, A Report to the U.S. Surgeon General." I am attaching a copy of that report, and letters of support from physicians, to these comments. Perhaps a direct quote that sums the report is this : *"Pharmacist's formal education appropriately prepares them to successfully perform clinical services related to the prevention and control of disease through medications. Pharmacists are also well-positioned (through accessibility, expertise and experience) to play a much larger primary care role in the U.S. health care system to meet these demands and improve health care delivery and the health of the nation."* This reports summarize over 20 years of research that has resulted in payment reforms in the pharmacy profession that encourage the pharmacist to meet face-to-face with the patient, providing coordination, information, and education to improve their outcomes.

Here in Ohio, there are many ongoing MTM programs that support the departments inclusion of MTM in its proposal. Berger Hospital in Circleville is having pharmacists in the hospital conduct discharge counseling with the patient prior to release, then communicate with the community pharmacist, who is immediately contacting the patient. The local pharmacist reinforces instructions from the hospital, checks to be sure that the drugs the patient takes for other conditions are coordinated, and makes sure that the patient makes their follow up appointment with the physician. An article from the American Pharmacists Association making note of this program is attached.

Another MTM program conducted by Anthem Health in Cincinnati with Kroger pharmacists providing MTM with patients with diabetes and heart disease. Dr. Barry Malinowski has presented information from this study that showed pharmacists making very positive changes in the outcomes of the patients. Just one measure was the improvement in the A1C of diabetic patients, a measure that is critical to the health of these patients. Before pharmacists were involved in face-to-face MTM with the employees of the city of Cincinnati, approximately 50% of the patients with diabetes had acceptable A1c scores. After the pharmacists intervened with these patients, over 75% of the patients tested as acceptable, indicated that the patients were better utilizing medications, testing, and doing the other treatments needed. An article from the Dayton Daily News discussing the positive results achieved by pharmacists is attached.

Pharmacists' clinical skills have been utilized in hospital practice and long term care pharmacy for over 30 years. These same skills exist in our community pharmacists, but are finally being recognized and paid. There are several areas that the Ohio project should improve to move the MTM process forward, including changes in health information technology.

WHAT CHANGES ARE NEEDED TO MOVE MTM FORWARD?

One of the greatest barriers to MTM is lack of understanding by patients and providers of what pharmacists are doing in providing MTM services. Patients, physicians and other prescribers should be given clear information about MTM, and why pharmacists are providing it. In every case, pharmacist involvement has resulted in increased physician visits and contact, reduced hospitalizations, and improved patient outcomes. Once physicians and patients experience MTM, there is recognition of its value. However, it is critical for ODJFS to discuss MTM in communications with patients to encourage them to keep appointments with pharmacists, and to prescribers to help them understand the importance of communication with the pharmacist.

The Patient Centered Medical Home is another place that pharmacists have a critical role. It was interesting that one of the first questions asked of Governor Kasich in a recent meeting with health care providers about the Medical Home was a physician asking how the social worker and pharmacist who he employs will be paid under the PCMH model. Pharmacists, regardless of practice setting, need to be paid for their services. The Surgeon General's report also recognizes this need, and suggests that Medicare recognize pharmacists as providers, so they can bill using their NPI number. We now have pharmacists who are creating new practices that include provision of MTM, but have a difficult time billing for these very cost-effective services.

A second change that Ohio should implement involves HIT. Pharmacists need access to the patient's record to make the most positive impact on patient care. Anthem's Dr. Malinowski indicated that this was one of the issues that pharmacists in his program faced, having to make repeated phone calls to get access to needed information. We are working with an

Ohio-based company that can query any computer system securely, and, with proper permissions, can automatically populate pharmacy records with the needed patient information. This system also needs to allow two-way communication with the prescriber, so that pharmacists can immediately contact the prescriber when a problem is detected by the pharmacist.

Currently, physicians are being rewarded for implementing electronic medical records, which includes eprescribing. However, we are estimating that between 20 and 30% of these prescriptions have errors. Many of these errors are minor, such as a recent one that authorized 50 refills instead of 5. However, even the minor errors require a call. It would be much better to have electronic communication. We are also seeing very serious errors, such as one prescription that came through as 10 teaspoonfuls three times daily, instead of 10 cc's, which is two teaspoonfuls. This error, had it not been caught by the pharmacist, would have resulted in injury or death. We are receiving wrong drugs, wrong doses, and other incorrect information. MTM is even more important when we catch these problems, and HIT has the possibility to assist in their correction.

Payment reform is also critical for pharmacists to perform MTM. There are a number of payment methodologies being used by the payers of MTM under Medicare D. Some pay a large initial sum for the initial visit, then a set fee for each follow up. Others have the pharmacist bill for their time, recognizing that certain patients with limited cognitive skills need more time to gain understanding. It is critical that Ohio review the different methodologies, and develop one that encourages pharmacists to participate in this very beneficial program. MTM will also require a method of billing that is similar to that used by other health professionals. Our current reimbursement system also needs restructuring, so that the medications needed by this population will remain accessible.

Most systems, including Medicaid, reimburse per prescription. Those fees do not even cover the cost of filling the prescription, which is about \$10. Ohio is paying \$1.80 under fee for service, and the MCO's are using whatever fee's the pharmacy benefit managers they hire are paying. The other part of current reimbursement is to cover what the pharmacist pays the wholesaler for medications. Both Medicaid fee for service, and the PBM's working for the MCO's are paying far less than cost for many drugs. Part of the reason is the huge shortages of various medications, causing overnight price spikes that the pharmacists have to pay. Generic drugs are increasing from \$10 per hundred to \$300 per hundred overnight, but the payment system continues to pay \$10, causing our small businesses to be harmed. We need payment reform of this system.

WILL MTM COST THE STATE MORE MONEY?

No, it will actually save the state money through appropriate use of resources, reduced ER visits, reduced hospitalizations, and fewer nursing home admissions. One of the most renown studies of pharmacist-provided MTM services in Asheville, North Carolina, demonstrated a reduction in costs per patient with diabetes of between \$1622 to \$3656 per program participant. These savings were seen after pharmacist payment, and included appropriate higher utilization of medication, and greater physician visits. The costs reductions were due to lower hospitalizations, and reduced negative consequences of diabetes that must be treated, such as gangrene.

CONCLUSION

We congratulate the Governor's Office of Health Transformation and the Ohio Department of Medicaid for proposing this innovative program. Pharmacists stand ready to bring improved safety through proper medication usage in Ohio.

State of Ohio Integrated Care Delivery System Dual Eligible Integration Demonstration

Rhys W. Jones, Vice President, Medicare Policy and Product Development, Amerigroup Corporation

- My name is Rhys Jones. I am Vice President, Medicare Policy and Product Development with Amerigroup Corporation. On behalf of Amerigroup, I want to thank you for inviting us to attend this meeting. Amerigroup affiliate health plans serve approximately two million members in 12 states. In addition, Amerigroup offers Medicare dual eligible special needs plans (or SNPs), serving over 16 thousand members in eight states.
- Amerigroup Ohio looks forward to participating in this important initiative to integrate care and services for Ohio's dual eligible beneficiaries; that is, people with Medicare and Medicaid. Amerigroup is backed by a strong organizational commitment and deep experience in Medicaid, Medicare and long-term care services to people with Medicare and Medicaid.
- The current systems for providing care to people with Medicare and Medicaid are fragmented and uncoordinated. And the health disparities affecting these individuals are well documented, as are the long-term implications for their health and disproportionate impacts on state and federal health budgets.
- The State of Ohio's proposed Integrated Care Delivery System Demonstration (or ICDS) provides an important opportunity to bridge the historic gaps between Medicare and Medicaid for this vulnerable group of public program beneficiaries. The State's design encompasses a significant beneficiary population and robust provider infrastructure in the seven demonstration regions; these factors will contribute to the success of program.
- While Ohio managed care organizations (or MCOs) don't arrange for long term services and supports (or LTSS) today, several Ohio MCOs offer broad organizational knowledge of Medicare, Medicaid, and understanding of LTSS and home and community based services (or HCBS) programs. Such organizations can contribute much to the success of Ohio's ICDS demonstration in terms of provider contracting approach, experience with credentialing, training and orientation; and development, implementation and management of client service plans.
- CMS' January 25th guidance on integrated payment demonstrations sets out general guidelines for these initiatives, including 11 pre-established program parameters and 20 preferred requirement standards. There are some important features in the demonstration guidance that are not widely understood. Beyond these general standards, CMS is relying on states – working with beneficiaries, plans, providers and other stakeholders – to build on the guidelines with their state's particular vision of an integrated system of care and services for people with Medicare and Medicaid.
- The CMS demonstration rules do not require participating ICDS plans to have a formal Medicare contract or SNPs; however, ICDS plans still must meet Medicare program requirements for network adequacy and other processes. We believe that allowing various kinds of organizations to participate as ICDS health plans will maximize the State's flexibility in terms of program design and in leveraging organizational expertise.

- There have been other programs that focused on improving care for people with Medicare and Medicaid while achieving program savings. But these earlier efforts generally have been unable to achieve savings for both Medicare and Medicaid. The capitated integration payment demonstrations accomplish this in an innovative way by basing rates on historical costs in both programs and then taking upfront savings as a discount from the final capitation.
- In our experience working with several other states on design of their integrated demonstrations, a key awareness has emerged: the compressed time frames for 2013 demonstrations. We should keep in mind that the demonstrations provide us with opportunities to streamline processes and eliminate duplication of requirements common to both programs. This awareness is critical to meeting the August 2012 readiness review and January 2013 implementation dates. One state has been holding weekly program design meetings with its participating MCOs since mid-January; it is clear that many operational decisions need to be made soon, even in an environment where much of the policy and regulatory structure is a work in progress.
- In terms of program design, any integration demonstration will need to balance what might be desirable with what is really achievable. For example:
 - While the proposal for a centralized health record is very desirable, stakeholders need to consider that no specific health record standard has been adopted, the Medicare/Medicaid blended payment does not include costs of implementing such systems, and that there may not be enough time to test and implement such systems before the January 2013 start date.
 - With respect to the proposal to “phase in” enrollment by the beneficiary’s birth month, we understand the desire for a gradual roll-out of the program but we are concerned this could also cause a great deal of uncertainty. The State, the enrollment broker and ICDS health plans will need to respond to questions and concerns from beneficiaries, providers and other stakeholders for at least 15 months instead of 3 months. ICDS plans will be challenged in projecting utilization, costs, telephone volume and staffing needs across uneven surges of enrollment from month to month. Statistical data on many important program characteristics will not be available for the first year, meaning that the second year would be the first full-year opportunity to establish a reliable baseline for many metrics.
- The great potential of Ohio’s demonstration lies in integrating the services and supports available through the Medicare and Medicaid programs to help people get the services they need in the most appropriate setting. People will still go to hospitals for definitive inpatient care but sometimes it will be more appropriate for them to receive care in an outpatient setting. People will still be admitted to nursing facilities; but in some cases the person will do even better in their home with ICDS providers coordinating an appropriate range of clinical services along with functional and social supports. In this way, the demonstration will foster creative ways to support people so they can remain in their homes and in their communities.
- This demonstration program and its stakeholders will need to remain agile and focused on execution of the essential program elements, given that only nine months remain for design and implementation. We look forward to having the opportunity to participate in Ohio’s ICDS demonstration and contributing to the development of this important initiative.

Thank you

Good morning. Thank you for the opportunity today to testify in relation to the formation of Ohio's Integrated Care Delivery System. I am Colette Riehl, with WellCare. I have experience in both direct service and management of services to multiple populations of dually-eligible people, in both the mental illness and mental retardation arenas, in several states.

Stakeholders are anxious about the systems and processes that will be going into place with the ICDS. Will these members, who often have multiple chronic conditions and/or a mental or cognitive impairment, be well cared for?

Successful coordinated care, through the Integrated Care Delivery System, will include many, many variables. I'd like to highlight three that I see as important: care coordination involving the use of natural supports; coordination with stakeholders and advocates; and integration of data systems.

It is assumed that care coordination will involve the many facets of both the Medicaid and Medicare systems. What is less often addressed is the need for care coordination involving natural supports. Years ago, when I was a case manager in another state, I had two individuals on my caseload whose wheelchairs were broken. This was interfering with their ability to participate in the community and to get to their medical appointments. I approached the Medicaid system for repairs. The Medicaid system told me that they could not do the repairs, as the wheelchairs had been purchased through Medicare. I approached the Medicare system and was told that the wheelchairs could not be repaired and that the individuals could not purchase new ones, as the five-year time period between purchases had not elapsed. I looked to the natural supports in that community to fill the need. I contacted the local newspaper, who featured my request in a weekly "feel good" column. (Obviously, I shared no PHI when making the request.) Within a week of the column being run, I received donations of over 42 wheelchairs from people in the community. I took the two best for the individuals on my caseload and donated the rest to a local free clinic.

Natural supports don't always have to be unpaid. I've also managed a program that reviewed medical appropriateness of paid supports and the use of natural supports, for all HCBS (Home Community Based Supports) services. On multiple occasions we filed reports with the state abuse hotline to investigate circumstances of potential abuse/neglect. My staff scrutinized all individual support plans, with a goal of providing savings to the state and improving care.

I know that the goal of improving care is shared by all stakeholders and advocates. Part of the reason for testimony today is to provide a public forum,

so that stakeholders have an opportunity to hear information as it is being developed. Since, as we know, regulations and processes are often changing, I recommend ongoing meetings with stakeholders and advocates. Transparent sharing of processes will help to alleviate anxiety. Providers and advocates will find, through these types of meetings, that they are an integral part of the overall care coordination for the dually-eligible population.

The last item I would like to touch upon is the need for good data integration through the ICDS. It's very important that vendors, for example, have the capability to bring into their system both Medicaid and Medicare data, so that full care coordination can occur.

Ideally, the vendors' data systems also will allow for the sharing of care plans with providers. At WellCare, for example, we have a web-based provider portal, which allows providers access to their members' care plans. This level of transparency also speaks to the importance of keeping providers involved in the care coordination process.

As I've stated, a successful integrated care delivery system will involve care coordination that incorporates natural supports, coordination with stakeholders and advocates, and smooth integration of data systems.

Managed care plans are at the forefront of implementing systems and programs that have a proven ability to coordinate care and also help states control their costs. Behind the managed care plans' systems and programs will be content experts, such as me, who have the care and compassion, as well as the ability, to deliver improved health outcomes by making sure that members get the right care, in the right place, at the right time.

Thank you for your time.

Public Testimony March 13, 2012

State Demonstration to Integrate Care for Medicare-Medicaid Enrollees

Easter Seals of Ohio, Pat Luchkowsky, Director of Public Affairs

I applaud the state's efforts to develop a care delivery system that is person-centered and allows Ohioans to choose their service setting; encompasses coordinating physical health, behavioral health, and long-term care; and recognizes the social needs of participants.

As a member of the Ohio Olmstead Task Force, I participated in the consumer engagement forums and heard the strong feelings that those consumers had about access to providers, frustration with inefficiencies, being heard, and the positive and negative of care management. In representing an organization, Easter Seals, that has been advocating for and providing home and community based services since the 1970s, I understand the strengths and weaknesses of our current system. As chair of the Ohio Respite Coalition, I hear continually of the desperate needs of family caregivers across the state.

Today I am here to specifically discuss access to community based long-term care services and supports and provide some recommendations for enhancement. In the state's proposal released on Feb. 27, there is a table summarizing proposed services for the integrated care delivery service (ICDS) program. The state needs to strengthen this section and ensure that all current HCBS waiver services are available to participants. In addition, the state needs to recognize and ensure other needed services are mandated, not optional, such as-

- Respite – By providing respite the state recognizes the efforts of family caregivers and their need for a short break from caregiving. Without family caregivers, the cost to the system would be tremendous.
- Assistive technology – with so many advances in assistive technology today, this service can help promote independence, service efficiency and community access.
- Transportation – during the consumer engagement forums we continually heard of the need for increased access to non-medical transportation so that participants can be a part of the community and not isolated in their homes.

To ensure that home and community-based long term care services are the first services offered, the state needs to incentive their use within the ICDS system.

As part of this effort, the state should also apply for the Community First Choice Option authorized under the Affordable Care Act to additionally increase home and community attendant services.

In order to support people with disabilities, chronic health conditions and the effects of aging, Ohio's ICDS program must recognize not only the medical needs of participants, but also the independent living needs. We all know that the vast majority of people want to remain at home and in their communities for as long as possible. To make this effort exemplary, people need to have the skills to take control of their services and supports whenever possible.

Finally, the infrastructure that will be needed to make this program successful must be based on strengths, community knowledge and, most importantly, choice. We heard time and again during the consumer engagement process that people want a choice of providers. They also emphasized that when something works well, the system should mirror that effort and not take it apart. The differences in care management from the PASSPORT program to the Ohio Home Care waiver were obvious and show that when an entity such as the Area Agency on Aging has the right philosophy of care, the right training of staff and a focus on customer service, participants are very satisfied with the system.

Additionally, the primary driver of provider rates should not be to save money, but to purchase value and positive outcomes. We cannot create a "weak link" in the home and community based service spectrum by paying a rate for these services where direct service workers are barely making minimum wage, providers cannot afford to cover health insurance costs and staff cannot afford to drive to deliver their service. The state needs to set an across the board "minimum" rate that is fair and equitable to agency providers and participant directed providers and allows the ICDS program to reward providers above and beyond the minimum rate who meet quality outcomes. The state must also mandate a payment system that recognizes the need for prompt payment of providers.

Thank you for the opportunity to provide these comments today.

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

SPECIFIC CONCERNS (BASED ON ADVOCACY PRINCIPLES FOR DUAL ELIGIBLE INTEGRATION POLICY INITIATIVES)	SPECIFIC ASKS (PROPOSED CHANGES)
CHOICE: DO NO HARM. PRESERVE EXISTING PROVIDER RELATIONS	
<p>Not strong on continuity of care, e.g.</p> <ul style="list-style-type: none"> • How do members maintain relationships with current providers? Including the ability to retain and hire independent providers. • Only two choices of ICDSs • How will the ICDS provide LTSS such as personal assistance, to allow people to live in the community • 	<ul style="list-style-type: none"> • Require a transition period • Require ICDS to have an open network in order to bring in members' current providers • Require ICDS to allow for Single Case Agreements so that out-of-network providers can be paid and relationships can be maintained • Ensure reasonable provider rates. The significant cuts (20%+) to independent providers 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. • 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)
COMMUNITY BASED LONG TERM CARE SERVICES AND SUPPORTS	
<ul style="list-style-type: none"> • Too much emphasis on medical model • Provision of all needed services is optional ("may" instead of "shall" in proposal) • 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. • Certain HCBS and behavioral benefits are listed only as "may be included" 	<ul style="list-style-type: none"> • Guarantee members <u>all</u> waiver and state plan services (change "may" to "shall" in proposal) • Add additional services that promote consumer choice and access to LTSS • Develop incentives for ICDS to reward increased use of HCBS • 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. • The need for Independent Living Services must be included in the assessment (doesn't usually appear in a traditional medical assessment) • Details are needed on the how LTC

	<p>Services and Supports will detailed in this proposal will interact with the Medicaid Health Home Proposal (Behavioral Health).</p>
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NON-DISCRIMINATION

<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"> • 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. • 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.
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INFORMED CHOICE; MEANINGFUL COMMUNICATION AND INPUT

<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"> • what an ICDS is, much less which one to enroll in • that the ICDS is managed care <p>Concerns that plan is being rushed through</p>	<ul style="list-style-type: none"> • Establish a navigator service, with independent navigators • Delay submitting proposal until details are worked out with stakeholders, particularly beneficiaries and their advocates
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ENROLLMENT

<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"> • 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?) 	<ul style="list-style-type: none"> • Presumptive Eligibility • Voluntary, opt-in • However, if passively enrolled, members need to be able to opt out of both Medicare <u>and</u> Medicaid • Develop an incentive program for Medicare enrollees to stay in the program
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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"> • State should take up the Community First Choice option to ensure personal attendant services (key to consumer directed care) • Members should have option of consumer directed services (Choices Waiver in Aging) • Each member must have an individual care plan developed with his/her participation and with team members they choose; member should approve plan. • Persons participating in ICDS should have the ability to hire independent providers for their HCBS
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EVALUATION, QUALITY MEASURES, AND TRANSPARENCY	
<p>The proposal contains very little detail</p>	<ul style="list-style-type: none"> • Need to provide details on evaluation measures that incorporate metrics specific to duals population (and sub-populations) • Consumer advocates need to have input into the procurement process (criteria). • Proposal should have specific requirements around transparency of finances and quality measures.

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



March 13, 2012

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RE: Comments on Integrated Care Delivery System (ICDS) Draft Demonstration Proposal

I am Susan M. Gregg, State Director of Caregiver Homes™ of Ohio. Caregiver Homes™ appreciates the opportunity to comment on the Demonstration proposal. In responding to the ODJFS's Request for Information issued in September 2011, we provided detailed descriptions of our capabilities to serve dually-eligible consumers who will be impacted by the ICDS program. We also provided specific recommendations that support the Department's priorities, as described in the Demonstration proposal, to improve health outcomes, provide meaningful alternatives to institutional services, and more efficiently meet the needs of dually-eligible consumers. Consequently, my comments here are brief.

As we have previously described, our model of Structured Family Caregiving (referred to in Ohio as Adult Foster Care and Adult Family Living) has proven to be effective in supporting medically and behaviorally complex elders and people with disabilities. Our model provides person-centered supports and assistance with activities of daily living in a setting of the consumer's choice from a qualified caregiver of the consumer's choice.

We have the capacity to engage with selected ICDS plans in delivering services to qualified consumers, and to have a profound impact on key measures of medical quality and cost such as falls rates, unnecessary hospitalizations and re-hospitalizations, and nursing facility admissions. For identified consumers, our professional staff can be fully integrated within an ICDS plan's care management model. We would welcome the opportunity to partner with selected plans to test innovative payment methodologies and quality incentive programs.

We ask that Adult Foster Care and Adult Family Living be included in the list of "Additional Community Support Services" included in Figure 4 of the Demonstration proposal. We will continue to participate in the Consolidated HCBS Waiver Initiative that is evaluating, among other issues, the covered benefits that will be included in the Consolidated Waiver. We think it important, however, that these services be specifically listed in the Demonstration proposal at this time to ensure that potential bidders have a full and complete opportunity to develop an

understanding of the services, and ensure availability in their contracted provider networks. (As you know, Ohio already recognizes the value of the inclusion of services such as this in a comprehensive home and community-based service delivery system by making such services available to participants in the Individual Options Waiver administered by the Department of Developmental Disabilities.)

Caregiver Homes™ looks forward to continuing our participation in Ohio's important work towards the development of an Integrated Care Delivery System, and to ensuring that the ICDS program provides comprehensive, accessible options for quality, community-based long-term services and supports for enrollees. I would be happy to answer any questions you may have, including how Caregiver Homes™ works with integrated health plans in other states. We currently provide services in Massachusetts through the Senior Care Options (SCO) and PACE programs and through Rhode Island's PACE program. I may be reached at 614-493-7666 or sgregg@caregiverhomes.com

Thank you.

Susan M. Gregg, MPA
State Director
Caregiver Homes™ of Ohio

Cc:

Michael Colbert, Director Ohio Department of Jobs and Family Services
John McCarthy, Director Ohio Medicaid
Bonnie Kantor-Burman, Director Ohio Department of Aging
Greg Moody, Director Governor's Office of Health Transformation
John Martin, Director Ohio Department of Developmental Disabilities
Tracy Plouck, Director Ohio Department of Mental Health

Public Testimony
Open Hearing for Providers and Other Stakeholders
Ohio Department of Job & Family Services
Integrated Care Delivery System
March 13, 2012

My name is Tracy Davidson and I am the Plan President for UnitedHealthcare Community Plan of Ohio. We currently serve over 120,000 Medicaid beneficiaries and approximately 97,000 Medicare members in Ohio. We are excited about the opportunity to provide insights from the lessons we have learned in creating meaningful, high quality programs to address the needs of individuals who are eligible for both Medicare and Medicaid. Medicare-Medicaid Enrollees are some of the most complex beneficiaries served by both programs today. These individuals are currently served in two disparate healthcare systems that result in significant fragmentation and fail to support coordination and early identification of patients' needs and alignment of services. We applaud the work of ODJFS in conjunction with CMS to create innovative approaches to truly integrated care for Medicare-Medicaid Enrollees.

Nationally, UnitedHealthcare serves more than 350,000 Medicare-Medicaid Enrollees in Medicare plans and more than 130,000 individuals in Medicaid long-term care programs. Our national experience has provided a strong foundation of knowledge and an appreciation for the complex needs of these most fragile members of our communities. Additionally, we have had more than 20 years experience in developing person-centered models of care that have improved quality, driven increased customer satisfaction, rebalanced long-term care systems, and reduced unnecessary and costly utilization.

Developing successful programs to address the needs of these complex populations requires many important considerations. Among them are things such as:

1. Creating responsibility for a single entity that is ultimately responsible for the comprehensive and holistic management of Medicare-Medicaid Enrollees;
2. Developing, maintaining and expanding innovative relationships with community-based organizations to ensure the appropriate and effective delivery of Long Term Supportive Services (LTSS); and
3. Aligned incentives to influence quality outcomes across the continuum

Many of our Medicare-Medicaid Enrollees have a broad spectrum of needs including physical, behavioral, long-term care/support services, psycho-social services and pharmacy. The interdependencies of these needs are dramatic and we have found are best managed by a single entity to ensure a holistic approach to person-centered care.

The cornerstone of an effective person-centered model of care is a single care coordinator whose role is to help strengthen the voice of the individual as they maneuver through the available

system of services, supports and choices. The personal relationship with a care coordinator allows for the Medicare-Medicaid Enrollee to truly have a voice in directing their desired care.

Creating person-centered models of care requires the ability to comprehensively assess individual needs and preferences and align resources and services accordingly. To establish this, Integrated Care Delivery System (ICDS) health plans should be responsible for:

- assuring that needs are properly assessed,
- aligning services and supports, and
- creating innovative relationships with community-based organizations to meet the needs of individuals served.

Overly prescriptive or restrictive requirements can hinder true innovation and strategic alliances.

There are many important considerations in shaping an integrated program and we appreciate the multitude of stakeholders engaged in program development such as envisioned in Ohio. We must all ensure a focus on achieving the Department's program goals of reducing fragmentation, increasing quality, and reducing costly, unnecessary utilization. Partnering with experienced health plans – those with expertise in both Medicare and Medicaid – can provide program stability and demonstrated outcomes that will positively impact Ohio's most complex citizens.

Thank you for the opportunity to speak in support of creating a solution for Ohio's Medicare-Medicaid Enrollees. We look forward to continuing to provide our national and local experience in support of the Department as it continues to develop this integrated model of care.

Hello –

My name is Linda Knapp. I live in Logan Ohio, which is a rural area of southeastern Ohio. I work for Fosterbridge, which provides personal care and homemaking services for consumers. The majority of our consumers are through the PASSPORT program through the Area Agency on Aging. I am also the secretary of the Home Healthcare Provider cooperative in southeast Ohio which Fosterbridge is a founding member.

The three-year demonstration project does not have any rural regions noted in testing for the managed care scenario. What works in urban centers will not work in rural Ohio settings. How can you have an accurate reflection of outcomes if you don't choose an accurate blending of consumers using the Medicaid programs?

In our rural areas we are dealing with low wages, little or no mileage reimbursement and minimal to no access to benefits combined with no chance for advancement in the home healthcare field which makes recruitment, training and retention of home healthcare professionals difficult.

We fear that managed care companies will limit small providers' ability to contract with them, or be members of their provider panels. This will eliminate small businesses and lose more jobs in an already seriously economically depressed and medically under-served region.

As always, our focus is our home health care client, that individual who wants to receive the end result of quality, timely care where they want it, in their home (which ultimately saves the taxpayers of Ohio over 60% of what nursing home care would be).

The PASSPORT program works. The latest consumer satisfaction survey shows over 99% satisfaction. In looking at utilization over the next ten years it is projected that 51% increase in home health care. This is not the time to change what is working. A shift to managed care with

any potential rate cuts could fracture the already tenuous home health care provider network in rural Ohio. We certainly do not want to begin to see care plan reductions that will negatively impact client outcomes, forcing those who might otherwise stay at home, in to nursing facilities.

Our concern about the push to managed care is that the ‘front door’ network with the Area Agencies on Aging is working. They work within a well-established array of community relationships to determine what client needs could be met outside of established waivers when they are not eligible.

Putting in place, several case management agencies versus one, concerns me. The accountability will be split too many ways. Having one major agency with reported 99% satisfaction survey results seems to make sense to keep that agency working for the state. Isn't the consumers' satisfaction what we should be focusing on? The provider agencies are being quality assessed and held accountable by PASSPORT. Let's not change what is working just to ‘try something different’ that may end up having the same end result but cost money to achieve that end result. There will be too many irons in the fire that may end up fragmenting the communication involved with all parties involved with each consumer's care. With the fractured communications come increased problems, which comes repeated hospital visits and doctor visits. Generally speaking, simpler is better.

Another concern is the elimination of the presumptive eligibility. This could result in a detrimental health concern for some clients along with a financial hardship of providing for services and supplies while waiting on the proverbial red tape to be measured out.

So to summarize, small, rural providers remain concerned that the Office of Health Transformation's dual-eligible demonstration project has absolutely no rural model to test over the next three years. The managed care companies do not have a presence in rural Ohio; they

cannot afford to. What will happen then when the waiver goes statewide? Will they understand the rural issues and concerns? What will happen to the consumers in these rural areas?

Providers who are small businesses and work to stay afloat in economically depressed settings cannot afford to be left out of provider panels or be faced with too many hoops to jump through to obtain access to the panels. We also cannot face further rate reductions. In the rural setting, we have further to travel to treat fewer clients and we already no longer receive additional funding for distances traveled-that was eliminated years ago. PASSPORT works, let's not change what is not broken.

In Appalachia, we work together – we are a community – we work hard to provide quality care to the ones we love. We feel that a shift to managed care will fracture the system we've worked so hard to build – at a time when we need it to be so strong!



To : Office of Health Transformation
From : Wanda Morris RN/ DON Interim of S.E. Ohio
Re : Integrated Care Delivery System (ICDS)
Date 3/13/2012

As the DON for Interim Health Care of S.E. Ohio of which is a Medicare/Medicaid home health agency this letter's objective is to state our agency's concerns regarding the ICDS. Our agency is AAA8's largest provider for Passport services for Washington county. Washington county is the largest county per square mile in the whole state of Ohio.

Our agency which is owned by a small business owner is concerned that managed care organizers will limit contracted provider panels, cut provider rates ,and eliminate small businesses. Our agency is one of very few that pays mileage to our employees who are providing home care for our clients.

Working locally with our regional AAA8 is easy and effective. Concerns/issues are handled quickly. Examples that our agency may work with AAA8 are changes in client's abilities to do ADLs, meds, safety , home delivered meals, transportation, new diagnosis, and community/state resources that can help keep the client safe in their own home versus nursing home placement that will raise state funds for care.

As the provider in our area who is one of two providers that does Pediatric nursing I have grave concerns for the clients also that are being effected by Ohio Medicaid and managed care. An example of concern is a premature infant of this agency's that was born 15 weeks premature. She should have been assessed by managed care last Nov. She is celebrating her first birthday this week and was notified last week that she is to be assessed in 5-6 weeks for LPN home services. Her mother had to quit her job to stay home with her which has effected this family income by 50 %.

Sincerely,

A handwritten signature in cursive script that reads "Wanda Morris RN DON".

Wanda Morris R.N. D.O.N.
Interim Health Care of S.E, Ohio



OHIO ASSISTED LIVING ASSOCIATION

Public Comments from The Ohio Assisted Living Association on the State's Proposal Regarding an Integrated Care Delivery System (ICDS) for Dual Eligibles

Thank you for this opportunity to provide public comments on the state's proposal to implement an Integrated Care Delivery System (ICDS) for dual eligibles, Medicare and Medicaid enrollees (MMEs). My name is Jean Thompson and I am the Executive Director of the Ohio Assisted Living Association, representing the largest number of assisted living providers in the state and over 164 Assisted Living Medicaid Waiver providers. This system change, utilizing managed care, will dramatically alter the current workings of the Assisted Living Medicaid Waiver and have a significant impact on all beneficiaries and providers given that almost all Assisted Living Medicaid Waiver clients are dual eligibles.

In order to understand the magnitude of this change it is important to know a little about the history of the Assisted Living Medicaid Waiver. The Waiver, something our Association fought hard to establish in Ohio has only been in existence since 2006. Initially, it started very slow due to constraints put on it in order to calm critics of this kind of rebalancing; however, in 2008, in the subsequent budget cycle, some of these were removed and it began to work for more consumers as more Assisted Living providers participated in the program. In our last budget, even more constraints were removed, however, its reimbursement, which was the same as at its initiation in 2006, was decreased by 3% along with other providers.

Now, the Assisted Living industry which is still vastly private pay, is being asked to not only work with the government regarding regulations and reimbursement for this population, but managed care companies as well. Many providers only serve a few Assisted Living Waiver clients, and may feel this move is not worthwhile from a business perspective. Certainly it may impact what we saw as an "integrated" delivery of Medicaid Assisted Living, among a broad group of providers to the delivery in more designated Medicaid settings. Additionally, as all of this moves rapidly forward without many details, another system change is coming into play with the consolidation of the Home and Community Based Waivers into a combined, Single Waiver.

What does this mean for providers? Essentially, they are being asked to stay in a program or become part of a program that is in flux, in terms of payment as well as potentially required services, yet have a state regulatory framework that must be adhered to, regardless of payment or required service provision. Additionally, during at least the first year of the program, they will need to work with two different versions of the program running at the same time until the end 2013.

First, a provider will need to “negotiate” with a large managed care organization. Since many will not have the necessary skills and experience, they will need to “hire” someone to assist them with negotiating a managed care contract. *Will the managed care organizations attempt to hold down their costs by sending only very high acuity residents to assisted living, rejecting or refusing to allow discharge, or by reimbursing less than the state’s current Assisted Living Waiver?*

If a provider decides to negotiate with the managed care company and become a part of their network; *Will they be able to decline a client? ... Will they be able to assess the client themselves prior to placement? Will the separate case management arm have the authority to increase reimbursement if needs change quickly... Or, will there be a delay waiting on authorization or approval from the managed care company?* Assisted living providers are required by law to meet the resident’s needs and these needs can often change quickly. They do not have a choice but to provide the needed services, with or without approval or reimbursement.

If all of these questions need to be addressed in an individual provider’s contract, will the managed care company decide to only work with providers who are willing to make concessions? Will the managed care companies be required to contract with all current Assisted Living Waiver providers, ensuring a continuity of care for all current program clients? Will quality providers be eliminated from the program by declining reimbursement or policies? Will these changes reduce consumer access and choice?

From a practical perspective; *Can rates be set individually, based on the individual needs of residents? Will providers have to guarantee a certain number of units or placements to participate? Will they have to “hold” all these units, even if they have a prospective private pay client? How will discharge decisions be made, (given the managed care company’s goal of reducing costs)? What timeframes and policies will be established for payment to provider? What guarantees? How will temporary absences from the community be handled? How will differences of opinion between providers and managed care organizations be handled?*

Given that so many details will be decided in individual agreements negotiated with managed care organizations by providers, the State should establish certain safeguards for them through their contracts with managed care organizations. We suggest the following safeguards:

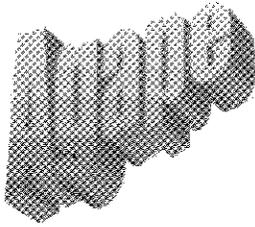
- All current Waiver providers should be included at no less than the current reimbursement rates.
- Providers should be allowed to meet with a potential resident to assess if their needs can be met prior to accepting a referral; providers should have the right to decline a referral.
- Providers should not be required to “hold rooms” for managed care placement.
- A minimum number of guaranteed placements by the provider should not be a requirement for participation in the managed care organization’s network.
- Case management should not be required to obtain prior authorization for increased services, if the needs are immediate; if this is not possible, then “retroactive” payment for services already delivered should be available.

- Assisted living providers need to be able to make discharge decisions based on their not being able to meet a resident's progressed needs.
- Providers need to be guaranteed prompt payment (within 30 days) and have a defined recourse in the event payment is not made appropriately.
- An impartial appeals process needs to be put in place to handle provider grievances related to the managed care company; related to their actions and/or decisions
- Assisted Living providers need to be paid a portion of the service fee during temporary resident absences as Assisted Living staff can not be readily adjusted

While to this point our comments have been questions and concerns and suggestions for the state to safeguard providers and ensure their continued participation, there are potentially some opportunities in all these changes, not just for assisted living providers, but for elderly Ohioans too. For example, up to this point, individuals who needed secure unit placement due to significant memory impairment have not been able to access the program in the Assisted Living setting because of its cost. Perhaps, if the possibility exists to negotiate higher payments for higher need residents, some of these individuals could participate in the program and benefit from Assisted Living. Additionally, it is possible that assisted living service requirements or reimbursement under a Single Waiver might change, allowing or encouraging the participation of more communities.

Thank you for your time and attention.

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Rayleen Wheadon, President/CEO

March 13, 2012

TESTIMONY

Before

The Office of Health Transformation

Agape Home Health Care, is a 501(c)(3) Ohio corporation that has been for seven (7) years and is currently a PASSPORT provider. From the perspective of an Ohio corporate citizen and very small Provider of health care services, that not only understands the necessity that gives rise for the Ohio Demonstration Proposal, but who daily looks into the eyes of clients that reflect their inability to cope with their conditions and circumstances and listens to their expressions of hopelessness, we, who are but road kill on this transformation superhighway, humbly submit for your consideration a few of our short notice observations contained in the Proposal. Agape is motivated by the understanding that a civilized society or family is judged, not only on their efficiency and expertise, but also on how they provide an umbrella and a safety net for the least of these, including that malady afflicted parent, grandparent or spouse.

1. We acknowledge the dual challenges confronting the Governor Kasich administration in reallocating the estimated FY 2011 expenditure of approximately \$3.7 billion providing services to Medicare-Medicaid Enrollees in the ICDS target populations and adopting “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 ...”

2. We were however disappointed that the Proposal neither promised nor hoped that the proposed transformed care management model would measure improved Enrollee care or reduce taxpayer costs.

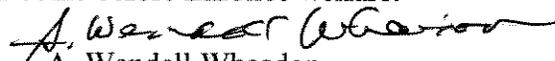
3. We were surprised that the Proposal did not consider the value of the existing wealth of real world experience and good will accumulated by

PASSPORT'S highly trained and professional management and staff, and preferred instead, "care management models for ICDS program participants [that] will evolve over time, [and] will no doubt benefit from the experience gained from real world experience."

4. We agree and applaud the holistic and coordinated approach taken by the Office of Ohio Health Plans, its staff, researchers and consultants, as well as, the input from the "Front Door Stakeholder Group," the 24 stakeholder groups that included health care delivery systems, care management and care coordination companies, provider associations, the Ohio Association of Area Agencies on Aging, social service and advocacy organizations and others and the 180 individuals that attended regional meetings and the 70 individuals that participated in the February 17, 2012, statewide teleconference.

5. Accordingly, it is recommended that the Office of Ohio Health Plans retain and implement Governor Kasich's vision, but revisit and revise its unsupported plan to forsake a dedicated, loyal and effective PASSPORT staff, and in the alternative invest the existing PASSPORT staff with the same authority and programmatic latitudes that are scheduled to be given to the two "competitively selected ICDS health plan" managers. With this scenario taxpayers will not be forced to pay multi-million dollar bonuses to private firm managers to implement sound state polices that existing state employees can do better.

6. Also, when an Enrollee answers that knock on their door, they will continue to see a PASSPORT case manager who is truly motivated in maintaining and improving their welfare rather than the bottom line of their company. In the real world, stockholder interest will always come before Enrollee welfare.


A. Wendell Wheadon
Chief Operating Officer



3/13/12

Good Morning,

My name is Rebecca Jenei - I work with Genesis Caregivers and also serve as the current President of the Home Healthcare Provider Co-op in the Southeast Ohio area with a dozen agency and education partner members, we represent nearly 1,000 home health care employees.

Our Co-operative was established by the Area Agency on Aging through the Ohio Cooperative Development Center at OSU South Centers. The group represents a variety of regional home healthcare provider representatives. The purpose statement of the group is "working together to benefit members with shared resources to strengthen the home health workforce."

The goals and vision for Home Healthcare Provider Cooperative are: to reduce employee turnover in home health agencies thereby reducing replacement cost overhead; to partner with educators to provide training (this way training and skill levels are standardized resulting in a higher quality of care for the patient); to reduce replacement costs and training overhead, in order that employers will be able to offer improved worker benefits and an incentive for individuals to enter and remain in the home healthcare field; and finally, to create a career ladder model in the home health industry.

While our Co-operative was formed to focus on strengthening the home health workforce, we are also engaged in the state's efforts to transform the way long-term care services are delivered.

Our Co-op members are providers of PASSPORT and other waiver services.

With the push toward the use of home and community based services in lieu of nursing home utilization, we believe that a shift toward managed care will negatively impact providers.

According to the proposal, elimination of presumptive eligibility of these waiver individuals will delay the start of services. It could be 2 weeks or more before a service would be able to start doing service and this person may have been discharged from nursing facility and at home



during this waiting period. This increases their risks of re-hospitalization. When a person is told they can be discharged they do not want to wait for this eligibility to be determined but want to go home NOW!

The three-year demonstration project does not have a rural region noted for testing of the managed care scenario. What works in urban centers, will not work in rural Ohio settings. In the rural Southeast Ohio area, low wages, little or no mileage reimbursement and little to no access to benefits combined with no chance for advancement in the home healthcare field already make recruitment, training and retention of home healthcare professionals difficult. As an agency, we struggle with finding home care aides to serve the “hard to serve” rural areas, Example: driving from McConnelsville to Stockport takes approx. 17 min. to go 8 miles and that is not a straight drive or highway, and that is saying they do not get lost trying to find the house or to Crooksville to Junction City 17 miles and takes about 26 minutes. These home care workers in the rural area are not walking from apartment to apartment and not driving well driven roads and have cell phone service for a job that pays them 8 hours with benefits. They are driving 17 miles to that client then another 17 miles to next client, 5 miles to next then after 8 hours driving home 17 miles or more for minimum pay (\$8.25/hr) and paying \$3.86 a gallon for gas. (with a prediction of \$5.00/gal).

We fear that managed care companies will limit small providers’ ability to contract with them, or be members of their provider panels. This will eliminate small businesses and losing more jobs in an already seriously economically depressed and medically underserved region. This shift will also cause decimation of the tenuous home health care provider network in rural Ohio.

Our continued focus is our home health care client – that individual who wants to receive the end result of quality, timely care – where they want it – in their home (which ultimately saves the taxpayers of Ohio).



In looking toward the future of home health care and its projected 51 percent increase in utilization over the next ten years, it is not time to change what is working. The PASSPORT program works – the latest consumer satisfaction survey of 99.7% satisfaction shows that.

Rural providers with established relationships with the Area Agencies on Aging are working hard on an individual level to build small-community-style services and provide quality outcomes. And, we are already managing waivers in a “managed care setting” – we manage to certain per-member, per-month costs and have real people, trained in level of care assessment models to know when it would benefit the consumer to make changes and when it wouldn’t. We certainly don’t want to begin to see care plan reductions that will negatively impact client outcomes forcing those who might otherwise stay at home into nursing facilities.

Another concern we have about the push to managed care is that the “front door” network with the Area Agencies on Aging is working. They work within a well-established array of community relationships to determine what client needs could be met outside of established waivers when they are not eligible. First priority of this network is to use available services that do not cost the state money. PASSPORT does not replace services already being utilized so they are the payer of last resort. If my client is receiving home delivered meals and the daughter is paying for this service, PASSPORT will not take over that bill just because they are in the home now.

The managed care companies will not take the time or devote the resources to this ever-important role of Medicaid diversion. What if the Medicaid enrollment increases because this critical service the Area Agencies on Aging provides is diminished? How will that save the taxpayer? The Area Agencies work with many community providers, ex. Senior Centers, to find alternative funding to keep giving the services that are needed in their community. Who will help these agencies?



In addition, some of our members already have direct experience working with other managed care providers in Ohio. In an informal discussion setting, as we compared outcomes with managed care providers and Area Agencies on Aging – we easily determined AAAs a winner.

It is easy because they are responsive, they care, they are connected to key resources and they've been doing this a long time. PASSPORT care managers work with our staff and together we helped obtain that great satisfaction outcome. Why are we trying to fix what isn't broken?

In rural Appalachia, residents have a fear of outsiders – a change in a care manager is a big change for someone who has perhaps after a long time of convincing by caregivers or family members, finally allowed someone to come into their home to provide care. The change to managed care will be confusing and upsetting to consumers.

We continue to hear that “services won't change.” But, in reality, they will. The service of case management will change in the home setting. As a home care provider, we often work closely with referral sources across community settings. We also fear that the network of professionals who are accustomed to calling an Area Agency on Aging will not know who to call to transition folks home or to help prevent a hospital or nursing facility stay. Community referral resources account for a huge majority of referrals into the Medicaid waiver system.

Small, rural providers remain concerned that the Office of Health Transformation's dual-eligible demonstration project has absolutely no rural model to test over the next three years. The managed care companies do not have a presence in rural Ohio, they cannot afford to. What will happen then when the waiver goes statewide? Will they understand the rural issues and concerns?



Providers who are small businesses and work to stay afloat in economically depressed settings cannot afford to be left out of provider panels or be faced with too many hoops to jump through to obtain access to the panels. We also cannot face further rate reductions. In the rural setting, we have further to travel to treat fewer clients and we already no longer receive additional funding for distances traveled – that was eliminated years ago.

In Appalachia, we work together – we are a community – we work hard to provide quality care to the ones we love and we feel that a shift to managed care will decimate the system we've worked so hard to build – at a time when we need it to be so strong!

Thank you



Good morning, my name is Jill Hreben and I am Chair-elect of LeadingAge Ohio (LAO) and President and CEO of Otterbein Senior Lifestyle Choices, a health and human service ministry, serving approximately 3,000 Ohioans. Otterbein's multiple locations include assisted living, adult day care, rehabilitation services, nursing care and home health care, and we are related to the East Ohio and West Ohio Conferences of the United Methodist Church. Thank you for the opportunity to provide testimony on behalf of LeadingAge Ohio, an association of not-for-profit senior service and support organizations that house and care for more than 100,000 elderly Ohioans daily.

We support the Governor's goal of appropriately rebalancing long-term care services, and pledge to work collaboratively with the Administration and the General Assembly in achieving this goal. We advocate an Integrated Care Delivery System (ICDS) demonstration project (project) that includes meaningful quality measures, consumer [and provider] protections, and appropriate utilization reductions. We have great concerns about using the managed care structure as the vehicle to accomplish the goals of ICDS.

To ensure the ICDS provides the appropriate care in the appropriate setting, LeadingAge Ohio supports the following components of an ICDS model:

1. Quality

Medicare Medicaid Eligibles (MME's) should receive high quality care from experienced providers that includes:

- Comprehensive and uniform measurement of health outcomes for all MME's regardless of payment type. LeadingAge Ohio has developed eleven managed care metrics that we intend on collecting on behalf of our membership for benchmarking improved outcomes.
- Access to experienced providers and plans that have a successful history of serving this population.
- A care plan that includes attention to the need for adequate direct-care staffing and workforce.

2. Consumer Protections

Program participants should have:

- Access to comprehensive benefits and providers
- Person-centered coordinated care that includes the individual receiving care, family caregivers, medical providers, and the care coordinator.
- Preventive Care
- Transparency of ICDS reimbursement rates, lengths of stay, and quality measures, similar to current cost reports.

3. Provider Reimbursement

LeadingAge Ohio strongly echoes Ohio Medicaid's position that cost savings achieved by the ICDS accrue from the more efficient utilization of services provided to beneficiaries, not from reductions in payment rates or utilization reductions. To accomplish provider protections, LeadingAge Ohio recommends:

- Statutorily or contractually prescribed reimbursement rates for Medicaid and Medicare that are adjusted yearly for inflation during the demonstration.
- High quality providers who are able to bring down costs and improve measured health outcomes should share in the cost-savings to the program with the ICDS.
- Pay-for-performance quality measures based on artifacts of culture change.

4. Provider Participation in ICDS Governance

The ICDS proposal states that ICDS plans will be required to have local governance bodies in each geographic region with 20% consumer representation. The panel should include at least 20% provider representatives,

representing low-income housing, home- and community-based services, assisted living, and skilled nursing facilities.

5. Additional Safeguards for Long Term Care Providers

In addition, LeadingAge Ohio also supports other provider calls for statutory or contractual safeguards, which include:

- **Any willing provider requirements that require plans to accept any high quality provider who is willing to accept the terms and conditions of a managed care plan, which will not prohibit new models of care such as small houses;**
- The state's licensure and certification requirements should serve as qualifications for contracting with ICDS's.
- Uniform (among plans) procedures and criteria for authorization of payment;
- Uniform billing procedures;
- Prompt pay requirements;
- Elimination of Medicare required three day hospital stay.

6. Strategic Partnerships and Innovation

LeadingAge Ohio's experience with the MME beneficiaries, as well as navigating the current fragmented system, positions our members an optimal partner for ICDSs to provide care, ensure better health outcomes, and identify cost savings for managed care organizations and for the state. LeadingAge Ohio members, who represent the full spectrum of care, currently coordinate care and services between housing with services, home care, assisted living, and skilled nursing care for approximately 10,000 MME beneficiaries per year. LeadingAge Ohio is exploring potential partnerships as the details of the demonstration program are developed. In particular, LeadingAge Ohio members will be essential partners in managing care transitions and hospital readmissions, as well as implementing innovative care models that provide high quality care that lead to better health outcomes and lower costs.

Thank you for your time and consideration; a more detailed report will be forthcoming. I would be happy to answer any questions you may have at this time.

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**Testimony by Pamela Tropiano, RN, CCM, BSN, MPA
Senior Vice President of Health Services, CareSource
ICDS Proposal Public Hearing
March 13, 2012**

Members of the Panel Review Committee, thank you for the opportunity to present here today. My name is Pamela Tropiano, and I am the Senior Vice President of Health Services at CareSource. CareSource is an independent, nonprofit health plan based in Dayton, Ohio that provides services to approximately 900,000 Medicaid consumers in Ohio and Michigan. In addition, we manage Medicare Advantage Dual Eligible Special Needs Plans (SNP) in both states. CareSource was established 23 years ago by community leaders in Dayton and we currently employ over 1,000 Ohioans.

I am here today to express our support for the Integrated Care Delivery System (ICDS) proposal advanced by the Governor and the Office of Health Transformation. This vision of providing a fully integrated approach to health care for consumers who are dually eligible for Medicare and Medicaid will not only result in substantial cost savings for the state but, more importantly, will best serve the needs of this vulnerable population as they receive care across the continuum.

Those eligible for Medicaid and Medicare represent some of Ohio's most at-risk citizens, yet today these individuals are forced to navigate across a confusing array of health care programs: Medicare FFS for their primary and acute health care; Medicaid FFS for Medicare cost sharing, wrap around benefits and long term care; MCD waiver programs; and Medicare Part D drug plan for prescription coverage. This complicated, fragmented system is difficult for many dually eligible consumers to understand and readily access and frequently results in poor quality outcomes and the delivery of uncoordinated care in the most costly settings. The ICDS program is an opportunity for Ohio to not only streamline and simplify the way care is delivered, but also to improve access to care and the overall quality of health outcomes for this vulnerable population.

To ensure the ICDS program delivers the highest quality health outcomes, we believe the program needs to incorporate three principles:

First, in order to ensure the safety and effectiveness of services, the program must allow for and support the engagement of high quality providers. Beneficiaries are best served and protected by encouraging plans to selectively engage providers with a demonstrated track record of superior performance and an ongoing commitment to deliver high quality services to patients and caregivers. Simply put, the program will not be successful in achieving high quality outcomes without high quality providers. We support strong credentialing and performance standards for all providers and recommend such standards be integrated into the program as a core beneficiary protection to assure the best possible health outcomes for all participants.

Second, the ICDS program needs to incent, rather than require, specific provider partnerships. We support the need for partnerships with traditional and non-traditional providers but believe that innovative and creative partnerships are best encouraged with a flexible program that incentivizes both providers and plans to join forces to contribute to quality outcomes. To further encourage innovative partnerships, we would also recommend that the state consider aligning the ICDS regional program boundaries with the AAA service areas allowing for greater flexibility and creativity in designing partnerships.

Third, the ICDS must carefully balance the need for continuity of care with the need to efficiently transition thousands of at-risk consumers to a new program of care. As stated, many dually

eligible consumers in Ohio have complex healthcare needs, and will require thoughtful and well planned transitions in order to support their ongoing health and safety. It is therefore our recommendation that a three-month transition period be incorporated into the program to ensure that every consumer is protected and faces no negative outcomes or disruption of services.

I have spent 30 years of my nursing career working with individuals and caregivers facing complex health care needs and attempting to navigate the complex, often frustrating system of uncoordinated care that exists today. The holistic, integrated care approach envisioned by the ICDS program will greatly benefit this complex population and undoubtedly result in cost savings, better health outcomes and greater consumer satisfaction.

I would like to share with you a case example which demonstrates the value of integrated care coordination in achieving optimal outcomes. Mark is a 47-year-old male with Bipolar Disorder, Hypertension, Hypercholesterolemia, Obesity, and Vertebral/Disc Injury with persistent pain, multiple skin and dental problems, intermittent bowel and bladder incontinence. Prior to entering the CareSource case management program, Mark frequently utilized the emergency room for his care and faced frustration and roadblocks in navigating and attempting to coordinate his care among the multiple providers required to address his complex health care needs. Mark frequently utilized the CareSource nurse triage line along with frequent trips to the emergency room.

Linking Mark to his physical and behavioral medical home was essential to improving his health and living status. Mark's problem list was long and he had multiple external service providers all of whom Mark himself was trying to coordinate. Unfortunately, this only led to uncoordinated care, problems not being addressed fully and unnecessary hospital visits. Mark's providers did not always know his story nor did they have the time to listen which added to his frustration. Mark and his providers were questioning his ability to continue to self-manage his complex needs while living alone with limited support.

When I met Mark, his frustration and despair were extremely evident! Each of Mark's problems was intertwined - physical, behavioral, and social. Utilizing a care coordination approach, we focused on tackling each of Mark's problems one by one, communicating and coordinating with every health care and service provider on a routine basis. Living situation needs and concerns were addressed including obtaining a bed, other furniture and equipment, changing apartments to ensure safety and the ability of equipment to be delivered without being stolen, and food assistance. Transportation to and from appointments was addressed which immediately decreased unnecessary trips to the emergency room and repeat provider visits to deal with the same or similar problems. Today, Mark is satisfied with his health and living situation and has stabilized as result of having a solid plan and a team he can trust. His visits to the emergency room have greatly declined and he continues to live on his own with support provided by his care coordination team.

Mark is just one of many individuals who will benefit from the holistic, enhanced care coordination envisioned by the ICDS. We applaud the vision and principles articulated by the Governor and the Office of Health Transformation in the ICDS program. Providing a fully integrated approach to health care for dually eligible consumers - integrating acute, long term and behavioral health care with fully integrated Medicare and Medicaid financing - is the right policy priority in this challenging fiscal environment.

Thank you again for the opportunity to testify today. CareSource looks forward to working with the State of Ohio to fully implement the ICDS proposal.



ICDS Demonstration Testimony March 13, 2012

Good morning, my name is Anne Shelley and I am the President and CEO of Universal Home Health and Hospice. Thank you for the opportunity to provide testimony on behalf of Midwest Care Alliance (MCA), an association that serves home, hospice and palliative care providers in Ohio. Our 250 members serve patients across the continuum of care from immediate post-acute to end of life. A majority of our members, hospice and palliative care, provide services in an environment where patient centered care and team decision-making are core to their philosophy and model of practice.

MCA supports an Integrated Care Delivery System (ICDS) model if the goal includes meaningful quality measures and appropriate utilization. Keeping participants out of acute care when possible will result in the greatest savings to the program. Palliative care, a medical-home model, physicians, and home care can play a strong role in the transition from acute to post-acute care, which will require greater utilization of community-based decision making and services to lower the hospital readmission rates for home- and community-based services.

To ensure the ICDS provides the appropriate care in the appropriate setting, MCA supports the following components of an ICDS model:

1. *Consumer Protections*

ICDSs should publically report measured health outcomes. This will help providers in the services they provide, as well as consumers in the choices they make between different ICDS plans. In addition, consumer participants should have:

- Access to benefits, person-centered continuous care, and preventive care.
- Comprehensive and uniform measurement of health outcomes for all MME's regardless of payment type.

2. *Provider Protections*

The ICDS should include appropriate authorization guidelines for managed care organizations. Currently in home health, Medicaid managed care providers have 13 days to authorize services. Patients are suffering during this period because providers do not know whether their services will or will not be reimbursed. Authorization for care services needs to be local, with 24/7 access at the provider/consumer/case manager level, and the state should work with federal guidelines to ensure appropriate authorization of services and care parameters.

In addition, MCA supports the following provider protections echoed by other provider groups:

- The ICDS local governance panel should include at least 20% provider representatives, representing low-income housing, home- and community-based services, assisted living, and skilled nursing facilities.
- Rate floors established by the Medicare and Medicaid fee for service rates; Cost containment should occur due to appropriate utilization of resources and services versus



continuing to cut rates. Some entities at the community level need to have rate floors identified, such as home care services.

- High quality providers who are able to bring down costs and improve measured health outcomes should share in the cost-savings to the program with the ICDS.

3. Strategic Partnerships

Midwest Care Alliance's members are well positioned and familiar with the MME population in order to help ICDSs coordinate care. MCA members currently coordinate care and services between acute and non-acute care for palliative care, home care, and hospice care, and often in coordination with assisted living and skilled nursing care, for approximately 35,000 MME beneficiaries per year. MCA's experience with the MME beneficiaries, as well as navigating the current fragmented system, makes our members an optimal partner for ICDSs to provide care, ensure better health outcomes, and identify cost savings for managed care organizations and for the state.

MCA plans to provide more detailed written comments, and looks forward to continuing our dialog around the ICDS demonstration. Thank you for your time and consideration, and I would be happy to answer any questions you may have at this time.

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A Discussion of the Integrated Healthcare Delivery System Proposal

Daniel J. Van Dussen PhD

Ohio Association of Gerontology and Education (OAGE) Policy Chair

Associate Professor of Gerontology

Youngstown State University

Dr. Nancy Orel

Associate Professor

Bowling Green State University

OAGE Board Member

Thank you for allowing me to present information that may help Ohio with this unprecedented set of proposed changes. The Ohio Association of Gerontology and Education (OAGE) is an organization dedicated to bringing researchers, practitioners and students in gerontology together to exchange ideas and to provide cutting edge research to Ohio based on our extensive and broad backgrounds in gerontology and our deep commitment to our aging population.

From OAGE perspective we provide evidence-based information. This information is grounded with empirical evidence, which is especially necessary if this information will be used to guide policy. Dismantling the current system, without having strong empirical evidence that indicates success is likely, runs a significant risk to the successes we have had over the past 4 decades and may cause us to slide backwards just as our older adult population is increasing in record numbers. Reform at this point poses significant risks to the aging network and should be carefully considered using all available evidence, stakeholder consultation, and working with OAGE and Ohio's gerontology programs, including Youngstown State University, Bowling Green, Miami, Kent State, and the University of Akron.

I would like to discuss some of the advantages and disadvantages of the current arrangements in Ohio for delivery of home and community based services for older adults and their families. The past 15 years have brought some important improvements in how services are delivered to Ohio's older adults. According to a 2011 report by Scripps Gerontology Center, despite a 15% increase in the number of older adults (defined as 60 and older) in Ohio, nursing home occupancy rates have declined resulting in 7,000 fewer older adults residing in Ohio's nursing homes since 1997. Further success is indicated by the large percentage of older adults who have transitioned from nursing home care with 75% remaining in their homes six months later.

Advantages:

- 1) A long history of quality care which has high client satisfaction ratings for users of long-term care and PASSPORT services.

- 2) A strong working relationship between the research community and the Area Agencies on Aging. This dates back 36 years through OAGE. The system has been in place for a long time and dismantling it is highly risky.
- 3) The Area Agencies on Aging are known for being the place to turn to when older adults or their families need help. The AAA's are then able to refer clients for services.
- 4) The Area Agencies on Aging have the ability to work within an integrated care delivery system because they have experience working within a smaller version of this system in the aging network. The aging network includes practitioners, state and federal funding sources, and researchers in aging to allow for strong collaboration and success in delaying long-term care utilization in Ohio and in other states.
- 5) The AAA's have been instrumental in enabling people to return to their homes from nursing homes, which saves money.

Disadvantages:

- 1) Extensive research on the impact of requiring people to participate in an integrative care program is just not available. We are taking a well-established network and rolling the dice to change the system with little empirical evidence. Perhaps a demonstration project with an extensive evaluation component would be feasible rather than scrapping something entirely.
- 2) Funding levels (can only do so much with Older American Act funding cuts) Can they continue under an integrated model as proposed?
- 3) How will funds funnel down to those that need it? How much will AAA's lose? How will this new funding system impact the consumers who are at greatest risk for LTC?
- 4) As initially prescribed, the OAA bars direct service delivery by AAA's. They are supposed to be a broker, but they have been forced to follow the funding to be able to serve older adults.
- 5) What would be the primary focus and/or balance between child and family services and older adults? AAA's have an unprecedented history of focusing on older adults, including grandparents raising grandchildren.
- 6) The Ohio Department of Aging has a streamlined staff that ensures money is being spent wisely, has the expertise in aging, and a strong working relationship with the AAA's. The new integrated model does not appear to allow this to continue and may add layers of bureaucracy that are unnecessary and may delay services getting to consumers and putting them at increased risk for more expensive care.
- 7) How easy to navigate would this new model be for consumers? What parts are integrated? Billing? Medical? Social Services? This does not appear to be the strength of the current proposal as it is not fleshed out.

Thank you for your time today to summarize, we run significant risks to our older population and their families if we make extensive changes to the healthcare system without the use existing evidence when making these changes in the system. One suggestion is to conduct limited demonstration projects to determine the feasibility of proposed changes. These projects would allow us to increase the chances of successful and meaningful changes to the way healthcare is delivered to our aging population and allows experts in the field who have high satisfaction ratings by consumers to continue to do what they do

best. OAGE and the academic members of the aging network are available to assist with any aspect of the healthcare delivery system.

References:

Applebaum, R., Bardo, A., Kunkel, S., & Carpio, E. 2011. "Right Place, Right Time, Right Care." Scripps Gerontology Center.

http://www.scripps.muohio.edu/sites/scripps.muohio.edu/files/Right_Place_Right_Time_Right_Carev1.pdf Retrieved March 9, 2012.

Mehdizadeh, S., Applebaum, R., Nelson, I.M., & Straker, J. 2011. "Coming of Age: Tracking the Progress and Challenges of Delivering Long-Term Services and Supports to Ohio." Scripps Gerontology Center

http://www.scripps.muohio.edu/sites/scripps.muohio.edu/files/Coming_of_Age_Brief.pdf Retrieved March 9, 2012.

TESTIMONY
on
Integrated Care Delivery System
Proposal

Tuesday, March 13, 2012

OHIO ASSOCIATION OF AREA AGENCIES ON AGING

Larke Recchie
Executive Director
Ohio Association of Area Agencies on Aging

What Ohio's Area Agencies on Aging Offer an Integrated Care Delivery System

Ohio's Area Agencies on Aging (AAAs) share the Office of Health Transformation's (OHT) goal of meeting the triple aim of creating better health outcomes and better care for lower costs while integrating Medicare and Medicaid for those who are dually eligible. As Ohio embarks on this massive transformation in health care delivery, it is essential to keep in place the pieces of Ohio's long-term services and supports (LTSS) system that are working. This will allow for a seamless transition to integrated care. We offer the following comments on the February 27, 2012, draft proposal to the Center for Medicare and Medicaid Innovation.

The o4a is an active member of the Ohio Olmstead Task Force (OOTF) and supports the advocacy principles put forward by OOTF for dual eligible integration policy initiatives. We believe that any integration of Medicare and Medicaid funds through the proposed Integrated Care Delivery System (ICDS) should provide consumer choice, do no harm and preserve existing provider relations.

People seeking long-term services and supports are usually in a crisis or vulnerable position as their own or their loved one's health leaves them needing assistance. A move to a managed care model will be a major change for 122,000 individuals in an untested demonstration. Ohio should maintain continuity and consistency for consumers, nursing facilities, hospitals, and home and community based providers as much as possible.

Aging and Disability Resource Networks

With a 25+ year track record of unbiased, accurate and consumer friendly Front Door activities, Ohio's AAAs have proven they provide a reliable and seamless entry into long-term services and supports for adults. Ohio's AAAs are designated Aging and Disability Resource Networks (ADRN) that combine federal, state, and local funds to maximize a seamless experience for Ohioans needing help accessing long-term services and supports. Outside evaluation has shown consistent success as evidenced by Level of Care accuracy and increased diversion of older Ohioans from institutional care without increasing the rate of individuals receiving LTSS. In a June 2007 Scripps research brief, 99.4% of PASSPORT consumers statewide met functional eligibility criteria for PASSPORT. Reviews of individual AAAs showed 100% of consumers reviewed met intermediate LOC

requirements. ADRNs work collaboratively with Centers for Independent Living and others to provide the expertise needed for Ohioans in need of LTSS.

Care coordination/management

The AAAs offer the ICDS a proven statewide network of care management for individuals over the age of 60. AAAs bring a unique ability to access multiple funding sources, assuring the consumer the ability to be serviced at home and in the community. The transitions to an ICDS will be enhanced by accessing the wide range of funds, community resources, and family supports AAAs utilize in their care management model. O4a believes AAAs should be mandated care coordinators/managers for those 60 and older using LTSS within the ICDS and available to provide nursing home screening and assessment. AAAs recommend using organizations with expertise in LTSS for other populations under age 60 but remain available to provide those services if appropriate.

Care Transitions

AAAs are trained and certified statewide in the evidenced-based Coleman Care Transitions model. Many AAAs have developed relationships with hospitals to provide transitional care and CMS has recognized Ohio's AAA network by giving 5 Ohio AAAs awards totaling over \$30 million in care transitions funds from a limited number of national awards to date. We believe the ICDS system should include a mandated role for AAA care transition staff in nursing homes, hospitals and physician practices with high concentrations of MMEs to facilitate transitions and reduce overuse of hospitals, nursing facilities and high cost medical care.

LTSS Provider Network Management:

AAAs have a 40 year history of developing, managing and monitoring service delivery networks in their regions. This experience has helped small businesses develop in rural and hard to serve areas and has created a system that Ohio's Attorney General's office has commended for being successful in preventing fraud and waste. By operating LTSS HCBS provider networks, AAAs would facilitate transition to an ICDS system. This can include development of providers in rural areas, certification, quality selection, and management as well as monitoring.

Participant Directed Care Assistance

AAAs have experience with consumer directed care through the Choices waiver. They recognize the many kinds of assistance needed by a wide range of consumers. Some need initial training, some more on-going technical assistance and others prefer more care management assistance. The Choices

model offers optimal consumer choice and excellent outcomes for helping people stay at home and preventing nursing home use. This model should apply to all dually eligible individuals and employ a fiscal intermediary so the consumer can be the employer of record. AAAs can offer assistance in conjunction with Centers for Independent Living with participant directed care through the ADRNs with training, technical assistance and/or hands on care management as needed.

Prevention and Disease Self Management programs

AAAs and Ohio Department of Aging offer extensive evidenced-based falls prevention, chronic disease self management, diabetes self management, depression self management programs along with a program on reducing disability in Alzheimer's disease for reimbursement from the ICDS. AAAs plan to continue to offer these services to ICDS plans.

Thank you for the opportunity to comment publicly on the proposed ICDS model for dual eligible integration. We welcome your questions and comments.



Public Comments

Kathleen Anderson, President, Ohio Council for Home Care and Hospice

Presented to The Ohio Office Of Health Plans ..March 13, 2012

Good morning and thank you for allowing me time today to discuss pending changes in the way Ohio delivers essential health care to thousands of our fellow citizens across the state.

My name is Kathleen Anderson and I serve as president/ceo of the Ohio Council for Home Care and Hospice, the largest association of home care and hospice agencies in the state and the longest serving home care association in Ohio. Our more than 550 members include large, medium and small agencies and we serve our fellow citizens in every county in Ohio. We take very seriously our role as the industry leader in Ohio and, as many of you know, have worked hard in recent years to make our knowledge and expertise available to those of you charged with making decisions that directly impact the delivery of health care in Ohio.

We are the only association to have conducted an in-depth economic study of home care Medicaid spending in Ohio. And we continue to study the impact of public policy on care delivery, which helps us work closely with elected officials, administrators and others – including some of you – to try and determine the best way to provide quality care in the manner the large majority of Ohioans prefer – in the comfort of their own homes and communities.

With your assistance and the assistance of others, we have witnessed some significant changes in recent years in Ohio regarding the delivery of home care. We are seeing more and more people receiving care at home – and expressing their appreciation to

the public officials who are helping make that happen. This ability to serve more Ohioans at home is due to a number of factors, including increased demand for such care from clients, better technology allowing patients to safely return home, and more enlightened public policies that take into account the expressed desires – and needs – of those receiving care.

It is the last point that I want to touch briefly on today.

As we all know, more than 250,000 Ohioans are covered by both Medicare, because they are over age 65 or disabled, and Medicaid, because they have low income. Primarily because these programs have often been managed with almost no connection to each other, the services that were provided were too often poorly coordinated. These so-called "dual eligible" individuals make up only 14 percent of the total Ohio Medicaid enrollment, but they account for 40 percent of Medicaid long-term care spending. Obviously, program changes that result in better coordination and delivery of care to these citizens – and all Medicaid and Medicare recipients -- is a worthy goal and the Ohio Council applauds those of who have spent countless hours studying these complex issues.

The implementation of Medicaid modernization initiatives is a way to make sure that precious federal and state dollars are providing essential services in the most efficient manner while also ensuring that clients are receiving the quality care they deserve. The incentives that currently exist in Ohio law result in many seniors on Medicaid being placed in expensive institutional care settings, when they would be happier in an assisted-living facility or at home with in-home care, either of which is far cheaper than an institution.

A properly managed health care program can serve as a central point of coordination for people's cases and can:

- Eliminate the cost of duplication of services through improved care coordination for the beneficiary;

- Lower cost and trauma to patients through improved medication management which can result in lowering hospitalizations or unplanned emergency department visits;
- Ensure that patients are cared for in the setting they prefer, which almost always is a home and community based setting that is the least intensive and least expensive.

As you move forward in considering systemic changes, we ask that you keep several imperatives in mind. First, we are talking about a very vulnerable client population. These clients are elderly, disabled, often struggling with very debilitating illnesses. Fortunately, many of them have very involved family members who can help provide guidance regarding care. But far too many of them do not have such a support system. It is essential that safeguards are in place – and enforced – to make sure that the delivery of quality care is the top priority. We all recognize that cost efficiency is very important – but it should not override quality care delivery.

Secondly, we all must recognize that Ohio's population is aging and at the same time we are seeing a reduction in the segment of our population that will provide the health care professionals who are the heart of our care delivery system. We are encouraged that some leaders have already recognized that cost efficiencies and savings could provide additional revenue to address such issues as the relatively low payments for in-home health aides. In addition, it is encouraging that there has been recognition that changes that reduce benefits, narrow choice or make provider reimbursements too cumbersome, are not acceptable.

Because time would not allow today, we are identifying provider issues and will pose them in question form. Then as suggested at my ULTCS Advisory Workgroup meeting last week OCHCH is developing what we believe should be the response. These will then be submitted through the OHT website.

For example:

How will the quality of care provided by a home health agency be determined and how will it be measured especially when there is such a difference between Medicare acute intermediate care and Medicaid Long Term Care patients?

How does the state guarantee that the projected increased capacity for home and community based care services is met?

How will the state assure that the reimbursement rates offered will attract and maintain home health agencies who provide excellent care and high standards when hiring nurses and aides?

Since there is no licensure of home care providers and since each program has their own requirements, who or what determines provider requirements or standards when it comes to home care services delivered by an agency or by a non-agency?

Thank you for your time and consideration and I would be happy to answer any questions.