Dear Director Corcoran, Jesse Wyatt, Lindsey Brigano, and other interested Medicaid parties:

Thank you for the opportunity to provide comment on the current version of the MyCare Conversion Charter.

As you know, Breaking Silences is a statewide advocacy group that addresses issues affecting many individuals with disabilities. One of our major areas of concern is Medicaid, which includes hurdles we've encountered in the past, those we are navigating in the present, and those we would like to eliminate for the future. As such, we produced this document that we hope will inform the direction of the MyCare Conversion.

We identified several areas of importance: ***Direct Care Workforce Providers, Care Coordination, Self-direction, Grievances and Appeals, Provider Networks, Health Equity, Reasonable Accommodations, and Transportation***.

Our concerns and suggestions are rooted in a desire to increase the quality of life, health, and safety of the **INDIVIDUAL** being served by the managed care organizations (MCOs). We believe these concerns are also priorities for Medicaid, as they are encapsulated in the mission statement for Ohio's Next Generation of Medicaid, "Focus on the **INDIVIDUAL** rather than the business of managed-care. We want to do better for the people we serve".

We welcome the opportunity to speak directly with you on these topics. We can arrange a meeting, or series of meetings, to delve into this information in more detail. We are deeply invested in creating a dialogue and collaborative effort, beginning today, and continuing over the next several years, as Medicaid transitions to the next generation of MyCare.

Thank you for your time and consideration.

Kind regards,

Maria Sutter
Host of the MyCare and Self-Direction Committee
Breaking Silences Advocacy Committee
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Direct care workforce providers: This topic is huge with no simple answers.

- ODM should:
  - **Increase pay rates** for all direct care workers, not just reimbursement rates
  - Prohibit MCOs from paying less than the standard Medicaid rate
  - Streamline **Enrollment**:
    - Clear timeframe for entire process, not exceeding (14) calendar days from receipt of all enrollee information
    - Simplify Enrollment
    - Simplify Application process
    - Ensure that independent providers are credentialed with all MCOs through a single credentialing process, just like Next Generation of Medicaid
    - Members have the right to choose their providers, so credentialing providers should not be at the discretion of the MCOs
    - Offer Enrollment Navigators
    - Have a provider navigator available for 1 year for new providers to assure that they are comfortable and understand the requirements
  - Have a 24-hour hotline for providers to seek support and assistance with enrollment, yearly reviews, paperwork, program requirements, EVV, billing, etc.
  - Offer **Incentives**:
    - Offer assistance with education for professional advancement
    - Offer Benefits:
      - ✓ PTO: Sick Leave, Vacation, Maternity/Paternity
      - ✓ Healthcare
      - ✓ Shift differentials
      - ✓ Holiday pay
      - ✓ Bonuses
      - ✓ Childcare vouchers
      - ✓ Gas mileage reimbursement
  - **Recruit** providers for home care:
    - Form alliances with nursing and STNA schools
    - Offer college credit incentives
    - Offer education and training to high school students to become direct care workforce providers (DODD is already partnered with the Department of Education and the Ohio Alliance of Direct Support Professionals (OADSP) to implement a program called DSP-U)
  - Thorough and robust trainings so that DCW know and truly understand their client.
    - Every client is different and has unique needs, as well as personal preferences
    - Paid on-the-job training directed by the member or a member representative is necessary before beginning actual work shifts

- **Billing process:**
    - There should not be time lapse for payments because billing and payments are an automated process
    - Establish transparent rules, in writing, for when providers must submit payments, and when the plans must pay the providers
    - Establish transparent rules, in writing, for when providers must submit payment, and when the plans must pay the providers
- Implement **financial penalties** for breach of contract, including, but not limited to:
    - Failure to enroll new providers within (14) calendar days after receiving providers enrollment information
    - Failure to credential providers within (4) calendar days of receiving providers credentialing information
        - ✓ NOTE: This affects existing providers who were not credentialed during their initial application process and will continue to be a problem for new providers if there is not a single credentialing process that is completed during initial enrollment, just like Next Generation of Medicaid
    - Failure to pay providers within (7) calendar days of providers submitting billing information
    - Failure to pay providers within (7) calendar days after a provider's billing error has been identified and corrected. If the billing error is the fault of the MCO, payment should be remitted to provider within (2) business days.
- Members should not be responsible for providing backup services for an extended time-period, exceeding 24 hours.
    - Case managers should be responsible for coordinating backup services

Care Coordination:

- ODM should identify care coordination models from other states and share with stakeholders for comparison and consideration
- ODM needs to ensure continuity between contract agreements and services provided by all MCOs
- There is a lack of consistent and clear information for members and providers regarding:
    - **Enrollment**:
        - Requirements for enrollment
        - Assistance with enrollment
        - Expediting enrollment
    - **Billing**
        - Assistance with billing issues
        - Quick turn around for payments and correction of billing errors
        - Acknowledgement when MCO makes billing errors:

- ✓ Providers Should NOT Have to Wait 30 to 45 days to be paid
- ✓ MCO employees would NEVER agree to that, and neither would ODM employees

- Lack of consistent knowledge by Member and Provider Service representatives
- Member Benefits
- **Medicare/ Medicaid Dual Eligibility Opt-In and Opt-Out:**
  - Conduct honest and clear discussion sessions with members to determine why members choose to opt out of dual eligibility
  - What are the benefits if a member opt-in
  - Work to rectify the problems that they encountered as an opt-in member

- **Ongoing Training** should be provided to Care Managers both within the MCOs and the AAAs.
  - MCOs should know ***AND Understand*** their member's needs
    - Information given to members is often inconsistent and changes depending on who you talk to and their interpretation of the rules/ guidelines.
    - Often members are educating the care manager about the rules/ guidelines.
    - Care Managers should offer support and empathy. Often, they are verbally abusive and apathetic and reporting this behavior often has no results.
    - Care Managers should NOT leave an individual on their own to find providers. They should assist and up-date the member about progress. AND, they should NEVER threaten a member with an impending Nursing Facility placement if a provider is not located. This is an ongoing issue.
    - Improved timing at matching providers to clients; care managers doing more of that work instead of it falling so heavily on members/families.
    - Individuals should not have their hours decreased if there is no change in improvement of health.
      - ✓ Waivers are in place to make it possible for individuals to remain independent in the community
      - ✓ If this occurs, and the member appeals, the member should receive a fair hearing
      - ✓ The hearing officer should not be condescending regarding the members limitations AND should NEVER ask if the individual has considered Nursing Facility placement.
        - Attitudes and statements such as this reflect an inherent bias toward individuals with disabilities and negates any ability to receive an equitable determination
      - ✓ Disability awareness education here is greatly needed!
  - The entire care management team needs ongoing disability awareness training
    - MCOs should contract with centers for independent living that specialize in community education training

    - For example, MCOs need to provide accommodations beyond ensuring wheelchair access to healthcare facilities or providing materials in alternative formats, such as person-centered service allowances that account for the additional needs associated with complex disabilities
- There should be knowledge and inclusion of a clear "disease specific process" that includes rare diseases including rare diseases like EDS
- **Accountability**: Consequences when care managers fail to do their jobs properly; MCO fees or a rating/disciplinary system for care managers

Self-direction:

- Applied Self-direction defines self-direction as "a model of long-term care service delivery that helps people of all ages, with all types of disabilities, maintain their independence at home. When a person self directs, **they decide how, when, and from whom** their services and supports will be delivered."
- Program is currently named participant directed. Needs to be renamed SELF-DIRECTION
- Consider creating self-direction as a separate waiver, instead of an option under existing ODM waivers. Examples of states who offer self-direction as a separate waiver:
    - Colorado https://hcpf.colorado.gov/complementary-integrative-health-waiver-cih
    - Illinois https://www2.illinois.gov/hfs/MedicalClients/HCBS/Pages/disablities.aspx
- Nursing should be included in Self-direction (currently nursing is not an option with self-direction)
- Better training for MCOs
    - More likely to offer it as an option to members
    - Case managers will have a better understanding of their role
- Include financial penalties to MCOs and Financial Management Systems (FMS) for breach of contract, including, but not limited to:
    - Failure to enroll/ credential providers within (14) calendar days of receiving providers credentialing information
    - Failure to pay providers within (7) calendar days of providers submitting billing information
    - Failure to pay providers within (7) calendar days after a provider billing error has been identified and corrected. If the billing error is the fault of the MCO or FMS, payment should be remitted to provider within (2) business days.
- **Enrollment** considerations:
    - Create a clear timeframe for entire process. This should not exceed (14) calendar days once all information is received
    - Simplify Enrollment/ Application process

- Provide enrollment navigators to guide applicants through the process
- Training requirements should be at discretion/ direction of the member
- Providers should not be required to credential with the MCOs

- **Program** requirements:
  - **Wages**:
    - Increase minimum wage for PCAs and nurses
    - Provide benefits for PCAs/nurses
      - ✓ PCAs are a valuable part of the workforce in the state of Ohio and will only become increasingly more important as baby boomers age.
      - ✓ PCAs should receive healthcare benefits
      - ✓ The governor of Connecticut did just this recently. The attached article explains. https://portal.ct.gov/Office-of-the-Governor/News/Press-Releases/2023/03-2023/Governor-Lamont-Announces-Agreement-To-Expand-Access-to-Health-Coverage-for-Personal-Care-Attendants
- **Home care schedules:**
  - Allocation of hours at the discretion of member
    - No longer required to state specific hours on the care plan (All Service Plan, ASP)
      - ✓ Currently hours must be on the care plan and the schedule cannot deviate without authorization from the care manager
      - ✓ If the hours do not match the care plan the provider does not get paid until next pay period, which could be an additional two weeks
    - This will create the flexibility self-direction is intended to provide
    - For example, consumer determines amount of home care hours and the days and times of home care shifts
- **Budget:**
  - Allocation of budget at the discretion of member
    - Having a clear formula for what member's budget is before beginning self-direction services
      - ✓ Clearly defining the entire budget amount before self-direction services begin
      - ✓ Consumer determines how the entire budget is divided
      - ✓ For example, consumer determines pay rates per shift
  - Option to choose if you use FMS or member manages budget independently
    - For example, the member approves timesheets and then payment is distributed by a third party payroll company of the member's choosing
    - Provider should be paid weekly
    - Establish transparent rules, in writing, for when providers must submit payments, and when the MCOs or FMS, must pay the providers

- Flexibility to use funds to increase quality of life, for example, alternative therapy
- Home modification services (refers to OAC 5160-44-13):
    - Should increase for inflation based on medical inflation
- Supplemental adaptive and assistive device services (refers to OAC 5160-46-04):
    - "Medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the individual, or a family member, or someone who resides in the same household as the individual, that are not otherwise available through any other funding source and that are suitable to enable the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance"
    - Should increase for inflation based on medical inflation
    - Unused portions of yearly allowance should be held in separate account to be used toward vehicle modification cost when member needs a new vehicle
    - Devices should include assistive technology (AT) like Alexa or Google Home Assistant, and associated controls for lights, thermostat, etc.
- DME services: (refers to OAC 5160-10-01),
    - Should increase for inflation based on medical inflation
- Home maintenance and chore services (refers to OAC 5160-44-16):
    - Should increase for inflation based on medical inflation
    - Expedited approval process for home maintenance emergencies that jeopardize the health and safety of the member
- **Additional considerations:**
    - No annual continuing education requirement
    - Create a 24-hour hotline for providers to seek support and assistance
    - Have a provider navigator available for 1 year for new providers to assure that they are comfortable and understand the requirements
    - EVV should not be required
        - Hours consistently change and if member is signing off on timesheets, then there should be no need to electronically clock in
        - It only complicates the process and contradicts what self-direction really represents

Grievances and appeals:

- Medicaid contracts with MCOs should be available for members to reference
- ODM needs to create a process for providers and members to file a complaint against a MCO if they are violating the terms of their Medicaid contract and include instructions in provider agreements and the member's handbook
- MCOs should have a standard process for filing a grievance or appeal that can be accessed from a standardized location on every MCO's website, clearly outlined in provider

agreements and the member's handbook, and easily accessed through a designated prompt when calling Provider and Member services

- Members must receive written confirmation that a grievance or appeal was filed, as well as written documentation of all decisions in the grievance and appeal process
- Establish a clear process for providers to submit billing issues that is consistent for all MCOs:
    - This includes specifying the role of Member Services/ billing departments, as well as case managers, so providers are not sent back-and-forth between departments.
    - The process should be provided in writing to providers in their provider agreement.
    - Failure to comply with the payment timeline should result in financial penalties.
- Establish a clear process to submit a reasonable accommodation request regarding services outlined in the MCOs contracts:
    - The process should stipulate the length of time MCOs have to review the request, determine how the request will be fulfilled, and the determination will be implemented.
    - Review and determination should not exceed (7) calendar days. Implementation should commence no more than (7) calendar days after determination has been made.
    - The process should be provided in writing to members in their member handbooks.
    - Failure to comply with the timeline should result in financial penalties.
- Establish a clear process to appeal a reasonable accommodation request determination.
    - The process should be separate from the established Medicaid appeal process and consider state and federal reasonable accommodation regulations.
    - The process should stipulate the length of time for the appeal process once a member has submitted documentation supporting their appeal. Review and determination should not exceed (7) calendar days. Implementation should commence no more than (7) calendar days after determination has been made
    - The process should be provided in writing to members in their member handbooks.
    - Failure to comply with the timeline should result in financial penalties.

Provider networks:

- Provider networks do not take access into account:
    - Virtual appointments should remain an option when appropriate
    - MCOs should be required to contract with visiting physician agencies/ offices
        - The visiting physician agencies/ offices must offer in home: lab work, ultrasounds, x-rays, EKG, etc.
    - MCOs should work with providers to ensure that offices have accommodations for individuals with various disabilities
        - This would include easy building access, wide doorways, automatic doors, ADA restrooms, large exam rooms with easy-to-move equipment, exam

tables that raise and lower, a height adjustable hospital bed, hoyer lifts, braille signage, a clear process for requesting interpreters, etc.
    - MCOs should create and enforce specialty appts for coverage
    - Need to consider individuals who fall under the category of rare diseases
    - To get into specialists it often takes several months, occasionally years
    - Rural counties have significantly less providers, so special consideration is needed to expand provider networks in rural areas
- MCOs should work with providers regarding disability awareness training
    - Many CILs offer disability awareness trainings. MCOs should contract with CILs for trainings
        - For example, providing accommodations beyond wheelchair access to healthcare facilities or materials in alternative formats, such as person-centered service allowances for the additional needs associated with complex disabilities

Health Equity:

- Rural counties are severely underserved, causing problems finding enough qualified home care agencies and independent providers, healthcare providers, transportation, etc.
- Transitioning from one managed-care plan to another can be very difficult
- A transition process needs to be created for members who relocate to another county where their current MCO is no longer available or MyCare is not available so their services are not interrupted
- Cannot always get transportation to appointments beyond the county in which they live

Reasonable Accommodations:

- Currently there is no clear process to formally request reasonable accommodations and have them reviewed, processed, and implemented in a timely manner with at least three of the MCOs:
    - As a result, if you're ever subjected to a state appeal for a reasonable accommodations request, the appeal process does not take into consideration federal laws, only OAC compliance, so a reasonable accommodation request will always be denied.
    - As such, Medicaid needs to create a distinct pathway for reasonable accommodation request consideration and include this in the MCOs contract obligations, as well as penalties for noncompliance.
    - Implement fees if the MCO fail to make reasonable accommodations.
- Additionally, MCOs need to understand their legal obligations under federal law related to the ADA, 504, and reasonable accommodations.
- This includes proper training for MCOs about disability awareness and legal rights of people with disabilities, especially as it relates to the services they provide, and their method of service delivery.

- Finally, Medicaid has a responsibility to be underscoring these obligations to the MCOs, as well as implementing and enforcing penalties for noncompliance.

Transportation:

- Must have availability for urgent needs/medical appointments and make exception for advance notice in these situations
- MCOs should reserve a certain number of urgent slots per day for emergencies
- Require no more than 48 hours advance notice
- Identify and accommodate any special transportation assistance needs (e.g., door-to-door assistance, attendant support, member-specific timeliness requirements)
- Transportation that accommodates individuals who cannot sit upright
- Pick-up times should not be more than 15 minutes before or 15 minutes after the pre-scheduled time
- Transportation must contact the member if they are not present at scheduled pick-up time
- Transportation must not leave the pick-up location before the scheduled pick-up time and must wait at least 15 minutes after the schedule pick-up time
- If transportation is being provided to more than one member, to more than one location, no single member's transit time should exceed 30 minutes more than the member's direct transit time would have been if transported separately
- Enforce financial penalties each time transportation requirements are not met

Additional Concerns about the MyCare Program:

- It takes away choice
- Very few options for each county
- Instead of Medicaid determining what's covered, MCOs do
- Inability to access important docs for rare disease- refusal to cover out of network
  Needs to be a clear path for out-of-network
- Privatization
- Special Needs should be removed from the name
- Should be a way to opt out of Medicaid Managed Care to stay with fee for service/ traditional Medicaid for complex diseases
- Better training for care managers so members don't have to educate them
- Its unfortunate people have to move counties to get the plan that will serve then best or suffer with inadequate care
- Emphasize the problems with providers getting paid from managed care - there's a reason more long-term care recipients are opt out
- Anti default enrollment- further removes choice and autonomy
- The FIDE Medically Complex Plan or FIDE High Support Plan