Ohio House of Representatives
Finance Committee
Subcommittee on Health and Human Services

Testimony Presented By:
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Chairman Romanchuk and members of the Subcommittee: Thank you for the opportunity to present testimony. My name is Steve Wermuth. I am a partner at Strategic Health Care (SHC) and serve as the Network Manager for the Ohio Aging Services Network, a managed care network of over 70 LeadingAge Ohio members providing services across the entire long term care continuum. I wanted to present some thoughts about Medicaid managed care from a provider perspective.

Three years ago the LeadingAge Ohio Board approached us at SHC to see if we could build a managed care network of its members in preparation of the MyCare Ohio Demonstration project. As a consulting firm that has delivered managed care contracting services for over 20 years and have developed several networks of providers, we felt confident we could help. However, understanding at that time that payment models were changing with a strong emphasis on quality we suggested building a network with a strong quality component.

After three years, we have a group of long term care providers collecting data on 21 outcome measures, aggregating that data and performing data analytics to show value to payors and our other health are partners. We have anchored our data to state and national benchmarks when available. Please see our most recent dashboard attached to my testimony.

We used this dashboard to negotiate reimbursement rates with the payors, develop pay-for-performance models with the payors to reward providers for achieving agreed upon outcomes, look for best practices throughout our network that can be shared and help facilities that struggle with peer to peer mentoring.

Last week, Kathryn Brod, President and CEO at LeadingAge Ohio, testified before this subcommittee as not being opposed to moving to managed care with appropriate safeguards. As a network of LeadingAge Ohio members, we support that position.

You also heard other long term care providers talk about all the problems with Medicaid managed care and their opposition to the movement to a more efficient system of care. Well, we have a different opinion of that position.

As a network of providers focusing in on quality outcomes, we look at the Medicaid managed care plans as our partners. We look at the hospitals as our partners. We look at the older adult and their family as our partners. We are working toward the same outcome, the highest quality of life in the most appropriate care setting. In some cases for different reasons, but collectively we can use the strength of all out partners to provide the best care leading to great outcomes. The movement to Managed Medicaid Long Term Services and Supports (MLTSS) is the natural progression to coordinate care and control costs. A system of care that is focused on quality and reimburses providers for meeting health outcomes that results in the best quality of life for the individual.

There is no doubt that there are some inefficiencies in the Medicaid managed care program and the MyCare Ohio Demonstration project. But we can't go back to a Fee-For-Service (FFS) system that does not:

- focus on quality
- hold providers accountable for outcomes
- reward providers for providing great care

Instead we should analyze these inefficiencies and look for way to fix them with ultimate goal of great care and controlling costs.

Many of these inefficiencies can be categorized as imbedding FFS provisions in a managed care environment. This has resulted in administrative burdens and barriers to providing right care, right place, right time. Let me give you some examples of these inefficiencies.

- Eligibility determination is still done using FFS provisions. The Medicaid managed care plan (Plan) has to get an 834 from the county JFS office which will determine Medicaid eligibility. Sometimes we wait 30, 60, 90 days for this document which delays care being delivered.

- Once eligibility is determined, Patient Liability (PL) is determined which is a calculation to determine how much a Medicaid beneficiary pays toward their care. This is a fixed dollar amount. If the PL changes and varies over $1.00, the a 9401 must be completed to re-establish the PL and if any corrections need to be made between the Plan and the provider will spark a services of event to pay

one or the other amounts a small as $2.00 - $3.00. There is an intense amount of administrative time and cost involved to make this correction.

- Any Willing Provider (AWP) – Under FFS, if a provider meets the conditions to be a Medicaid provider, they are eligible for reimbursement. The Plans are held to AWP, which means if there is a provider who cares for one Medicaid beneficiary they have to be loaded into their system. And, there are no guidelines regarding the quality of that provider.

These are just some examples of the FFS inefficiencies imbedded in the Medicaid managed care program. Developing a Medicaid managed care program that is built on the concepts of managed care can help reduce administrative burden for the provider and the Plan and allow us to focus our energy on serving the older adult and their family.

Following the Patient Centered Medical Home (PCMH) model of care, every older adult coming into the MLTSS system should have a care management plan that identifies the co-morbidities, the outcomes to be met and how that will be accomplished. The family, provider and Plan all sign off on this plan. This replaces the 834 process.

If the older adult is required to pay something toward their care, it could be a percentage (co-pay) versus a fixed dollar amount. This replaces Patient Liability and the 9401.

Understanding that Medicaid beneficiaries have more intensive health care needs, building the Medicaid managed care system should focus on holding providers and Plans accountable for the outcomes they can achieve not making sure a box was checked on a form.

As a network of long term care providers, we are in the business to serve people. We would like to be part of a system that allows us to serve older adults, holds us accountable for achieving outcomes and rewards us when those outcomes are achieved.