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Good morning, Chair Romanchuk, Ranking Member Sykes, and members of the subcommittee, my name is Pete Van Runkle. I am Executive Director of the Ohio Health Care Association. We represent nearly 1,000 skilled nursing centers, assisted living communities, and providers of services to people with intellectual and developmental disabilities (IDD).

I am here because our members have several concerns about the Executive Budget. I will list all of our concerns in my testimony, but I would like to focus on two issues that are far and away the top priorities: 1) the Department of Medicaid's (ODM's) proposal to move the entire Ohio long-term services and supports (LTSS) population, aside from IDD, into managed care; and 2) their proposal to cut skilled nursing facility rates by $263 million over the biennium. When I say "long-term services and supports," that means services in a skilled nursing facility or a home and community-based waiver.

Managed care. From our experience, we believe managed care is not appropriate for the LTSS population. At the very least, whatever benefits managed care may have for LTSS are unproven in the state of Ohio.

For the last three years, Ohio has experimented with managed care for LTSS through the MyCare Ohio demonstration program. MyCare operates in 29, largely urban counties. The lessons from this program should help determine whether it is a good idea to expand managed care to LTSS consumers in the remaining 59, mostly rural counties.

Empirical data about the MyCare experience for LTSS is lacking, so ODM's proposal appears to be driven by ideology. As Director Sears testified, the Administration's philosophy is that 100% of the Medicaid population should be in managed care. This philosophy seems to be the real reason behind the proposed managed LTSS expansion.

Lack of evaluation. Director Sears' presentation included a slide that listed several generic benefits of managed care, such as coordination of care, but she did not provide this subcommittee with any data showing that MyCare Ohio has delivered those benefits to LTSS consumers.

To the contrary, as a trade association representing LTSS providers, we have heard from members for three years about the problems that MyCare creates for them and their patients.

At the top of the list are slow pay, inaccurate payments, erroneous denials, difficulty getting approval for services, and inadequate service. Members have incurred considerable time, effort, and expense in dealing with these issues, in many cases having to add staff.

We did a survey of our members in May 2016 that detailed all of these things, which I can provide to the subcommittee if you would like. While the survey is from last year, and in fairness, the situation has improved since MyCare began, we unfortunately continue hear of new problems on a regular basis.

Recent Examples

- Two plans denied access to Medicaid SNF benefits by improperly applying Medicare criteria.
- A third plan denied Medicaid hospice room-and-board payments, incorrectly claiming Medicare pays this.
- A fourth plan erroneously recouped a years' worth of claims for one patients, forced the provider to appeal each month separately to get the money back, and then denied some of the appeals as untimely.

To the plans' credit, some of these issues are being addressed, but they keep cropping up.

State statute - ORC 5164.911 - requires ODM to do annual evaluations of MyCare. The statute lists a number of specific issues to be included in these studies. To my knowledge, ODM has not produced such an evaluation. Certainly, they have not shared one with us or with the subcommittee.

The federal Centers for Medicare and Medicaid Services contracted with consultants to evaluate MyCare and similar demonstration programs in the handful of other states that are pursuing them. This evaluation is not finished, not even a preliminary report. In fact, ODM asked the federal government to extend MyCare for two years after its planned sunset at the end of 2017 to give more time for evaluation.

Lack of other evidence. Without waiting for the evaluation, ODM wants to expand managed long-term services and supports to the rest of the state on July 1, 2018. Although the timetable is unrealistic, perhaps the managed-care expansion could be justified if there was other evidence outside of the evaluation showing that managed LTSS has been successful. This evidence should address, at the very least, cost, health outcomes, and burden on providers. Apparently, ODM has no such evidence, or they surely would have presented it to you.

Instead, Director Sears gave you two anecdotes about a skilled nursing facility that was evacuated and another that was not. There may be some disagreement about the facts of those two anecdotes, but that is not the point. The point is there are more than 90,000 people in

MyCare, of whom close to half are in LTSS, and two anecdotes do not substitute for data on how MyCare is working for them.

Director Sears also made reference to HEDIS measures listed in a MyCare progress report that ODM issued last November. In their contract with the managed care plans, ODM established 25 different quality measures. Bear in mind that MyCare covers people living in the community (the so-called "community well") in addition to people in LTSS. The list of measures includes items to address each of these populations.

The list includes 16 HEDIS (or CAHPS) measures and 9 measures that are specific to LTSS. The HEDIS and CAHPS measures are principally designed for the community-well population. They are things like getting appointments quickly, breast-cancer screenings, and high blood-pressure medication. These are the measures ODM covered in the progress report.

By contrast, the report was silent on the contract's LTSS-specific measures, which deal with LTSS issues like pressure ulcers and urinary tract infections as well as how well the managed care plans moved people out of SNFs and into the community, compared with providers' existing work in this area (we already return an estimated 160,000 patients to the community every year).

We also thought it was telling that earlier this year, when the Ohio Association of Health Plans released a consultant's report touting Medicaid savings from managed care, MyCare Ohio specifically was excluded from the cost analysis.

Care coordination. ODM puts heavy emphasis on care coordination as a benefit of managed care. We can see how this concept could be a value-add for consumers living in the community and receiving fragmented care, but that is not the case in LTSS.

In a facility setting, the provider is responsible for meeting all of the patient's health-care needs, pursuant to a detailed assessment and plan of care. The patient receives an extensive package of services within the facility, for which the center is paid what is essentially a per-member, per-month amount, minus coinsurance. For anything else the patient needs, the center arranges for the service and makes sure the person receives it. This is the very definition of care coordination. Extensive federal regulations on the subject (42 CFR 483) have required SNFs to provide this care coordination for decades.

The same is true on the HCBS waiver side, as Ohio's area agencies on aging, in collaboration with service providers, have coordinated care for waiver consumers for some 30 years.

Our members have reported throughout the MyCare experience that occasional contacts from a care manager who works for a managed care company add little to the ongoing care coordination that our members provide on an everyday basis.

Lack of rate floor. Another huge concern about ODM's managed LTSS proposal is that it eliminates the rate floor SNFs and assisted living providers have under MyCare. The floor is critically important because otherwise, plans have a clear economic incentive to cut rates, which our members have experienced with managed care in other contexts.

OHT Director Moody highlighted the rationale for removing the rate floor in his testimony to the full committee. He said the idea is effectively to take SNF rates out of statute (eliminating legislative involvement) by letting the managed care plans disregard the statute. While in theory it would be possible for the plans to pay higher rates, such as for high-quality facilities, history shows the net impact would be cuts.

Conclusion. ODM has not made a case for moving more LTSS beneficiaries into managed care. Their case is based on ideology - their opinions - not on evidence.

As a side note, they are also in a hurry. Their proposed go-live date of July 1, 2018, is extremely aggressive given the many other populations the managed care plans will be trying to absorb over the next year and given the incredible start-up problems MyCare endured because ODM rushed its implementation.

We would support an amendment prohibiting ODM from moving forward with the managed LTSS expansion or at least waiting until there is solid evidence and analysis of whether or not managed care is working for LTSS. This could be done through a study committee of stakeholders, with legislative participation.

Rate Cuts. ODM proposes to change the formula for skilled nursing facility rates to cut the direct-care component (the one that funds nurses and nursing assistants) by an average of $9 per day.

Rebasing and the deal. This proposal stems from rebasing of SNF rates in the last budget. Centers in Ohio went 10 years without a price increase, until the current fiscal year. By statute, our rates had to be rebased (updated with newer data) for State Fiscal Year 2017. In the budget bill two years ago, the legislature made some changes to the reimbursement formula for purposes of the rebasing. These changes were prompted by ODM, including the RUG grouper, another reduction of the rate for low-acuity patients, and a payment amount tied to quality.

Taking a short detour, I'd like to address ODM's suggestion that SNFs that score well on the quality measures are paid the same as those that do not. That is not true. The quality formula awards providers $0.58 per day per quality point, so a center that gets all five quality points receives $2.90, while a center that gets only two points receives $1.16.

Back to rebasing. After the legislature passed the rebasing language, the Governor vetoed the portion specifying the RUG grouper. Subsequent negotiations between ODM and the provider organizations led to an agreement on that issue and other aspects of the rebasing formula.

In July of 2016, ODM calculated and began paying rates under the new, agreed-upon formula. The rates the department calculated ended up being higher than they had estimated during the negotiations. ODM went ahead and paid the rates and did not say anything about the situation until now, in the budget bill.

Importance of rebasing. It is helpful to put rebasing in context. As I mentioned earlier, SNFs had not received an increase for 10 years. Even the rebasing increase, as welcome as it was, did not fully equate to growth in facility costs or even in the Consumer Price Index during those 10 years.

The rebasing increase still leaves Ohio's SNF rate below those of all 5 surrounding states.

State	Rate
Indiana	$238.98
Kentucky	$196.77
Michigan	$240.05
Ohio	$193.20
Pennsylvania	$215.51
West Virginia	$213.91

Our members used the rate increase to give some overdue wage relief to our staff. There currently is a severe workforce shortage in LTSS, so we need to be able to offer a reasonable wage. Even with higher wages, members report considerable difficulty finding qualified employees. The rate cut proposed by ODM would make this situation worse and likely lead to cutting positions, which would negatively affect quality.

As an example of the impact of the proposed cuts, a typical SNF would lose $180,000 per year in reimbursement. This equates to $2 per hour for all of their nursing assistants or 5-6 positions.

Changing the deal. ODM has offered no explanation for their rather hefty proposed cut. They just keep saying they under-estimated the rates. They conveniently omit the fact that the "deal" on rebasing was about the formula. The dollar estimate was just a guess by ODM staff that proved to be wrong. No criticism of them - almost all Medicaid spending estimates turn out to be off. The rates as they exist are simply the product of the agreed-upon formula. Clearly the SNF rates did not upend the Medicaid budget, as Medicaid spending overall will finish the fiscal year more than $1 billion under the estimate.

So now ODM wants to change the deal and claw back money from providers. Director Sears suggested that if the actual payments had turned out to be less than the estimate, providers would have been "trued up," offering as an example some payments ODM made to home-health aides.

This claim rings hollow when one notes that for five of the seven years from SFY 2010-2016, SNF spending was below the estimate (it may have been under in the other two years, but we can't tell because the data are distorted by a delay in implementing MyCare Ohio). In none of those years did SNFs ever receive a "true-up" payment.

The proposed rate cuts would break the rebasing agreement and would devastate providers' ability to deal with the labor shortage. We ask that they be removed from the bill.

Other issues.

- We are not in favor of the **ICF/IID reimbursement formula** being in the bill. As Director Martin testified, the work is not finished. OHCA is committed to supporting legislation to implement the formula, once it is agreed upon, on the consensus date of July 1, 2018.

- We are not in favor of the **Department of Health's proposed fines** for assisted living residences and their proposal essentially to take over operation of facilities (with more fines). The assisted living fine proposal is a solution in search of a problem. The majority of assisted living facilities are deficiency-free on survey. Issues can be addressed through ODH's existing tools, such as more frequent monitoring by ODH and the ombudsmen. The other proposal about ODH issuing orders to facilities is totally unnecessary. The department already has authority under federal regulations to impose fines on SNFs, to direct them to take specific corrective actions, and to install temporary management.

- We are not in favor of adding **unlicensed facilities to the Assisted Living Waiver**. We support establishing a new waiver for affordable housing with services.

- We support defining the proposed **Assisted Living Waiver rate increase** in statute and phasing it in starting in State Fiscal Year 2018.

Thank you for the opportunity to testify. I would be happy to answer any questions you may have.