The Academy of
Senior Health Sciences Inc.

Testimony presented before the Ohio House Finance Health and Human Services Subcommittee
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Chairman Romanchuk, Ranking Minority Member Rep. Sykes, members of the House Finance Health and Human Services Subcommittee, my name is Chris Murray, CEO of The Academy of Senior Health Sciences. "The Academy" is an advocacy organization representing Ohio skilled nursing and assisted living facilities. Thank you for your time today.

The Academy has major concerns with three proposals in House Bill 49: the rate cuts to skilled nursing facilities, the move of long-term services and supports to managed care, and the policy change to SNF payment for "low resource use" residents.

We Oppose the 3.67% SNF Rate Reduction

In H.B. 49, the administration is proposing to reduce SNF payments by about $7.10 per day or 3.67%. The rationale behind this cut is founded in the process that led to the current reimbursement methodology used to set the rates. To fully understand where we are today with SNF rates, it is necessary to briefly revisit the past.

About 12 years ago, an agreement was reached between SNF representatives and the Ohio Department of Job and Family Services to move to a different reimbursement system. The change was a move away from a "cost based" system to a "pricing" system. Under the cost based system, SNFs were paid a rate calculated on reported costs and addressed by the General Assembly, ODJFS, and provider associations during budget proceedings. If there were budget concerns, at times a "mean rate cap" would be used to limit growth in the rates. The move to pricing meant the Medicaid rate for SNF services would be set using fixed prices "based" on a cost reporting year. The prices were set for a period of up to 10 years, case mix adjusted for acuity every 6 months. The initial prices were based on 2003 cost report data, subsequently inflated, and a transition period ensued. Per statute, the state must "rebase" at least once every 10 years to "true-up" the prices to more current costs.

The rebasing of the prices occurred during the last budget cycle. Besides rebasing the prices to 2014 cost report date, The Ohio Department of Medicaid, of their own initiative, decided to move from the RUG III to the RUG IV resource classification system – i.e. how residents are "grouped" for the level of resources required to care for them. The result of the rebasing and classification change led to an expenditure for SNF services above the budgeted amount. ODM proposes to set the SFY 18 -19 SNF rate at the SFY 17 budgeted level by reducing the direct care prices 7% resulting in an average 3.67% rate cut.

Key points to our opposition of the rate cut:

- Under the cost based system, "mean rate caps" were employed to better target budgeted amounts.

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    - At no point during discussions around rebasing or the classification change did ODM express a desire to cap potential rate growth or potential expenditures (i.e. budget the changes)
- SNF prices had not been rebased since initially set using 2003 costs at the 25th percentile.
    - The agreed upon methodology is sound and the resulting rates are reasonable.
    - Other than acuity adjustments, the rates may not change significantly for up to 10 years.
- The resident classification change was an administration initiative and thus they should take the responsibility of paying for it.
    - Much of the discrepancy between the estimated rate and the actual rate can be attributed to higher than ODM estimates on the case mix score because of the classification change.
- These rates are being paid TODAY.
    - Providers have given raises and made other decisions based on these rates
    - Reducing rates will negatively impact a provider's ability to continue to provide, or increase, the quality of care to their residents.
        - Concerns over the workforce shortage in LTSS and its impact on quality of care.

We propose leaving the agreed rate methodology in place and maintaining the resulting rates.

We Oppose the Move of LTSS to Managed Care

In H.B. 49, the administration is proposing to move all long-term services and supports (LTSS) to managed care. While managed care has had some success in the Medicaid community landscape, there is little to no evidence that moving LTSS to managed care will create efficiencies or better outcomes for LTSS recipients. The reason for this is the significant difference between the LTSS population served in skilled nursing facilities and LTSS waivers and the community population.

One of the significant benefits of managed care is the ability to coordinate services and to work directly with beneficiaries to help generate better outcomes (i.e. medicine management, doctor's visits, reduce emergency room use, etc…). These benefits do not translate to the LTSS community. While in a skilled nursing facility or on a waiver, care coordination and resident care planning is already being provided. Individuals receive a person-centered care plan and all the necessary supports are provided, especially in the SNF setting. And these are required under federal and state regulations, so any care coordination provided by the MCO is redundant and creates inefficiencies in the health care system.

Furthermore, any benefit to the LTSS consumer under managed care is suspect; there is currently no evidence to support better health outcomes for LTSS consumers under a managed care system. There is no guarantee of quality outcomes - most of the alternative payment models and quality initiatives are forced upon MCOs by government. They are not a natural consequence of the managed care market place. These initiatives can also be addressed in the fee for service market, as evinced by ACOs and bundled payment models. Add in the substantial costs, not just in redundant services, but also in the administration of managed care LTSS for providers, and clearly managed LTSS can be very inefficient.

Given the limited benefits and substantial costs, The Academy would like to pursue the policy of managed LTSS in a data driven, evidence based manner. To that end, the MyCare Ohio demonstration program provides an opportunity to determine the impact of managed LTSS on the Medicaid elderly and disabled population. We believe using data from the demonstration, along with expansive research in alternative delivery models, will allow elected officials to determine the policies that will provide the best outcomes for consumers, providers, and tax payors.

Key points to our opposition of managed LTSS:

- The same care coordination will occur under managed care as fee for services LTSS creating inefficiencies in the system and in some cases, decreased ability to meet consumer needs
    - *Providers* are heavily regulated in regards to care plans and meeting consumer needs
    - In MyCare, the use of managed care networks made it difficult to provide some services, especially transportation
    - Some high-quality providers left out of managed care networks
- There is a lack of evidence that outcomes are better under managed care and plenty of evidence that costs to providers are increased
- The alternative payment models and other quality initiatives are NOT a natural evolution of managed care, but a creation of government

We propose the creation of a committee to collect data and research the costs and benefits of LTSS under managed care.

We Oppose the Changes in Low Resource Utilization SNF Reimbursement Policy

The Ohio Department of Medicaid created a separate rate for skilled nursing facility individuals that are in the two lowest RUGs grouper – PA 1 and 2. The rate, originally set at $130 per day, was well below the average per diem and established at the lowest Medicare PA1 rate in the state at that time. ODM took the PA1/2 residents out of the case mix scores as part of an agreement for the lower rate. ODM then subsequently lowered the rate to $115 in the last budget to further incentivize SNF providers to discharge these residents to the community. A spreadsheet provided by ODM in 2015 estimated savings from the PA1/2 lower rate to be $18 million. During rebasing, the savings was estimated to be $24 million; however, with the move to RUGs IV, ODM determined that removing the PA1/2 residents from the case mix score (thus raising the average used to determine the rate for all residents) costs the state $10 to $20 million. Thus, the lower rate is a net savings of about $14 million. ODM has proposed the best of both worlds in H.B. 49, including the PA1/2 residents in the Medicaid rate calculation for all residents while paying the lower $115 rate.

We propose maintaining the current policy of a $115 rate and exclusion from the case-mix score calculation.