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Testimony before the Senate Finance Committee
House Bill 49

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Good afternoon, Chair Oelslager, Ranking Member Skindell, and members of the committee. Thank you for the opportunity to testify. I'm Pete Van Runkle, and I am with the Ohio Health Care Association, Ohio's largest organization representing long-term services and supports providers.

OHCA supports two key provisions in the budget as passed by the House that deal with long-term services and supports. One is the delay and study of managed long-term services and supports (MLTSS). The second is the hard cap on Medicaid payments to skilled nursing facilities (SNFs).

We ask the Senate to retain both of these items.

The House's caution regarding MLTSS makes sense. Ohio is currently running an MLTSS demonstration project called MyCare Ohio. It operates in 29 urban counties. The demonstration period runs through December 31, 2019.

The Administration seeks to expand MLTSS to the remaining 59, rural Ohio counties, but the House language delays implementation until the demonstration period concludes and the results are available. This approach allows learning from the demonstration project and an opportunity to make adjustments in MyCare to improve its operation.

If MyCare was working well, we would not be talking about this issue, but it is not. Our members tell us that. In a survey of OHCA members just one month ago, more than 300 respondents spoke overwhelmingly.

Table 1
Survey Responses on Sample MyCare Elements

Add value in coordinating care	81.0% disagree
Moving consumers to community	44.3% less effective 51.4% about the same
Timeliness of payment	81.5% dissatisfied
Accuracy of payment	79.6% dissatisfied
Authorization of services	81.2% dissatisfied
Recommend extending MLTSS	95.4% no

These are just examples; there are many more.[1] These problems should be repaired, within MyCare, before the state expands MLTSS.

In addition, 154 respondents wrote 12 pages of personal comments. Here is a small sampling of the comments, in their own words:

> "MyCare has not increased the transition of SNF residents to less expensive settings. In fact, we've found that it has lengthened them ...."
>
> "My parents are both covered by MyCare in a SNF and honestly have had more problems with their care as a result of the lack of coordination from the insurance NP with the physician."
>
> "Patient transportation is a nightmare."
>
> "Very hard time getting accurate and timely payments."
>
> "With traditional Medicare and Medicaid the turnaround for payment is 1-2 weeks. By using MyCare we are waiting at least 30-45 days and then the liabilities are not always correct which makes it hard to correct."

Our members' opinions are important, but is there any objective evidence that MyCare is effective in improving care and reducing cost, specifically for the MLTSS consumer?

MyCare covers MLTSS consumers, who make up about 45% of the total 100,000 population in MyCare. The other 55% are the so-called "community-well": dual-eligible individuals who live in the community and who do not receive long-term services and supports.

The Department of Medicaid (ODM) contracts with the 5 managed-care plans that participate in MyCare. The contract specifies 25 quality measures for services covered by MyCare. Of these, 16 pertain to the community-well, such as whether people are taking their blood-pressure medications and whether they are making doctors' appointments.

The other 9 measures are specific to MLTSS, and are commonly used for that population outside of MyCare:

- Help with activities of daily living;
- Restraints;
- Falls with injury;
- Urinary-tract infections;
- Pressure ulcers;
- Catheterization;
- Nursing facility diversion;
- Long-term care rebalancing;
- Long-term care overall balance.

[1] See the complete survey results at http://www.ohca.org/docs/documents/191/MyCare%20survey%202017.pdf.

ODM has not reported on a single one of these measures, so we have no data showing the impact of MyCare on the quality of MLTSS.

Relative to saving the state money, the managed-care plans make the unsupported claim that they move more people out of skilled nursing facilities (SNFs) and back to the community than was the case previously. (Note that there have been no data reported on the three "rebalancing" measures in the MyCare contract.)

MyCare cannot take credit for any reduction of Medicaid days in SNFs. It is a trend that pre-dated MyCare. Ohio's SNFs send 160,000 or more patients home each year. The state has steadily grown the availability of Medicaid waiver services. The effectiveness of these efforts resulted in year-over-year declines in Medicaid SNF days starting in the early 2000s, long before MyCare.

The trend continues to this day, but not because of MyCare. In fact, when we asked our members about MyCare's effectiveness in moving patients to the community, 51% said it has no effect and 44% say it actually is an impediment. As described in some of the individual comments on our survey, the managed-care plans often delay or deny the home and community-based services a patient needs when they move out of a SNF. Pre-MyCare, it took PASSPORT one or two days to approve services; now it can take the plans weeks, while the person stays in the SNF.

MyCare has not proven that managed care is good for the long-term services and supports environment, where care already is managed by SNFs, for their patients, and by care-management organizations such as the area agencies on aging and CareStar, for recipients of Medicaid waiver services.

As part of its MLTSS proposal, the Administration wants to take SNF rates out of the hands of the legislature by allowing the managed-care plans to set rates wherever they wish. They say the plans will pay higher rates to better-quality centers and that having rates set in statute prevents them from doing so. To the contrary, though, nothing in the Revised Code has prevented plans from paying higher rates during the three years of MyCare. They simply chose not to do so. This mirrors our experience with other managed-care programs.

We agree with the House's solution of allowing the demonstration project to run its remaining 2 1/2 years and then deciding, based on the results, whether expanding MLTSS statewide is a good idea. If the state can improve MyCare's performance sufficiently, then expansion could be warranted.

The second provision in the House budget that OHCA supports and asks that the Senate leave intact is the Medicaid spending cap on SNFs. The cap achieves $137 million of the $237 million savings from the rate cuts the Administration proposed in the as-introduced version of the budget. It does so by holding the Medicaid appropriation for SNFs to the cap level. The language is very clear that if at any time, spending is projected to exceed the cap, all SNFs' rates will be cut by the percentage necessary to meet the cap.

The Administration's up-front rate cuts, on the other hand, would be very harmful and reflect lack of concern about the quality of care. SNFs just last year received their first base-rate increase in a decade. See Table 2, below, for the history.

Table 2
Skilled Nursing Facility Base Rate Increases
Before SFY 2017

State Fiscal Year	Rate Increase Percentage
2007	Pricing system begins
2008	1%
2009	0%
2010	0%
2011	0%
2012	(6%)
2013	0%
2014	0%
2015	0%
2016	0%

Medicaid rates matter to quality. Sixty-three percent of SNF patients in Ohio are on Medicaid, so SNFs are very dependent on Medicaid for the resources needed to deliver care.

The Administration recently published a spreadsheet of various data on SNFs in Ohio. Those data showed two very important things: one, that SNF costs, on average, are more than $20 per day higher than the average Medicaid rate they are paid, even before the proposed cuts; and two, that the more dependent a center is on Medicaid, the lower it is likely to fall on the 5-Star Ratings.

Table 3
Medicaid Dependency and Star Ratings

Star Rating	Average Medicaid Percentage
5	51.6%
4	60.2%
3	63.2%
2	66.1%
1	67.4%

When a center depends to a high degree on Medicaid revenue, it must drive its costs well below the state average - which means fewer resources for staffing, facility upkeep, and other things that have an impact on quality. There are of course exceptions to every rule, but the averages show this relationship plainly.

We also note that even without the proposed cuts, Ohio pays SNFs lower rates than all of the surrounding states, as shown in Table 4. This affects our standing relative to quality.

Table 4
Ohio and Surrounding States Medicaid SNF Rates

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

Rates are current statewide average SNF rate.

Notes (all amounts per patient day)
Indiana pays supplemental through hospitals. SNF share conservatively estimated at $50 is included above.
Kentucky pays $12.85 provider tax supplemental to most SNFs (included above).
Michigan pays $40 provider tax supplemental (included above).
Ohio pays $16.44 provider tax amount included in the rate.
Pennsylvania pays $15.12 provider tax supplemental (included above); $0.41 DSH payment, $0.87 High MA Access Add-On (not included).
West Virginia pays facility-specific case-mix add-on (not included).

The House budget is an elegant solution. It provides budgetary certainty by imposing a hard cap on SNF spending, but avoids the potential negative impact on quality of the Administration's proposed, up-front rate cuts. We recommend that you leave it in place.

Thank you for your consideration. I would be happy to respond to any questions.