OHCA
OHIO HEALTH CARE ASSOCIATION

55 Green Meadows Drive South
PO Box 447
Lewis Center, OH 43035
P: 614.436.4154 / F: 614.436.0939
www.ohca.org

Joint Medicaid Oversight Committee
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Good morning, Chair Patton, Ranking Member Antonio, and members of the committee. I am Pete Van Runkle from the Ohio Health Care Association. OHCA is Ohio's largest association representing long-term services and supports (LTSS) providers. Our membership includes providers of assisted living, home care, hospice, intellectual and developmental disabilities, and skilled nursing services. I appreciate the opportunity to appear before you today to discuss the impact of Ohio's Medicaid managed care programs on our members.

Ohio has two Medicaid managed care programs that affect LTSS. The first program is traditional managed care for low-income individuals. The other program is MyCare Ohio. MyCare is a federally-sanctioned demonstration program for people eligible for both Medicare and Medicaid. It combines Medicare and Medicaid benefits under a single managed care plan. Beneficiaries can opt out of the Medicare portion. MyCare only operates in the urban areas of Ohio.

The two Medicaid managed care programs have different impact on LTSS. More than a third of MyCare enrollees are in LTSS. About 18,000 are in skilled nursing facilities (SNFs) and 33,000 are in Medicaid home and community-based waiver services (HCBS). HCBS services include home care and assisted living.

Traditional Medicaid managed care covers a much smaller proportion of the LTSS population. The SNF benefit is time-limited unless the beneficiary is in the expansion population. If a beneficiary needs to stay in a SNF longer, they move into fee-for-service.

These two programs are both efforts to privatize Medicaid. They transfer day-to-day operations to managed care plans. The plans are paid handsomely for this function. Program oversight and policy direction remain the responsibility of the Department of Medicaid (ODM). Managed Medicaid is still must meet all federal and state Medicaid requirements. The idea is to offer the same benefits and perform the same functions as fee-for-service Medicaid but to do them better. The state must ensure that the program meets this goal.

ODM exercises its oversight responsibilities primarily through two mechanisms. First, it enters into contracts with the managed care plans that establish requirements for the plans. ODM

updates the contracts frequently to add or to revise requirements. Second, ODM must ensure that the plans comply with the contracts and with Medicaid rules. They perform this function by reviewing plan performance, addressing complaints, and issuing formal or informal directives.

This oversight must be strengthened. Medicaid beneficiaries and providers must be assured that managed Medicaid works as least as well as fee-for-service Medicaid.

At OHCA, one of the ways we serve our members is to help them with managed care issues. Our members regularly call on us to address problems they are unable to resolve with the plans. These issues typically do not exist in fee-for-service Medicaid. We often have difficulty achieving resolution because ODM is reticent to intervene with the plans or even to interact with us.

We in no way suggest that the oversight problem reflects bad faith or incompetence on the part of the department. We view both ODM and the managed care plans as partners in caring for Medicaid beneficiaries. We feel the problem stems from insufficient oversight resources and a philosophy of deferring to managed care business practices.

I will give three examples.

One Medicaid managed care plan is paying out-of-network providers only 60% of their Medicaid rate. These providers are approved Medicaid providers. They are delivering services to Medicaid beneficiaries. Medicaid rates are already very low. These providers should not be paid 60% of that already-low rate. ODM must ensure that the plans pay at least the same rate as fee-for-service. The contract between Medicaid and the plans requires it.

In traditional Medicaid managed care, the SNF benefit is limited by time and by the beneficiary's level of care. The managed care plan has the responsibility to ensure proper transitions of care. If the beneficiary is out of time but still meets SNF level of care, the plan must disenroll them from managed care. The beneficiary then moves to fee-for-service payment. If the beneficiary no longer meets SNF level of care, the plan must ensure they have a safe place to go and any necessary services follow them. Instead, plans often simply stop paying the SNF and do not disenroll the beneficiary or arrange for safe discharge.

Patient liability is a federal Medicaid requirement. A Medicaid beneficiary must contribute most of their income to offset the state's cost for their services. Providers must collect the patient liability from the beneficiary. Beneficiaries in HCBS have lower patient liability because they keep more of their income to pay for their room and board. When beneficiaries move from HCBS to a SNF, their patient liability must be increased because they no longer need to pay for room and board. The managed care plans often do not adjust the patient liability. This deviation from Medicaid rules confuses providers and threatens beneficiaries' eligibility.

These are just three examples of Medicaid managed care not working according to Medicaid requirements. In each case, OHCA brought the issue to ODM's attention, to no avail. We struggle even to get meetings with ODM.

We have two recommendations for improving oversight.

First, strengthen the managed care complaint process. It should be a way for providers or beneficiaries to resolve issues without having to involve OHCA or ODM management. The complaint function currently is under-resourced, lacks transparency for the complainant, and typically defers to the managed care plan. ODM should reform the complaint process so it effectively polices managed care practices and treats the complainant as an equal partner.

Second, take a much more active role in addressing systemic issues that OHCA or other organizations raise on behalf of their members. These issues typically involve managed care plans not following Medicaid principles or requirements. The plans are contractors of the state and must operate according to Medicaid requirements. ODM should be stronger in using contract amendments and written directives to resolve problems.

December 31, 2022, marks the currently-scheduled end of the MyCare Ohio demonstration. It is an opportunity for the state to decide whether to extend the demonstration. It should not be extended unless the state has improves its oversight. ODM must ensure that managed Medicaid works at least as well as fee-for-service Medicaid. They cannot simply bow to the wishes of their contractors.

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