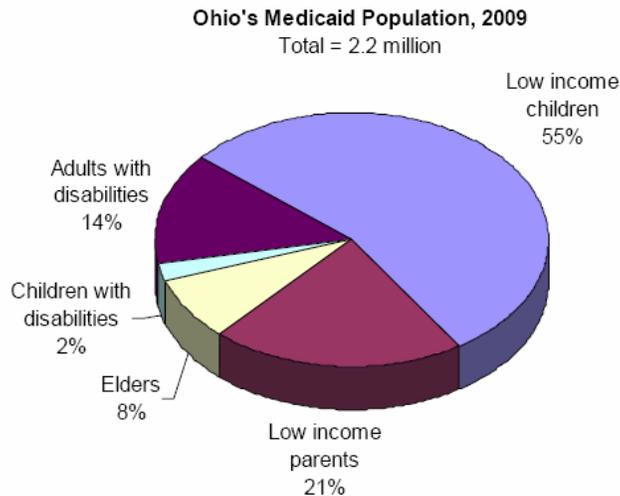


**Health and Human Services Subcommittee**  
**Testimony of John R. Corlett**  
**Medicaid Director, Ohio Department of Job and Family Services**  
**March 11, 2009**

Madam Chair Brown, Ranking Member Burke and members of the Health and Human Services Subcommittee of the Ohio House Committee on Finance and Appropriations, my name is John Corlett, and I am the Medicaid Director for the Ohio Department of Job and Family Services. Thank you for this opportunity to testify today. I will begin with a brief overview of the Medicaid program, a description of some remaining issues related to coverage expansions in H.B. 119, a summary of our successful efforts to contain costs and become more efficient, and our major policy proposals for FY 2010 and 2011. During these difficult economic times we were tasked with reducing our dependence on general revenue funds while protecting eligibility and vital services. We've accomplished this goal by restructuring the financing of the Medicaid program, and leveraging fees from our four largest provider categories. This takes pressure off the general revenue fund, maintains essential services, prevents rate reductions, and provides greater long term sustainability for the program.

**Medicaid Overview**

It is clear that many of our fellow Ohioans are experiencing great difficulty. They've lost jobs, seen retirement accounts evaporate, lost homes, and many more have lost their health care coverage, and have turned to the Medicaid program to help buffer them from some of the effects of this recession. We are proud of the fact that despite rapid growth in enrollment we have been able to stay very close to our projected budget in FY 2009 due to successful efforts to contain and control costs.



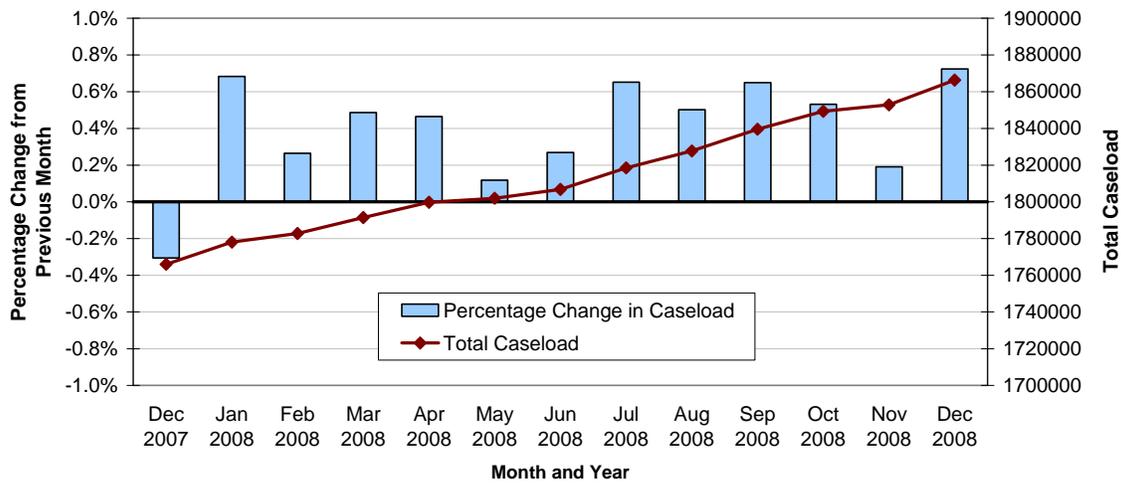
Ohio Medicaid is the largest health care insurance plan in the state, both in terms of the number of lives we cover and the claims we pay. We contract with tens of thousands of health care providers and process over 60 million health care claims each year. Medicaid is Ohio's largest source of federal revenue bringing 8 billion dollars of federal matching funds into Ohio's economy. The Governor's budget then, doesn't just ensure health care coverage for 2.2 million Ohioans, it also preserves, and or creates new employment in health care and other businesses across Ohio.

**Medicaid Caseload**

Since December 2007, Ohio's Medicaid caseload has grown by more than 110,505 enrollees (approximately 6%). This caseload growth was above our original projection for the biennium. Most of the caseload growth has been among persons in the lowest income categories – families with

incomes less than 150% of the federal poverty level. We attribute most of the caseload growth to the economic downturn. The graph below illustrates that caseload change through December 2008.

**Chart 1**  
**Ohio Health Plans Caseload Trends, 12 07 - 12 08**



By the end of the next biennium Medicaid caseloads are expected to increase by 172,700. Of this amount, 148,675 (86%) are within our Covered Families and Children category and the remaining amount (24,000) are members of the Aged, Blind and Disabled category.

**Medicaid Spending**

The ODJFS-administered portion of the Medicaid program represents approximately 85 percent of all Medicaid spending (the remainder is administered by the sister agencies). When taking into account all funding sources necessary to support this spending, fiscal years 2010 and 2011 Executive Budget recommendations are as follows:

Fund Type	Fiscal Year 2009	Fiscal Year 2010	Fiscal Year 2011
General Revenue Fund (GRF)	\$9,877,719,907	\$8,814,479,115	\$10,693,668,495
Other (non-GRF) Funds	\$1,986,131,735	\$3,777,190,076	\$3,193,650,099
Total	\$11,863,851,642	\$12,591,669,191	\$13,887,318,594

GRF appropriations for fiscal years 2010 and 2011 include the use of enhanced federal reimbursement that will be deposited to the GRF as reimbursement for ODJFS Medicaid expenditures pursuant to the stimulus bill. Over the biennium the enhanced reimbursement estimated for deposit to the GRF is projected to be \$419,156,122. Non-GRF ODFJS appropriations for fiscal years 2010 and 2011 also include the use of enhanced federal reimbursements of \$1,390,336, 172 over the biennium.

As the table above indicates, there is a notable decrease in GRF funding from fiscal year 2009 to fiscal year 2010. In fiscal year 2010, the Executive Budget recommends funding a greater portion of Medicaid expenses through the use of non-GRF funds, including use of enhanced federal reimbursement amounts that will be drawn into non-GRF funds as a result of the federal stimulus, and increased resources that will be collected from various provider franchise fees. In fiscal year 2011, ODJFS Medicaid funding increases its reliance on the GRF, and uses fewer non-GRF resources when compared to fiscal year 2010.

I would also offer these additional observations about growth in our budget. The percentage increase from FY 2008 to FY 2009 is skewed because the last managed care payment for FY 2008 was made in FY 2009. This means 11 managed care payments were made in '08 and 13 will be made in '09. Once the skew is removed, the estimated percentage growth from FY 2008 to FY 2009 is 5.9%; from FY 2009 to FY 2010 is 6.1%; and, from 2010 to 2011 is 10.3%. Much of that is driven by growth in the caseload; the impact of the full year increase in hospital rates; growth in managed care trend, and the full year rate increase to account for the increase in the managed care tax.

## **Implementing Provisions of H.B. 119**

### **State Funded Children's Buy-In Program**

In April 2008 we began accepting applications for our state-only funded Children's Buy-In program. This program offers health care coverage to families at income levels over 300 percent of the federal poverty level (approximately \$66,156) in annual income for a family of 4). Families whose children have been uninsured for at least six months, and who have special health needs can purchase state-funded health care coverage for their children. Despite processing 460 applications, we've only enrolled three children. The primary reason families have been turned down is that their incomes were below 300% of the federal poverty level. We still believe there are families who would benefit from a revamped CBI program and would like to work with this committee to make changes in the current statutory language. We believe there should be exception to the waiting period for children whose parents have lost employment and also lost their health care coverage. This is particularly important during the current recession.

### **Children's Coverage Expansion, 200-300% FPL**

The last health care expansion authorized in HB 119 is the one that has caused us the most frustration – coverage for children between 200-300% FPL. Beginning in September 2007, Ohio repeatedly requested Federal approval for this expansion. Finally, after more than a year of wrangling, we were notified that our request would be approved. We estimate that 18,000 newly eligible uninsured children will enroll, and another 18,000 children already eligible will enroll because of awareness created by the expansion. It's important to remember that when children are enrolled in Medicaid/SCHIP they are more likely to have well-child visits, get important vaccinations, and have fewer hospitalizations and emergency room visits than uninsured children.

## **Cost Containment and Improvements to Efficiency**

Cost containment is a major focus of the Medicaid program. As you know, ODJFS reports to the General Assembly every quarter on our Medicaid cost containment efforts. Successful cost containment is imperative if we are to be successful in making the Medicaid program sustainable over the long term.

Some of you may be familiar with our responsibilities for third party liability (TPL) which is a key element of Medicaid cost containment. TPL is a process of ensuring Medicaid is the payer of last resort when an enrollee has any other health insurance coverage. Third party payers include commercial health insurance, worker's compensation, and of course the Federal Medicare program. Over the past two years, Ohio Medicaid has implemented a very extensive TPL business function to assure Medicaid is only paying for services not covered by another insurer. This includes:

- Capturing and updating insurance coverage information for all Medicaid enrollees so that we can avoid costs before Medicaid pays, also known as "cost avoidance;"

- Collecting payments made in error also known as “pay and chase”

Both “cost avoidance” and “pay and chase” rely on capturing current enrollment information from other insurers and cross referencing it with Medicaid enrollment files. Last May, we had 591,000 TPL files within our system. Today we have more than 2 million. They represent over 80% of all the commercially covered lives in Ohio.

In the coming biennium we plan to continue pursuing other cost containment initiatives including;

- Increasing the number of Medicaid consumers enrolled in the Federal Medicare program.
- Implementing a clinical claims editor in our Medicaid Information Technology System,
- Increasing medical support collections related to child support cases,
- And maximizing family planning claiming which the federal government reimburses at 90%

### **Continued Implementation of Reform Recommendations**

Over the past seven years, the Ohio Medicaid program has been studied by several bodies – including the Ohio Commission to Reform Medicaid, the Medicaid Administrative Study Council, and the Auditor of State’s performance review - all of which made recommendations for improvement. I am pleased to report that we have implemented, are in the process of implementing, or have implemented in a modified way almost 70% of the recommendations from the Auditor of State and 80% of the recommendations from both the Ohio Commission to Reform Medicaid, and the Medicaid Administrative Study Council. In fact, we recently received updates from the Auditor of State and the Ohio Commission to Reform Medicaid, both of whom acknowledged that we have made significant progress in implementing their recommendations.

We may not have implemented recommendations exactly as they were envisioned over the past 7 years, but we have made changes we believe are consistent with the spirit of the recommendations. The result has been improved health care for Ohioans, a more efficient Medicaid program, and savings to the taxpayers of hundreds of millions of dollars

### **Unified Process for Disability Determination**

One of the recommendations from the Commission to Reform Medicaid and the Auditor of State was to integrate the disability determination processes currently used for Ohio Medicaid (administered by ODJFS) and programs operated by the Social Security Administration (administered by the Rehabilitation Services Commission.) The recommendation makes a great deal of sense since both agencies use the same standard for what constitutes a disability and many consumers apply for both programs. The goals of unifying the process include improved efficiency, reduced administrative expense and a simplified process for applicants. ODJFS is pursuing, with the Rehabilitation Services Commission and county partners, an integrated process for disability determination for Medicaid and Social Security programs. However it is important to remember that we must first obtain approval from both the Social Security Administration and the Centers for Medicare and Medicaid Services before a unified process can go forward in FY 2011.

### **Eligibility Gateway & Ohio Benefits Bank**

For the past several years, ODJFS has been working to make Medicaid enrollment more efficient and accessible for current and potential consumers. In partnership with the Governor’s Office of Faith Based Initiatives and the Ohio Association of Second Harvest Food Banks, we have made tremendous strides using the Ohio Benefit Bank. The Ohio Benefit Bank is a web-enabled, volunteer counselor-assisted program allowing low and moderate-income Ohioans to electronically access a broad range of state and federal benefit programs – including for the first time, Medicaid. Last December, ODJFS

developed an “E-Gateway” where program applications completed in the Benefit Bank are transmitted electronically to county Departments of Job and Family Services. Because of the E-Gateway completed applications are immediately transmitted to counties where caseworkers can review them, print them if desired, and enter the data directly into CRIS-E without having to re-key the information. This new feature reduces the administrative work of county caseworkers, reduces errors, and speeds up the application and eligibility process for Ohioans who need our services. I am pleased to let you know that there are currently over 900 Benefit Bank sites throughout Ohio where over 3,200 trained volunteer counselors are assisting Ohioans in applying for a variety of public programs and services.

### **Electronic Prescribing**

Beginning Spring 2009, ODJFS will begin offering electronic prescribing (“E-Prescribing”) to all Medicaid providers who prescribe or dispense prescription medications within the traditional fee for service Medicaid system. This system will be voluntary, allowing any eligible provider to request access to the system and personal training to use it. The ODJFS system will have the benefit of offering online access to the individual prescription histories of Medicaid consumers. The first target group for implementation will be hospital emergency departments who do not usually have access to patient records. Other provider types will be phased in following hospital emergency departments. The system will be accessible via the internet and will not require providers to invest in equipment other than a computer with internet access. This program represents a step forward and will be especially useful for those providers that have not yet invested in additional hardware and software.

### **Pricing for Durable Medical Equipment**

Effective January 1, 2009 the Federal Medicare program reduced by 9.5% the reimbursement they pay for certain Durable Medical Equipment (DME) items. Ohio Medicaid is precluded, by state rule, from paying a higher reimbursement rate than Medicare. So, to comply with this Federal change, ODJFS proposes to reduce the fee-for-service rates for 43 DME items for which current payment rates will exceed Medicare rates. The rate changes will mostly affect wheelchairs and oxygen. Based on the Administrative Code Rule making process, we anticipate this change becoming effective April 1, 2009. We will continue to evaluate this program to determine whether there are other steps that we might take to reduce costs and improve efficiency.

### **Increasing Automation and Use of Technology**

The Medicaid Information Technology System (MITS) offers opportunities for automation and paper reduction. Many Medicaid service providers have already moved to submitting their Medicaid claims in an electronic format via electronic data interchange (EDI). But despite the recent growth in the use of EDI transactions, many aspects of the Ohio Medicaid program still rely on paper being sent back and forth between the state and Medicaid providers and consumers. A large part of the rationale for developing the Medicaid Information Technology System (MITS) was to reduce or eliminate manual and other paper intensive processes. Consequently, many MITS business requirements focus on these goals.

One example is our successful effort to virtually eliminate paper claims submission. In the last year we reduced the average number of paper claims that we receive by about 15% which helps to reduce our processing costs. Towards the end of 2008 we brought up a web portal allowing our Medicaid providers to submit their claims electronically. As a result, we are seeing another substantial reduction in the volume of paper claims. Once the MITS system is fully operational, the number of papers claims should be nearly eliminated.

Another improvement that we have made was our development of an online website where providers can check Medicaid eligibility for our consumers. I have been told some Medicaid providers had

previously been paying national commercial sites as much as a \$1 per eligibility check. Since the web portal went live last summer use has steadily grown to the point that we are now averaging over 12,000 inquiries a day. As you can tell, the savings to health providers can really add up, and it's a good example of how we can use technology to save administrative dollars for the state and individual providers which can be reinvested in providing health care.

The following are a few additional opportunities for paper reduction that will be expanded or newly available with the implementation of MITS.

- ***Claims Status and Adjustments / Resubmissions:*** With MITS implementation, Medicaid providers will be able to check the status of any claim submitted regardless of how submitted (paper, web portal, EDI, etc.) Providers may also submit claims adjustments or resubmit corrected claims.
- ***Prior Approval for Medical Services and Equipment:*** With MITS implementation, requests for Medicaid prior approval can be submitted electronically using the Medicaid web portal.
- ***Submission and Renewal of Provider Applications:*** Medical service providers seeking to participate in the Ohio Medicaid program will be able to complete and submit a provider application on line using the Medicaid web portal.

### **Major Policy Proposals for 2010 and 2011**

As I stated at the beginning of my testimony, the Medicaid caseload increased by 100,000 in calendar year 2008, and we are projecting another 172,000 persons will be added to the caseload through the end of state fiscal year 2011. Last month, Office of Budget and Management Director Pari Sabety testified before the Ohio Finance and Appropriations Committee that the administration's revenue forecast assumes a baseline decline in Ohio tax revenues through FY 2011. The combination of rising caseloads and declining state revenues meant that the Medicaid program needed to identify non-GRF sources of revenue.

This led to the Governor's proposal to increase the franchise fee on skilled nursing facilities, on ICFs/MR, and to impose a new franchise fee on hospitals. While the fees total \$892 million the Medicaid program is able to use these funds to generate an additional \$2,155 million in federal medical assistance payments (FMAP). Finally the executive budget proposal assumes skilled nursing facilities, ICFs/MR, and hospitals receive \$443.2 million in additional funding.

If these franchise fees are not approved, the Medicaid program would have very limited options in replacing the nearly \$3 billion in lost funds. The American Recovery and Reinvestment Act precludes states from reducing Medicaid eligibility as a condition of receiving just over \$2.9 billion in Medicaid fiscal relief from the federal government. This would leave us with only two real options. One, eliminating some number of optional services for adults that the Medicaid program currently covers (I have attached a chart of those optional services that we could eliminate). Two, sharply reducing rates for all Medicaid providers. Many state Medicaid programs around the country are currently pursuing both of these options.

A little over 4 years ago the previous administration, when Ohio was not facing an economic crisis like the one we face today, the Medicaid proposal included the elimination of Medicaid eligibility for more than 25,000 working parents with incomes below 100 percent of the federal poverty line, and the elimination of dental and vision coverage for adults. This is not the path that Governor Strickland wants to pursue.

While I realize that these increased fees may create some hardships, the alternative of reduced rates and the elimination of optional services would create even larger hardships not just for providers but for the millions of Ohioans who depend on the Medicaid program as a source of comprehensive, high quality health care.

### **Nursing Home Franchise Fee**

The budget assumes the Medicaid nursing home franchise fee will be increased from \$6.25 to \$11 per bed per day beginning July 1, 2009. The Ohio Revised Code states that the nursing facility franchise fee Medicaid rate component is equal to the per bed per day assessment amount. As a result, the Medicaid rates calculated under the pricing system will reflect an increase in the franchise fee. State law states that nursing homes cannot directly pass the cost of the provider fee (or an increase in the provider fee) through to its residents. The increase in the franchise fee is expected to generate approximately \$122.2 M state share in FY 2010 and \$162.9 M state share in FY 2011. In FY 2010 and 2011 estimated Medicaid payments to skilled nursing facilities will total \$2,589.9 M and \$2,587.1 M.

### **ICF/MR Franchise Fee**

The budget assumes that the Medicaid ICF/MR franchise fee will be increased from \$11.98 to \$14.25 per bed per day (7/1/09). This will generate \$2,707,839 state share in FY 2010 and \$3,315,012 state share in FY 2011. Existing statute states that the franchise fee component of the rate is equal to the per bed per day assessment. Pursuant to this provision, the franchise fee rate component will be increased from \$11.98 to \$14.25. In FY 2010 estimated Medicaid payments to ICFs/MR will total \$546.5 M, and in FY 2011 estimated Medicaid payments to ICFs/MR will total \$547.2 M.

### **Hospital Franchise Fee**

The budget assumes the creation of a new hospital assessment of 1.27% in FY 2010, and 1.37% FY 2011. The fee is expected to generate \$282.8 M in FY 10 and \$315.6 M in FY 11. It is important to note that the budget assumes an average 5% inpatient and outpatient increase effective January 1, 2010, leaves the current Hospital Care Assurance Program (HCAP) unchanged and continues a supplemental Medicaid payment to Children's Hospitals.

### **Medicaid Managed Care Tax Replacement**

Due to federal law changes, Ohio's Medicaid managed care tax, as it is currently structured, expires on October 1, 2009. This change will result in an annual loss of approximately \$520 M all funds. In order to make up for the loss of funds, the managed care industry proposed broadening the base of existing taxes. First, by including Medicaid managed care plans as a taxable entity under the sales and use tax; Second, removing the exemption for Medicaid managed care plans from the existing health insuring corporation tax. State funds generated by this new approach are estimated at \$163.3 M in FY 2010 and \$254.1 M in FY 2011. In FY 2010 and 2011 estimated Medicaid payments to managed care plans will total \$4,458.8 M and \$4,714.3 M over the biennium. I will be happy to answer general questions about this proposal at the completion of my testimony, but it may be helpful to have representatives from Departments of Taxation and Insurance appear to answer any technical questions about the operation of their respective taxes.

### **Managed Care Reform**

In fiscal year 2009, spending on Medicaid managed care is projected to represent 39 percent of all JFS Medicaid subsidy budget expenditures. As of December 2008, more than 1.3 million people were enrolled in a Medicaid managed care plan. To effectively manage the current program within Ohio Medicaid, we are proposing a series of program reforms.

First, recognizing the need to develop care management programs based on quality improvement and cost-savings principles, Ohio Medicaid partnered with the MCPs to create an improved framework for care management for Medicaid consumers. This new framework places an emphasis on consumers who are high-risk or high-cost users of services and require intensive interventions. The revamped approach also allows MCPs to design care management programs that direct resources to members based on demonstrated health care needs.

By moving in this new direction, Ohio Medicaid joins the ranks of premier organizations, such as the Center for Health Care Strategies and the National Committee of Quality Assurance, that recognize the importance of tailoring interventions based on the consumers' health status and preventing them from reaching a critical point of needing an intensive level of services.

The Executive Budget assumes the "carve out" of the pharmacy benefit from the managed care program and returns its administration to ODJFS. We are taking this action as a way to maximize drug rebates, and to bring more consistency to the pharmacy benefit. According to the Ohio Business Roundtable, of the 32 states that have managed care programs 11 have carved out all drugs and another 9 have carved out select drugs. Seven other states are considering pharmacy carve outs. This is expected to generate a net \$5.2 M (all funds) savings and revenue in fiscal year 2010 and \$235.5 M (all funds) in fiscal year 2011. This proposal is subject to review and approval by the Centers for Medicare and Medicaid Services (CMS).

We will begin paying Medicaid managed care plans on a retrospective, rather than prospective, basis. With the exception of Medicaid managed care, all other Ohio Medicaid providers are paid after services are rendered. The Executive Budget aligns the payment timeframes for managed care plans with these other providers. This is expected to result in a one-time cost avoidance of \$270.4 M (all funds) in the first year of the budget.

The budget contains language requiring hospitals participating in Medicaid, but not under contract with a Medicaid managed care plan to provide medically necessary services to Medicaid participants in the state Medicaid managed care system, and to accept the same payment that they already accept when they bill the state directly under fee for service. This provision protects the state from paying costs above the Medicaid rate when there is not a contract in place between the Medicaid managed care plan and the hospital. This is projected to save \$35.1 M (all funds) in FY 10 and \$110.5 M (all funds) in FY 11 in payments to the Medicaid managed care plans.

### **Unified Long Term Care Budget**

It is no surprise to any of us that Ohio's population is aging – certainly not to me as I was recently the recipient of my first AARP membership card. It is also no surprise that the majority of spending for Ohio Medicaid services (67%) goes toward the ABD population. Not only is the population aging, but they are demanding a different set of services than those traditionally provided. This cultural change, the changes in the types of services available and the need to operate a more efficient and better coordinated program have driven the long term care services and supports proposals. These include continuing previously initiated projects such as the Home Choice (also known as Money Follows the Person), the Unified Long Term Care Budget and fully transitioning nursing facility reimbursement to price.

### **Implementation of Home Choice (Money Follows the Person)**

Ohio is one of 34 states to receive funding for the Money Follows the Person (MFP) demonstration projects, which were enacted by Congress as part of the Federal Deficit Reduction Act of 2005. Ohio

will receive funds to enable about 2,200 seniors and persons with disabilities to relocate from institutions to home and community-based settings. Since the program began last October, Ohio has already assisted 48 persons in relocating from institutional settings to the community.

The intrinsic goal of “money following a person” is contingent on Ohio “balancing” its Medicaid expenditures between institutions and home and community based settings. In this way, the project is closely linked with the Unified Long-Term Care budget. Both initiatives support the vision of individual choice of where a person lives and receives services, transitioning consumers who want to live in the community, and implementing a system that ensures the provision and improvement of person-centered and quality services in both home and community-based settings. Together, these initiatives lay the foundation for balancing Ohio’s long-term care system.

### **Transition Nursing Facility Reimbursement To Price**

Currently, rates for nursing facilities (NFs) are determined by a formula based on individual factors for each facility such as size of the facility, type of patients typically served, and location. This often results in significant differences among payments to NFs across the state. To more equitably distribute funds and save money by stopping overpayment, this initiative standardizes the rates for NFs by paying the same base rate to NFs across the state. The rate will continue to be case mix adjusted on a quarterly basis. This action completes the implementation of a strategy that was established in H.B. 66, the fiscal year 2006-2007 operating budget. A phase-in period of approximately four years was anticipated so facilities would have sufficient time to modify their business models to prepare for the eventual full implementation of the price-based model. The full implementation is expected to save \$55.9 M (all funds) in fiscal year 2010 and \$56.3 M (all funds) in fiscal year 2011. To put this in perspective, it represents roughly 2% of the annual budget for skilled nursing facilities.

### **Implement Priority Access To Waivers For People From Certain Institutions**

Procedures will be established whereby ODJFS (1) identifies persons located in certain institutional settings who are also on a waiting list for a waiver; and (2) determines if the individuals are qualified for the waiver and choose to leave the institutional setting to be enrolled on the waiver. The opportunity to implement this process is part of ODJFS’ commitment to its overarching strategy to provide an array of choices to consumers in need of long term care services.

### **Increase Waivers Focusing On Self Direction**

As a part of recommendations made by the Unified Long Term Care Budget workgroup, this proposal would give consumers who are mentally alert, have a physical disability and are enrolled on either the Ohio Home Care Waiver or the Transitions II Aging Carve-Out Waiver more choice in how their healthcare resources are spent, empowering them to make personal decisions about the kind of care to best meets their needs. Home care attendant services are consumer-driven services furnished by a single unlicensed home care attendant that encompasses assistance with self-administration of medications, assistance with the performance of nursing tasks, and personal care aide services.

### **Improvements in Preadmission Screening and Resident Review (PASSR)**

ODJFS is working with the Department of Aging and the Department of Mental Health to close the front door to nursing facilities for inappropriate placement. We’ve also involved a wide variety of stakeholders in this effort. In order to meet our goal of stopping inappropriate placement we will need to identify increased community supports so consumers have safe and appropriate housing to meet their needs. Efforts will be regionally focused with significant work planned to prepare stakeholders for implementation. Rules are planned for 2010.

Finally, the Skilled Nursing Care Coalition released a report critical of our long term care proposals and included a list of the “15” highest paid facilities that would be “most negatively affected by the executive budget.” One might assume that these higher paid facilities would be the highest rated by CMS, have higher levels of nursing staffing, higher levels of occupancy, and fewer health inspections. Unfortunately that is not the case. Nearly a third of the facilities on the list received only one star on the CMS 5-Star ranking system. In 2008 the Ohio Department of Aging completed their survey of family members regarding skilled nursing facilities. Approximately half of these highest paid facilities scored below the statewide average of 88.2%, and one other facility chose not to even participate in the survey. We see no statistical correlation between whether a facility is below, at or above the price and their scores on these rankings.

### **Conclusion**

Thank you for the opportunity to speak with you today and for your patience. I look forward to your questions.