OHCA
OREGON HEALTH CARE ASSOCIATION

Oregon Health Care Association Opposes SB 703

OHCA believes in a long term care system that provides the highest quality care to seniors and people living with disabilities. That's why OHCA supported Oregon's first-in-the-nation quality metrics program for community-based care providers. **SB 703 misses the mark by reinventing the wheel and diluting the power of existing quality metrics.**

SB 703 duplicates and compromises existing programs and requirements

Community-based care already has a quality metrics reporting system in place.

- In 2017, the Legislature passed a series of reforms regulating long term care facilities. One of those reforms was establishing the Residential Care Quality Measurement Program, which requires providers to annually report uniform quality metrics to the state with the intent of allowing consumers, policymakers, and providers themselves to compare performances among facilities.
- Every facility must report a series of workforce, clinical, and consumer quality metrics to the Oregon Department of Human Services (ODHS), which are publicly available.
- Quality metrics facilities must report starting in 2021:
    - Retention of direct care staff.
    - Compliance with staff training requirements.
    - Number of resident falls that result in injury.
    - Incidence of use of antipsychotic medications for non-standard purposes.
    - Results of annual resident satisfaction survey conducted by an independent entity.
- The Quality Measurement Council may consider and adopt *new* metrics that facilities must report.
- Facilities that perform substantially below statewide averages on quality metrics will be considered for the ODHS Enhanced Oversight Program.
- SB 703 ignores the important role of the Quality Measurement Council and the authority it *already* has to do this work.

SB 703 conflates quality metrics with financial reporting

Financial data of a private entity are not the same as quality care metrics. SB 703 imposes new, onerous reporting on providers with no understanding of how or why it would be used.

- The reporting requirements in SB 703 conflate quality of care with financial reports. How much revenue, profit, or losses a provider brings in does not indicate the quality of care it provides to seniors and people living with disabilities.
- SB 703 also gives OHA and/or ODHS carte blanche authority to request additional financial metrics as it may choose to meet requirements in the bill.

SB 703 ignores the Medicaid reimbursement rate-setting structure

SB 703 purports that community-based care providers should meet the same financial reporting standards as skilled nursing facilities. Here's why that doesn't make sense:

- Skilled nursing facilities (SNFs) are fundamentally different from assisted living and residential care facilities. SNFs serve higher-acuity residents whose payer sources are almost entirely Medicaid and Medicare.
- The same cannot be said for community-based care, where **60%** of residents pay privately.
- Most importantly, SNFs report certain allowable costs set in federal law because those are what's used to set reimbursement rates on a per-patient, per-day basis. Assisted living and residential care facilities Medicaid and Medicare reimbursement rates are a flat, monthly rate that do not take allowable costs into account.