OHCA
OHIO HEALTH CARE ASSOCIATION

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Testimony on House Bill 64

Before the Senate Medicaid Committee

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Rebasing Promise

- Rebasing = updating rates to reflect current costs of providing services.

- Before 2005, each provider's rate was rebased every year.

Rebasing Under Pricing

- In 2005, General Assembly and Taft Administration created pricing system that sets a fixed price for all SNFs in a peer group.
- Prices set using 2003 costs.
- Once prices set, idea was to apply annual inflation factor, with a “true up” after a period of time by rebasing to current cost.
- Legislature gave Department of Medicaid flexibility on when to rebase, but set outer bound at 10 years.

What Really Happened Over Ten Years

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	Direct	Ancillary	Capital
SFY 2007	$44.64	$58.36	$11.86
SFY 2016	$44.53	$56.66	$8.90

Impact

- Prices have not increased in 10 years – in fact, they went down.
- ODM did not rebase during entire period, but law requires it for SFY 2017.
- Except once (1% in SFY 2008), no inflation factor ever was applied to the prices.
- Prices were cut in SFY 2012 as part of deficit reduction.
- During this period, SNF loss per Medicaid day steadily increased: $10.62 in SFY 2007 to $19.50 in SFY 2014.

Current Law on Rebasing

- Requires rebasing no later than SFY 2017.
- Allows ODM to choose the cost report year.
- Uses older patient acuity classification ("grouper") – RUG III – but ODM can change by rule.
- Applies occupancy requirements to three price components.

House Bill on Rebasing

- Keeps promise: retains rebasing.
- Keeps payment system in statute.
- Updates grouper to RUG IV 48 group version (reduces cost by $6-8 million).
- For the first time ever, uses licensed beds instead of Medicaid certified beds for occupancy standards in price calculations (reduces cost by $47 million).
- Deducts $1.79 per day from rebased rates to fund quality payment (shifts $30 million).

RUG IV

- Released in 2010 by CMS in multiple versions, including 66 group and 48 group models.
- CMS guidelines:
  - "The 66-group model was developed by CMS to be used in Medicare SNF payment system beginning 10/01/2010."
  - "The 48-group model is a further simplification of the 57-group model and is intended for use in state Medicaid payment systems."
- Few Medicaid patients fall into the 18 additional RUG categories.
- 66 group version would cut $40.9 million more out of rebasing than 48 group version.

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Current Law on Quality Payments

- Part of Ohio reimbursement statutes since 2005.
- Current system dates to 2011, funded by a “carve out” from the existing rate.
- Pays up to $16.44 per day based on meeting 5 of 20 measures; one must be clinical.
- Redistributes any money left over based on number of measures met.
- Nearly all SNFs receive full $16.44 payment.

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House Bill on Quality Payments

- Returns $16.44 “old quality payment” to base rate.
- Shifts $1.79 per day ($30 million) from base rate to fund “new quality payment.”
- Leaves a portion of rebasing intact instead of shifting the dollars.
- Requires entire quality fund to be paid out, based on each SNF’s level of achievement.

Quality Indicators

- Specifies five measures (two of which have two parts) for new quality payment.

- Leaves to ODM's discretion the thresholds to meet measures and amount paid per measure met.

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Current Law on Low Acuity Patients

- Rate for PA1 and PA2 patients lowered to $130 per day in SFY 2012.
- Policy argument: these patients should not be served in SNFs long term.
- We are responding: SNFs are by far the largest referral source to HOME Choice (out places long term patients).
- But, it's illegal to move patient out without safe/appropriate destination.
- PA1s/PA2s almost always admitted with higher level of service need.

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House Bill on Low Acuity Patients

- Reduces rate to $115 per day ($9 million reduction).

- Additional reduction to $91.70 (ODM's number) if ODM not satisfied SNF is cooperating with ombudsman efforts to move out PA1 and PA2 patients.