OHCA
OHIO HEALTH CARE ASSOCIATION

9200 Worthington Road
Suite 110
Westerville, OH 43082
P: 614.436.4154 / F: 614.436.0939
www.ohca.org

Testimony Before the Senate Medicaid Committee

House Bill 33
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Good morning, Chair Romanchuk, Vice Chair Wilson, Ranking Member Ingram, and members of the committee. I am Pete Van Runkle from the Ohio Health Care Association (OHCA). I appreciate the opportunity to appear before you to discuss skilled nursing facilities (SNFs) in relation to the state budget.

OHCA is a trade association representing long-term services and supports providers. Along with SNFs, we count among our membership assisted living communities, home care and hospice agencies, providers who serve people with intellectual and developmental disabilities, and a host of businesses that furnish goods and services to those health care providers.

House Bill 33 as introduced did not address Medicaid funding for SNFs in any way, even though last session's House Bill 45 expressed legislative intent to rebase Medicaid rates for SNFs in this budget using 2022 cost report data and to consider a reimbursement incentive for private rooms. The statements of intent in House Bill 45 followed last summer's extensive discussions in the joint legislative Nursing Facility Payment Commission. Instead of addressing SNF reimbursement in the Executive budget, the Governor opted to appoint another task force to discuss SNF quality. The task force has met numerous times over the last few months but has not yet finalized recommendations.

While the Executive budget was silent on rebasing and SNF rates in general, the Governor acknowledged the legislature's intent for rebasing in the State of the State address and afterward. While the Governor's task force has been meeting, the legislative budget process has continued, as it must. House Bill 33 as passed by the House of Representatives comprehensively addresses rebasing and many other issues relating to SNF reimbursement. We support the House-passed provisions, which reflect the consensus recommendations of the three SNF organizations you see here today, with a few suggested tweaks.

At the outset, I would like to emphasize that reimbursement and quality are inextricably linked. To paraphrase an administrator who spoke out at Monday's task force listening session, we care

deeply and we want to provide quality services, but we don't have the resources. The common thread that binds reimbursement and quality is workforce.

The story actually starts with the last budget bill, House Bill 110, when the legislature added a provision creating the NF Payment Commission. This commission was the legislature's response to concerns we and others raised in the last budget process about the 17-year-old formula for SNF rates. The formula was flawed from the beginning and has become more broken in the intervening years.

Senator Romanchuk co-chaired the commission, and Senator Huffman was a member. The commission's charge was to take a deep dive into SNF reimbursement at a time in the legislative session when it was possible to do so without the pressures of a budget bill. The commission spent considerable time thoroughly examining the SNF rate formula, rebasing, the quality incentive, private rooms, the impact of reimbursement on quality of care and life, and a variety of other issues. The commission process ultimately led to House Bill 45, with its statements of intent to rebase rates and to address private rooms in this budget and its creation of a "bridge" to those reforms by appropriating ARPA dollars as a short-term workforce fix.

Rebasing is a common concept in SNF reimbursement systems across the country. Rebasing recalculates rates periodically to reflect changes in operating costs as documented in annual cost reports that providers certify to the state. Under current law, Ohio rebases once every 5 years. Most states rebase more often, generally every year or two. Another common feature in SNF reimbursement systems is inflation adjustments between rebasings. Ohio does not currently have such a feature. The combination of relatively infrequent rebasing, lack of an interim inflation factor, and other fundamental flaws in Ohio's reimbursement formula has caused our rates to lag behind our neighbors, as shown in Table 1.

Table 1
Current SNF Rates - Ohio and Surrounding States

State	Current Rate
Ohio	$232.07
Michigan	$251.69
Kentucky	$244.31
Pennsylvania	$290.44
Indiana	$272.64
West Virginia	$296.98

Another key issue that the commission considered in its work was the relationship of Medicaid rates to facility operating costs. It is critical that the Medicaid rate at least get close to covering a provider's costs of providing care. Failure to cover costs affects staffing and quality of care and life in facilities. Eventually, it threatens the viability of the business.

Since its inception, Ohio's formula has not reimbursed even the average cost of providing care to SNF residents. The immediate problem that led to creation of the commission and the legislative intent to rebase in this budget is that today, without rebasing, rates have fallen incredibly far behind cost. Table 2 shows what has happened to the rate-cost gap over the years since the current formula took effect.

Table 2
Ohio SNF Cost-Rate Comparison Over Time

Fiscal Year	Average Cost - Preceding CY	Average Rate July 1 of FY	Gap
2023	301.16	231.73	-69.43
2022	278.27	226.44	-51.83
2021	250.60	209.14	-41.47
2020	244.44	202.12	-42.32
2019	237.62	195.90	-41.72
2018	229.28	194.41	-34.87
2017	224.24	192.20	-32.05
2016	219.71	177.33	-42.39
2015	218.09	175.06	-43.03
2014	214.86	174.97	-39.90
2013	214.13	173.34	-40.79
2012	212.74	166.20	-46.54
2011	197.12	176.57	-20.54
2010	184.35	176.11	-8.24
2009	177.91	165.93	-11.98
2008	175.56	164.12	-11.43
2007	172.74	154.60	-18.13

The gap shown above, an average of $69 for every day of care to a Medicaid resident in Ohio, is based on 2021 costs. It is nearly a billion dollars of underfunding each year. Although the 2022 cost report data are not yet available, we know the gap grew even more last year, probably to more than $80 per day. By surveying 284 SNFs, we found that their 2022 direct care costs increased 4.85% and their ancillary and support costs grew 6.78% over 2021. Because rates did not grow commensurate with the cost growth, the rate-cost gap expanded further.

The average SNF currently is losing 35% on every Medicaid day. Not many businesses can survive when they have a negative margin of 35% per unit on the majority of their sales. SNFs have made it through the past three years only because the legislature and the Administration provided three lump-sum cash infusions, one in 2020, one last year, and one earlier this year, for which are deeply grateful. But these pandemic-related cash infusions are ending. Reimbursement reform is critically needed to sustain the SNF industry and to support quality care for the frail elderly and disabled Ohioans our members serve.

Recent growth in the gap between Medicaid rates and per-diem costs illustrates a significant problem with Ohio's current rate policy. The last rebasing, which determined the rates the state pays today, used 2019 costs. Those costs in no way reflect current reality. COVID-19, the workforce crisis, and general inflation combined to drive pre-pandemic costs up sharply. Table 3 shows cost increases for the two main SNF cost centers, direct care and ancillary and support, which contain all of the labor costs.

Table 3
Ohio SNF Cost Changes 2018-2022

Year	Average Direct	Percent Change	Average Ancillary/Support	Percent Change
2018	$120.04		$83.39	
2019	$122.44	1.8%	$85.84	2.9%
2020	$137.52	12.6%	$95.25	11.0%
2021	$148.65	8.1%	$103.33	8.5%
2022 (est)	$155.86	4.9%	$110.36	6.8%

Since the beginning of the pandemic, the table shows that per-patient-day direct care costs rose by 27% and ancillary and support costs by 28%. None of these cost increases are included in the current rates.

In the past when inflation was low, lack of rebasing for a couple of years or even longer – while still not good policy - had a less dramatic impact. But the cost increases in the last three years cast a harsh light on Ohio's systemic flaw of rebasing only every 5 years with no inflation factor in the interim. The massive discrepancy today between costs and rates has SNF providers struggling to survive, even with the one-time payments during the pandemic. Many providers throughout the state are on the brink financially.

The financial struggle adversely affects quality of services. The Governor was not wrong to point out that serious problems exist in some of Ohio's SNFs. We too are aware of those quality issues and are very concerned about them. We are participating actively in the Governor's task force. In those deliberations, we consistently point out the elephant in the room: lack of resources leads to lack of staff which leads to reduced quality.

To understand the connection between Medicaid reimbursement and quality, there are two fundamental facts. First, Medicaid pays for the care of 65% of SNF residents, making it the predominant payer. Second, close to 70% of the cost of operating a SNF is labor. If Medicaid does not pull its weight, providers do not have the money to pay for labor.

The quality connection runs through workforce. No one seriously questions that quality of care and quality of life in a SNF require a strong workforce of caregivers, or in the parlance of SNFs, quality staffing. It is not just a numbers game, but numbers have a lot to do with it. In the task

force sessions, the consistent refrain from the many residents, families, and caregivers who have spoken is that more workers are desperately needed.

The Governor pointed out that Ohio ranks 39th in overall stars in the federal star-rating system. Star ratings are made up of three components: survey stars based on inspection results; stars for staffing levels; and stars for clinical quality measures. The federal Centers for Medicare and Medicaid Services (CMS) normalizes the survey stars because there are radical differences in survey culture and stringency in different states. As a result, every state has roughly the same average number of survey stars.

Where the five-star system differentiates among states is the staffing and quality measures stars. Ohio is above average (15th) on the clinical quality measures. On staffing, however, we are 47th. The staffing measure is the reason our overall rating is low. According to Bureau of Labor Statistics data, Ohio's SNFs lost 13.1% of their workforce from early 2020, when the pandemic began, to the second quarter of 2022.

Ohio's low staffing ranking compared to the rest of the nation is borne out by the observed quality problems. Almost all of the most serious issues result from inadequate staffing, either numbers or competency or both. In many cases, it is because of the presence of temporary staff, who we refer to as "agency." These workers are not familiar with the patients and have no particular commitment to the facility or incentive to deliver good care. Moreover, agencies entice facility-employed workers by offering higher wages and hurt the morale of those remaining as they see co-workers paid more for less work.

It is no coincidence that quality problems in SNFs started to multiply as the staffing crisis intensified and agency use skyrocketed. We estimate the average facility's cost for agency staff grew 67% from 2021 to 2022 and an astounding 670% since 2019, the year used for the last rebasing. No provider chooses to use agency – it is more expensive and poorer quality. The vast expansion of agency in Ohio's SNFs happened because providers had no choice to staff their buildings. They could not find enough workers otherwise.

During the commission hearings last year, Scripps Gerontology Center presented another way of looking at the connection between reimbursement and staffing and, ultimately, quality. Scripps showed that there is an inverse relationship between staffing levels and dependence on Medicaid funding. In other words, the more Medicaid patients a facility has, the lower its staffing tends to be. We at OHCA found the same inverse relationship between Medicaid dependence and star ratings: SNFs with more Medicaid tend to have lower star ratings. The bottom line is Medicaid does not pay enough to fund adequate staffing, which leads to reduced quality, especially in higher-Medicaid buildings.

Inability to staff leads to Ohio seniors losing access to SNF care. Since the pandemic began, 31 SNFs in Ohio have closed officially, and I am aware of at least three others that have not made it onto the state's list yet. Beyond that, an untold number of facilities are limiting or refusing

admissions because they do not have enough workers to take care of additional residents. This leads to challenges for hospitals that cannot find a place for patients ready for discharge.

This committee heard extensively last week about the workforce crisis in the developmental disabilities system and its root in Medicaid rates that do not support competitive wages. SNFs likewise are subject to this broad-based problem.

The statewide average wage for nursing assistants (STNAs) per the 2021 cost reports was $17.18 an hour. This figure is not the true base wage, as it includes overtime, shift differentials, and other things providers did to try to cope with the staffing shortage. Providers could afford even this level of wages, which is well below the $20 per hour that we believe is the market standard, only because of one-time COVID-19 stimulus cash that now is ending. We are concerned that absent rebasing, providers will not be able to sustain the wage increases they've already given, let alone increase wages to a competitive level. The impact on staffing is obvious and was highlighted by SNF administrators at the task force listening session on Monday.

As we consider how to improve quality of care and life in Ohio's SNFs, the answer has to start with rebasing, both now and in the future, to give providers the cash to compete in the marketplace for workers. Additional staff will help Ohio's standing on metrics like the staffing stars and on Health Department surveys, but more importantly, it will give additional eyes to see call lights, additional hands to help residents with eating, mobility, bathing, and treatments, and additional ears to hear alarms when someone tries to leave the building.

We support the House-passed budget bill, which reflects the joint recommendations of the three organizations that represent SNFs in Ohio. It would implement the legislative intent to rebase the direct, ancillary and support, and tax rate components in this budget using the 2022 cost reports. The House-passed budget would apply the median cost instead of the 25th percentile to rebase direct care and ancillary and support. This change would rectify a serious system flaw that played a major part in creating the huge discrepancy between rates and costs that exists today. The median at least gets us to the middle instead of the bottom quarter. Ohio simply should not fund care for our seniors and people with disabilities at the lowest common denominator. Because the House-passed budget would use cost report data that are only 6 months old to rebase, it would eliminate the inflation factors in current law that updates two-year-old cost data to the time of the rate-setting.

To avoid being in same position in the future as we are today, with growing costs outstripping stagnant rates, the House-passed budget would shift from a 5-year to a 2-year rebasing schedule. More frequent rebasing is a long-term solution to shore up the SNF workforce and to prevent the need for crisis responses.

The Governor recognized that the legislature intends to rebase rates and added that rebasing should be tied to quality. We agree. The House-passed budget, similar to House Bill 45, would allocate 60% of the added money from rebasing to the quality incentive. It would give Ohio by far the largest quality incentive of any state, making us a leader in this area. Not only would

rebasing enhance the ability of all SNFs to secure the staffing necessary for quality, but it also would direct more funding to providers who already have demonstrated that they can deliver quality as defined by the four statutory metrics Ohio uses.

Additionally, the House-passed bill would expand the dimensions of quality used for the incentive. Currently, the quality incentive is based on four clinical outcome measures from the federal star-rating system (pressure ulcers, ability to move worsens, urinary tract infections, and catheters). In the first year of the budget, the House-passed bill would add a fifth measure, occupancy. Then in fiscal year 2025, it would add three more measures (falls, decline in ability to perform activities of daily living, and antipsychotics). By July 1, 2024, Ohio's program would include all 7 quality measures for long-stay patients that the federal star-rating system uses, plus occupancy, for a total of 8 metrics.

Again following the precedent of House Bill 45, the House-passed budget would eliminate arbitrary barriers to participating in the quality incentive. This approach would give every SNF operator the incentive to improve their performance while not taking away critically-needed funding for improvement. Every facility would receive an incentive that reflects how well they did on the specified measures. The incentive could be anywhere from nothing, if a facility gets no points, to around $80 per day if they qualify for the maximum number of points. The only exception under the House-passed bill would be for certain changes of operator (CHOPs), discussed below, which would result in temporary loss of the incentive.

The House-passed bill includes another way to tie reimbursement to quality, a financial incentive for offering private rooms to Medicaid residents. Private rooms were discussed extensively in the commission process last year, resulting in intent language in House Bill 45 directing the Department of Medicaid to bring forward a private-room legislative proposal. As ODM has not done so yet (the deadline is June 1), the House included private room language in the budget bill. The language would provide a $30 add-on to the normal rate and would include both existing private rooms and private rooms that providers create by giving up licensed beds.

The quality-of-life benefits of private rooms are obvious, and forward-thinking SNF providers have moved in that direction, as has CMS. It took the pandemic to shine a spotlight on the benefits for quality of care, namely preventing spread of infections – not only COVID-19, but also pre-existing communicable diseases like flu that can have severe negative consequences for people who already are medically compromised.

The private room incentive also would remove excess beds from the system. As workforce hopefully improves and Ohio SNFs can admit more patients, there still will be thousands of empty beds in the state. The rate add-on gives providers the incentive to give up unused beds and to convert the space permanently into private rooms.

The House-passed bill would give SNFs another reason to remove unused beds: a 5% rate penalty for occupancy under 65%. We have a suggested amendment to this provision. The House version of the budget specifies that an operator can boost a facility's occupancy by surrendering beds

before May 1 of this year, which already has passed. Many providers were not able to take advantage of this opportunity in time for a variety of reasons, so we suggest moving the date to July 1.

Another key element of the House-passed budget is CHOP reform. Concerns have existed for years about inexperienced, unprepared, or otherwise unqualified operators entering the Ohio market or expanding their footprint. In the 2019 budget, the General Assembly enacted provisions to tighten up regulation of CHOPs, but they have proved to be ineffective. Then two years ago, House Bill 110 specified that a new operator following a CHOP does not get to keep the previous operator's quality incentive, as an exception to the normal rule that the rate simply transfers. This provision is unfair because it penalizes all new operators regardless of their qualifications and is ineffective because it doesn't capture stock sales, which are outside the definition of a CHOP. As a result, virtually all changes of operator today are via stock sales.

The House-passed budget would close the stock-sale loophole, would prevent operators with less than 5 years' experience or with specified sanctions on their records from getting licensed, and would allow owner/operators who take over after a CHOP to retain the quality incentive. Operators who take over through leases or management agreements would lose the incentive for 6-12 months. With the much higher quality incentive under the House-passed bill, this penalty would be heavy. We are recommending another amendment in this area, which would strike language in the House-passed bill that would make this penalty retroactive to transactions that occurred starting April 1, 2023.

While not directly about reimbursement, another piece of the House-passed bill also would improve quality. The House budget includes a set of statutes to regulate staffing agencies, which currently are the only type of health care provider that operates without any regulation. A number of other states have passed legislation to regulate agencies in the last couple of years. The regulatory provisions in the House bill are modeled in large part on last session's House Bill 466. They would ensure that staffing agencies register with the Department of Health, operate according to statutorily-prescribed standards, supply workers who are appropriately credentialed and prepared to provide high-quality care, and charge reasonable fees for their services. The regulatory requirements would target the problems with the quality of workers supplied by agencies, and the fee caps would help providers compete with agencies to attract staff. We feel it is time for Ohio to join the parade of states that are regulating staffing agencies.

Lastly, the House-passed budget would amend the existing statutes on discharges from SNFs and assisted living communities in ways that essentially duplicate existing provisions but with different language that would cause confusion. We recommend stripping these new provisions out of the bill.

Again, I thank you for the opportunity to speak with you today. I would be happy to answer any questions you may have now or through follow-up at pvanrunkle@ohca.org or 614-361-5169.