The Academy of Senior Health Sciences Inc.

Testimony of Chris Murray, CEO of The Academy of Senior Health Sciences, Inc., before the House Finance Committee

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Chair Stewart, Vice Chair Dovilla, Ranking Member Sweeney, members of the House Finance Committee, my name is Chris Murray and I am the CEO of The Academy of Senior Health Sciences, Inc. The Academy's membership is comprised of facility-based providers of long-term services and supports. We are an organization focused on promoting and advocating for policies that improve the quality of life and quality of care for individuals receiving facility-based long-term care services and supports and the well-being of the staff and businesses that provide those services. My testimony today on H.B. 96 will address nursing home policy.

Nursing home policy touches several state agencies: Ohio Department of Medicaid, Ohio Department of Health, and the Ohio Department of Aging. There are also several boards and other state and local entities that fall within the scope of NH policy. (Area Agencies on Aging, BELTSS, State Ombudsman, Board of Nursing, CDJFS…). Each plays an important role for nursing homes to provide quality services to the elderly and those most in need of NH services.

H.B. 96 impacts nursing homes in several areas. The implementation of findings from the Nursing Home Quality and Accountability Task Force, the purchase of nursing homes, and nursing home reimbursement. This written testimony will cover each of those areas in detail; however, due to time limitations, the oral testimony presented before the committee will predominately focus on the adjustment of medicaid rates based on resident acuity and the transition to the Patient Driven Payment Model (PDPM).

Patient Driven Payment Model (PDPM)

History

Reimbursement for nursing home services at the federal level has varied based on resource use since at least 1998 with the introduction of the RUG-III case-mix classification model. The Center for Medicare and Medicaid Services (CMS) used a payment system that tried to capture the resources used to provide services based on patient characteristics and the services provided. More recently, CMS used a staff time measurement study: Staff Time and Resource Intensity Verification (STRIVE) Project to align resource use[i]. The project collected data from 2006 to 2007 and ended in 2009. The result of STRIVE was an updated assessment instrument – MDS 3.0 – and a change in the Resource Utilization Groupers (RUGs-IV) used to determine case-mix scores and payment. This new system went into effect on October 1, 2011 and a version was adopted by Ohio's Medicaid program and is in use by Medicaid today. However, it is not in use by CMS for Medicare NH residents. CMS has switched to the Patient Driven Payment Model (PDPM) effective October 1, 2023.

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RUGs and Payment

To fully understand the transition from RUGs to PDPM, we must first look closer at the relationships between the assessment instrument (MDS 3.0), the RUGs groupers, and payment. The data collected through the MDS 3.0 assessment captures the clinical characteristics of the resident. Based on these clinical characteristics and services required, a resident is assigned to the highest "grouper" for which they qualify. ***Under RUGs, there is a hierarchy system such that the more services the resident needs, the higher the grouper.*** For example, a resident with a stage IV pressure ulcer would be placed higher than someone with reduced physical function. An index number is assigned to each grouper that is derived from the STRIVE study. This represents the resources used to care for a resident with the MDS characteristics that put them in that group. ***The higher the grouper, the more services the resident needs, the higher the index number***. This is the case-mix score. The goal of the score is to align resident needs with the resources to meet those needs to adjust reimbursement.

For Medicare, the resident is assigned to a grouper. Then the facility is paid the rate for that grouper based on costs and the case-mix score. Medicaid works differently. The rate the medicaid provider receives is not directly based on that resident's RUGs category. Instead, a facility receives an average case-mix score based upon the Medicaid residents in the facility at the end of the quarter, not including those in the lowest resource use groupers. (***PA1 or PA2 get a fixed payment of $130 to incentivize the use of HCBS by those individuals.***) This average case-mix score is then used to adjust the Medicaid direct care rate paid to the provider *for all Medicaid residents.* Under Medicaid, the pressure ulcer resident and the resident with low needs have the same payment rate. This rate gets adjusted every six months using the average of the two most recent quarterly case-mix scores.

Why PDPM?

The RUGs-IV payment methodology began October 1, 2011 and remained in effect for Medicare until October 1, 2023 with the implementation of the Patient Driven Payment Model. Why the change? As noted above, the RUGs system is based in part on the services provided to the resident. CMS discovered utilization patterns that suggested overuse of services that increased payment. This was especially evident in one service area that put residents near the top of the RUGs hierarchy and thus the highest rates – physical therapy. It is noted in the Federal Registry why CMS was moving away from RUGs-IV:

> *"More specifically, as discussed in section V.E. of the FY 2015 SNF PPS proposed rule (79 FR 25767), we documented and discussed trends observed in therapy utilization in a memo entitled ''Observations on Therapy Utilization Trends'' (which may be accessed at https:// www.cms.gov/Medicare/Medicare-Fee- for-Service-Payment/SNFPPS/ Downloads/Therapy_Trends_Memo_ 04212014.pdf). The two most notable trends discussed in that memo were that the percentage of residents classifying into the Ultra-High therapy category has increased steadily and, of greater concern, that the percentage of residents receiving just enough therapy to surpass the Ultra-High and Very-High therapy thresholds has also increased. In that memo, we state ''the percentage of claims-matched MDS assessments in the range of 720 minutes to 739 minutes, which is just enough to surpass the 720 minute threshold for RU groups, has*

> *increased from 5 percent in FY 2005 to 33 percent in FY 2013'' and this trend has continued since that time."*[ii]

CMS continues in the Federal Registry to note three different Office of the Inspector General reports that suggest significant upcoding by skilled nursing facilities to put residents into the higher groupers and thus receive higher payment. CMS's response to this was to implement the Patient Driven Payment Model that made several changes, the most significant related to payment was breaking the system into six separate components: Nursing, Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Non-Therapy Ancillaries (NTA), and non-case mix expenses (room and board, capital costs, etc…). Each of the five case-mix categories (Nursing, PT, OT, SLP, and NTA) have their own case-mix score for Medicare and corresponding rate component. CMS also put limits on how long Medicare will pay for certain services. For example, after day 21, the payment for PT and OT begins to decline.[1] And, the diagnosis of the resident impacts their classification under PDPM. CMS notes their objective again in the Federal Registry:

> *"We explained in the proposed rule (83 FR 21041) that while the RUG–IV model utilizes a host of service-based metrics (type and amount of care the SNF decides to provide) to classify the resident into a single RUG–IV group, the proposed PDPM would separately identify and adjust for the varied needs and characteristics of a resident's care and combine this information together to determine payment. We stated we believe the proposed PDPM would improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care."*[iii]

PDPM and Medicaid

State Medicaid agencies using the RUGs case-mix scores for payment were not immune from any "upcoding." Ohio nursing homes could place residents in the higher RUG category, increase their average medicaid case-mix score, and increase their medicaid rate for their medicaid residents. Similar to CMS's rational for moving away from RUGs, Ohio Medicaid could also benefit by switching to PDPM. Regardless, CMS made changes to the MDS that, effective October 1, 2025, remove a state's ability to collect the data necessary to implement RUGs. ***The move to PDPM is inevitable and must happen before July 1, 2026.*** Yet PDPM is a payment model designed for short-term care. How can we use PDPM in the long-term care setting?

PDPM and Long-Term Care

Medicaid covers services in a skilled nursing facility for the Medicare/Medicaid population after 100 days.[2] Recall that the purpose of a case-mix adjustment is to pay a provider a higher rate for a resident that requires more resources, and vice-versa. ***The case-mix score should reflect resource use as much as possible***. ***It is not a tool to manipulate rates.*** To the extent that the needs of long-stay residents are different than short-stay residents, the case-mix methodology should reflect this difference. CMS even

[1] Please note that Medicare Part A only covers the first 100 days of a SNF stay. Some Medicare benefits are available in a SNF after 100 days under Part B.
[2] The Group VIII population is on admission and not eligible for Medicare

does this within the short-stay Medicare payment by reducing payment for select services the longer a person is in a facility.

When reviewing the different components of PDPM, ***the nursing component is the best fit for long-stay residents.*** A majority of services provided to long-stay residents are nursing services. Nursing is the largest resource employed by nursing home providers. And it is the direct care costs, which capture nursing, that are being adjusted by the case-mix score. Therefore, the nursing component should be used as the case-mix adjustment for Medicaid rates. There is also the benefit of administrative simplicity given that the nursing component best reflects the current RUGs system (without therapy). ***Furthermore, there is no data to suggest that incorporating or using the other components improves the accuracy of the case mix score for the long-stay population.*** The only proposals we have heard to use other components as part of the case mix score are not based on the case-mix reflecting resident clinical characteristics as intended, but rather to manipulate rates. Many other states have begun using, or plan to use, the PDPM nursing component only. (Georgia, Colorado, Illinois, Kentucky, Massachusetts, Nebraska, Pennsylvania, Missouri, Kansas…) ***We support Ohio using only the nursing component of PDPM as found in the As Introduced version of HB 96.***

Transition

Analysis of available data suggests that the move to PDPM can create significant changes in a provider's medicaid rate. As noted above, direct care is a major cost to providers and the case-mix score is used to adjust the rate based on these costs.[3] Small changes in the case-mix score can create large rate changes. There may be several reasons behind a provider's difference between their RUGs and PDPM case-mix scores. A provider's RUGs score could be higher because of physical therapy. Or it could be from the use of isolation as the PHE expired. Regardless, providers will need a transition period to adjust to PDPM.

Recall that Ohio Medicaid adjusts rates every six months based on the average case mix scores of the two most recent quarters available. Because of the time it takes to submit and review the assessment data to calculate the case mix scores, there is a quarter delay. July 1 rate adjustments are based on December and March case mix scores. January 1 rate adjustments are based on June and September case mix scores. Once the decision is made on how ODM will use PDPM, providers will need at least 2 quarters to adjust. However, given the decision will not be finalized until after the period for July 1 case mix scores (Dec. and March), the first opportunity to adjust rates under the new PDPM scores would be January 1, 2026. The case mix scores for that rate setting would be June and September. Providers will only have learned the PDPM medicaid case mix score methodology in June. This gives providers only one quarter to adjust to that methodology under the current HB 96 transition language. Given that limited timeframe, ***providers should have the option of freezing their RUG score for the first fiscal year. We also recommend giving providers that are ready to use PDPM the opportunity to do so beginning July 1, 2025.*** That gives providers who choose to wait three full quarters under PDPM to prepare for the transition.

After the initial 12 months, we recommend a six-month stop loss at one-third, followed by full implementation January 1, 2027. This start date mirrors the date currently found in H.B. 96; however, we are proposing a longer "freeze" period with the option to start immediately and a shorter transition for those that froze their scores.

[3] Based on 2023 cost report data: 53% direct care, 36% ancillary and support, 10% capital, and 1% taxes

We also recommend adjusting the PDPM values by a multiplier to reflect the difference between the PDPM values and the RUGs values. This multiplier can be designed to be budget neutral. It would not be necessary after the next rebasing. The next rebasing would use the PDPM case mix scores and adjust the prices, thus removing the need for the multiplier.

PDPM Summary

Below is a summary of The Academy's position on the transition to the PDPM case-mix scores for nursing homes:

- Use the nursing component only as it is the best component that matches the resources used by the long-term population.
- Create a 12-month case mix freeze period for providers that chose not to use the PDPM July 1, 2025.
- After the freeze, there would be a six-month 1/3 stop loss and then full implementation of PDPM on January 1, 2027.
- PDPM indexes would have to be adjusted until there is a rebasing.

Private room payment

Ohio was the first state in the country approved by CMS to offer medicaid enhanced payment for private rooms. Private rooms improve the quality of life of the resident. They help to reduce the spread of infectious disease. They allow care to be provided in privacy, thus helping to maintain the resident's dignity. These are just a few of the benefits of having a private room.

The current medicaid private room enhanced payment rate is capped at $160 million per year. The ability for providers to bill for the enhanced rate is determined through an application process. That application process is done, in part, to try and prevent the state from exceeding the expenditure limit. As of mid-January, the department approved over 27,000 rooms. Medicaid assumes a 50% utilization rate when determining if they should approve rooms or not for the program. The latest numbers from the department suggest they are still below the cap. Our concern is that utilization will exceed 50% and Medicaid will reach the cap prior to the end of a fiscal year. We cannot predict how a provider will respond to the rate reduction; however, we have concerns that the resident could have a roommate, be moved to a different room, or a new resident denied the opportunity to have a private room.

We recommend removing the cap on spending for private rooms. This provides certainty for the nursing home providers so they can properly plan. It provides certainty for the residents as they do not have to be concerned about losing the benefit of the private room. And it allows for potential growth in a program that enhances the quality of life of the resident while also providing the benefit of reducing the spread of infectious diseases. It is not possible to know at this time if the cap will be reached, so there may or may not be an additional cost.

Capital Reimbursement

The environment someone lives in is important to the quality of life of that person. The capital component of the Medicaid nursing home reimbursement rate fails to consider the quality of the environment a resident lives in. The current pricing system pays the same amount to a provider in a

peer group regardless of the characteristics of the facility.[4] ($10.33 was the Jan 1 average of the six prices.) A new building with nice amenities and large rooms - $10.33 a day. A building built in 1974 with limited upgrades or improvements - $10.33 a day. ***Yet the environment a person lives in directly impacts their quality of life.*** This should be reflected in the capital reimbursement paid to nursing homes. The departments of aging, health, and medicaid, along with the state ombudsman and provider associations, should develop an Environment Quality Payment to replace the current capital reimbursement price. The payment should focus on both the value of the facility **and** specific factors of a facility that improve the quality of life of residents. We are proposing that a workgroup of stakeholders be convened to determine the new reimbursement system in FY 26 with the new environmental quality payment beginning in FY 28.

Nursing Home Ownership and REITs

Nursing home owners that use their facilities mainly for a return on investment with little concern for the quality of care is a nationwide problem. These owners create complex business relationships that siphon-off funds better used to provide care; this can result in residents receiving poor care. In many cases, these are out of state providers with no connection to the community they serve. They view the building as an asset and the residents as cash flow. Real Estate Investment Trusts (REITs) are just one of a variety of financial ownership structures.

Ohio recently made changes to Change of Operator (CHOP) regulations to try and deter those types of owners from entering Ohio. This included putting more restrictions on both the incoming operator and owner, requiring a bond for owners that are not also the operators, and broadening the definition of what constitutes a CHOP. Unfortunately, we continue to see some facilities undergo repeating CHOPs.

H.B. 96 contains language that would ban health care REITs from owning nursing homes going forward. We are not convinced that banning REITs would necessarily solve this problem. Given the already limited financial markets available to buy a nursing home, excluding REITs from that market may make it easier for other “bad” owners to purchase homes. Furthermore, there is no indication that the type of financing used to purchase the building is indicative of the quality of the operator and thus care provided.

We recommend allowing REITs to continue to purchase nursing homes; however, we should consider regulatory changes that connect the owner of the facility to the financial stability of the operator and the quality of services. By strengthening this connection, we send a message to potential owners that purchasing a nursing home in Ohio is not just an asset, but a commitment to caring for those residents.

[4] There are six prices paid to NH providers for capital: $7.99, $9.54, $10.17, $10.50, $10.79, and $11.11. A facility gets one of the six prices based on location and +/-100 beds. $10.33 was the average of the prices paid for all facilities for the Jan 1, 2025 rate setting.

Improve the Quality of Care

Health Outcomes

Nursing homes care for some of the most vulnerable people in our population. Many residents are at the mercy of the provider to ensure their most basic needs are met and they can live a fulfilling life. Yet too many times we have heard of providers failing their residents. During the past decade the legislative and executive branches have listened to our call to improve the care in Ohio's nursing homes. Ohio has made a continual investment in better health outcomes for nursing home residents via incentivizing providers to achieve those outcomes. Reimbursement for Medicaid providers based on the provider's score on select quality measures (QMs) has increased significantly. The quality component of the nursing home Medicaid per diem has gone from a "*withhold-payback*" mechanism of $1.79 per day (1% of the rate) in 2016 to an average *additional payment* of $39.87 per day (14.5% of the rate) in 2025. The highest quality payment is $59.40 per day. During this time the number of QMs has increased, with four new QMs added this last biennium, including a staffing measure. ***And over time we have seen improvement in the QMs when there is a monetary incentive to improve.*** The result is fewer urinary tract infections, catheters left in, and decreased mobility among residents. We all need to remain steadfast in our commitment to paying more for better health outcomes.

Resources

There are still nursing homes that struggle to provide the level of care we want for our parents, grandparents, and loved ones despite the incentives. The NH Quality and Accountability Task Force set out to identify and address the gaps in care. I will highlight one outcome that directly impacts a provider's ability to improve the quality of the services they provide and is already being implemented – available resources. The creation of PREP gives NH providers access to free resources and best practices to improve quality. The EXCEL Academy, while limited in the number of providers it can serve, offers extensive help with select topics, such as anti-psychotic use or infection prevention and control. Furthermore, ODH offers assistance with patient assessments via their RAI Coordinator. Finally, ODH and ODA are planning a summer conference for nursing home providers to permit the exchange of ideas and networking. These efforts, while in their early stages, provide a framework for nursing homes to improve the quality of the services they are providing to residents. And with CMS's Quality Improvement Organizations also providing free resources, there is no excuse for a provider not to be engaged in improving care. We applaud the state's efforts in creating these resources and we will continue to promote their availability and encourage their use to nursing home providers.

Staffing and Technology

Finding staff continues to be a struggle for nursing home providers. It is not a unique problem for Ohio; the demographic changes combined with the arduous work have made it a problem across the US and even many European countries. There is no easy solution; higher wages and benefits, better marketing, and increased worker satisfaction help, but they will not provide a cure. The bottom line is there are fewer workers as demand increases. Technology that allows for more efficient use of staff can be of great help. Unfortunately, there is little to no incentive for nursing home providers to invest in technology. The large upfront costs and the far-off returns create barriers to its adoption. Furthermore, current policies are aimed at increasing staffing ratios while ignoring the potential benefits of technology utilization. [For example, CMS does not permit the use of civil monetary penalties collected

by the state to aid nursing homes in the adoption of technology.] We recommend that the General Assembly consider policies that facilitate the adoption of technology by nursing home providers and residents. The technology will allow workers to be more efficient and create better outcomes for residents while also helping to alleviate the staffing shortage and increasing the quality of care.

Conclusion

In summary,

PDPM: Use the nursing component only, allow providers that are ready to start using PDPM July 1, 2025, those that are not, frozen case mix scores until July 1, 2026, and then a six-month transition period with a stop loss of 1/3.

Private rooms: Remove the cap on private rooms to allow for greater certainty that payment will continue and avoid any potential impact on residents.

Capital component: Replace the current capital pricing system with an Environmental Quality Payment that considers both the value of the facility and environmental factors that improve a resident's quality of life.

Nursing Home Ownership: Continue to allow REITs to purchase NHs, but strengthen the connection between ownership and operator performance.

Quality Improvement: Keep moving forward with the current quality incentive payment and create an Environment Quality component in place of the capital price. Continue to build and develop free resources for nursing home providers to help them improve quality. And reduce barriers to the adoption of technology in nursing homes so staff can work more efficiently and improve outcomes.

Thank you for the opportunity to testify and I will be happy to answer any questions.

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[i] Please see https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/timestudy for more information on STRIVE and links to other resources.

[ii] 83 FR No. 153, August 8, 2018 Page 39184: FR-2018-08-08.pdf

[iii] Ibid. Page 39194.