OHCA
OHIO HEALTH CARE ASSOCIATION

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

Before the House Medicaid Committee
Testimony on House Bill 96 As Introduced

March 4, 2025

Good afternoon, Chair Gross, Vice-Chair Barhorst, Ranking Member Baker, and members of the committee. I am Pete Van Runkle, representing the Ohio Health Care Association. We are the largest statewide membership organization for long-term services and supports providers, with more than 1,200 members.

Almost all of our members are Medicaid providers and are significantly affected by legislative and administrative decisions about the program at both the state and federal levels. Medicaid payment rates, in particular, are vitally important for our members to grow business in Ohio, employ Ohio workers, and deliver high-quality services and supports for the steadily-increasing number of Ohio seniors and people with disabilities.

Given the way HB 96 was divided among the House standing committees, I'm here today to discuss the budget for only one of our member constituencies, skilled nursing facilities (SNFs), and only as it relates to Medicaid reimbursement for SNF services. We are addressing parts of the budget that affect other provider groups within our membership and an additional issue affecting SNFs in other committees.

Medicaid reimbursement for SNFs is a perennial topic in every budget bill. HB 96 is no exception. I would like to start, though, by expressing our sincere gratitude for the outstanding work of the House and Senate in last session's budget, HB 33, to increase Medicaid rates and help offset the extreme cost increases SNFs saw during the early years of this decade, particularly in the cost of labor.

HB 33 also shifted much of the increased funding out of reimbursement for costs and into the SNF quality incentive payment. A significant portion of that funding is the subject of pending litigation, so we will not be discussing quality incentive payments or the underlying statute in our budget bill advocacy until the litigation is resolved. We expect a decision by the court during the budget process. We then will address the quality incentive with you and other members of the General Assembly, taking into account the outcome of the case.

The foundational aspect of the rate increases in HB 33 was rebasing. Rebasing is a statutory requirement to adjust rates to reflect changes in operating costs, most of which is labor expense.

HB 33 placed a strong emphasis on direct care labor costs by requiring rate rebasing in 2023. Current statute does not call for another rebasing – that is, a general rate increase – for five years, which would be 2028. We are not asking the legislature to change that cadence, although five years is on the outside of rebasing frequency across the country, which normally is every 1-3 years. Because we are not requesting rebasing in this budget, the proposed policy adjustments I will discuss today do not have the impact on Medicaid funding for skilled nursing services that HB 33 did.

Experience with HB 33, however, shines a light on several areas where reimbursement policy needs to change. We are proposing an amendment that addresses three of those areas. I apologize that these issues are all "deep in the weeds," but they are important to our members.

First is Ohio's case-mix system, which adjusts each SNF's direct care rate to account for the acuity of its residents – their health conditions and service needs relative to other residents. The system or "grouper" historically used in Ohio and many other states is called Resource Utilization Groups or RUGs. It takes data elements from the required, nationally-standardized resident assessment, the Minimum Data Set (MDS), to determine acuity scores for each resident. Ohio uses the RUG-IV-57 model of RUGs.

More recently, CMS began to phase out RUGs and the version of MDS that supports RUGs and replace it with a new case-mix system, Patient-Driven Payment Model (PDPM). CMS started using PDPM for Medicare rates beginning in October 2019, based on a new MDS assessment, and instructed states that were using RUGs to move to PDPM. One of the challenges, though, is PDPM is designed for short-stay Medicare residents who are in a SNF for post-acute rehabilitation and typically have a different medical and cognitive profile than longer-stay Medicaid residents.

CMS delayed the phase-out of RUGs and the related MDS version during the pandemic, but afterward set a hard date of September 30, 2025, for states to transition. After that date, both RUGs and the MDS version currently used to populate RUGs, the Optional State Assessment (OSA), will no longer be available.

In HB 33, with the end date still two years away, the General Assembly put in place an interim case-mix system that gave providers the choice to freeze their case-mix scores (commonly called "case-mix index" or "CMI") where they were on March 31, 2023, or continue completing OSAs and having a new RUGs CMI calculated every 6 months as was the case previously. Over 60% of SNFs chose to freeze their scores, but more than 200 buildings still are doing OSAs to capture changes in resident acuity.

The interim solution ends on June 30, 2025. Ohio must decide what system to use beginning July 1. In the as-introduced version of HB 96, the DeWine Administration offers an idea. We support some aspects of their proposal but request several adjustments.

The administration's proposal is to use only one of the 5 case-mix-adjusted components of PDPM, the nursing component, and leave out the other 4. They would begin to phase in the nursing

component throughout calendar year 2026, after a 6-month CMI freeze that ends December 31, 2025. Starting January 1, 2027, the nursing component would make up 100% of each facility's CMI.

Two things are important to know about the transition to PDPM. One is that PDPM was not made for Medicaid, as I mentioned earlier. The other is that because it is a different methodology, switching to PDPM from RUGs results in "winners and losers," just like any other change in a payment formula. In other words, if PDPM was implemented tomorrow, approximately half of the state's SNFs would see rate increases and the other half would see rate cuts, even though everyone is still serving the same residents and delivering the same care as they are today.

Based on the modeling we have done, many of the increases and cuts would be quite large, up to $50-60 per day. We are particularly concerned about the cuts. Sudden rate reductions of that magnitude would jeopardize the ability of the affected SNFs to continue operating and could lead to closures and unfortunately moving residents to other facilities. In some areas of the state, those facilities could be far away. On the other hand, some providers could be perceived to be receiving a windfall if their rates by a large amount just because of a methodological change.

The problem of winners and losers is why the administration is proposing a phase-in. We agree that a phase-in is needed, but the administration's approach doesn't solve the problem. We also disagree with their proposal to use only one PDPM component to measure the acuity of Medicaid residents.

Instead of using only the nursing component and ignoring the other pieces of PDPM, we recommend that 70% of overall CMI be from the nursing component, with the remainder coming from the speech-language pathology component (20%) and the non-therapy ancillaries component (10%). The names of the components don't matter, the important part is they include common conditions among Medicaid residents that are not captured by the nursing component alone. These conditions include cognitive impairment (dementia) and diabetes, among others. While we agree that the bulk of CMI should come from the nursing component, we were advised by a group of PDPM experts from Ohio and elsewhere that it is important to add in a bit of the other two components to make PDPM better-suited for Medicaid residents.

In addition, using the nursing component alone maximizes the winners and losers in terms of impact on their rates. Nursing-only generates bigger cuts and bigger increases than the blended model we are proposing.

The phase-in is intended to mitigate wins and losses for a period of time while providers adjust to the new system, which requires different assessments and emphasizes different data elements within the assessment. Individual nurses coding MDSs in the 924 Medicaid-certified SNFs across the state will need to be trained on the new process and have time to assimilate and implement the training.

We agree with the administration's proposed timeline of a 6-month CMI freeze and gradual implementation of PDPM over the following 12 months. Our amendment would correct the language in HB 96 on the 6-month freeze, which cannot be implemented as currently written.

For the 12-month phase-in, we recommend two changes. One is to require in statute adjusting the prices used for setting direct care rates to account for the different scales used in RUGs and PDPM. A facility's direct care rate is the product of the per case-mix unit price for its peer group (there are 3 peer groups in Ohio) multiplied by its CMI. RUGs CMIs average around 3.0 while PDPM CMIs average around 1.4. If the same price is multiplied by a much lower nominal CMI, it would result in a gigantic rate cut. Our amendment would adjust the three prices by the percentage difference between the average CMIs, which means multiplying each peer group price by about 2.13. This approach would even things out globally, although not for each facility.

To address the impact on individual SNFs, our amendment would use a different phase-in methodology than the administration has proposed, while leaving the timetable intact. In HB 96 as introduced, the phase-in would be a blend of each SNF's previous direct care rate under RUGs and its rate under PDPM. For the first 6 months of 2026, the blend would be 2/3 RUGs and 1/3 PDPM. For the second 6 months of the year, it would be 1/3 RUGs and 2/3 PDPM. After that, it would be all PDPM.

We agree with moving to all PDPM as of January 1, 2027, but do not agree with the blending approach for the phase-in because it would result in rate cuts starting January 1, 2026. For instance, if full PDPM would cut a facility's rate by $60, the administration's phase-in would impose a $20 cut on January 1 and a $40 cut on July 1. CMI is calculated from MDS assessments that were done in the past. The PDPM CMI for January 1, 2026, would be based in part on assessments done before HB 96 passes before providers know what the new system will look like.

Our amendment would prevent any rate cuts during the phase-in period. The first cuts would occur January 1, 2027, based on assessments done starting April 1, 2026. That means MDS nurses would have 9 months to learn and adjust to the new case-mix system. It is not much time, but we believe it would be sufficient. We are strongly opposed to penalizing providers and their residents during this learning period just because the system changed.

The amendment also would limit rate increases for "winners" to $5 per day. Once the phase-in period is over, SNFs would feel the full impact of moving to PDPM, positive or negative, but hopefully providers who would be negatively impacted will adjust and either eliminate or significantly mitigate the cuts. There would be some cost incidental to this phase-in policy, which we estimate to be $16 million all funds ($5.6 million state share) in each of fiscal years 2026 and 2027.

The last change we are proposing to the administration's PDPM plan would eliminate the antiquated $115 total rate for residents on the two lowest rungs of the acuity scale. This rate is now far below the base rate for assisted living, let alone the average SNF daily rate of around

$270. These residents currently are excluded from the CMI calculation because they are paid at the low rate. Under our amendment, they would be included in CMI, which would have the effect of lowering it.

The second policy issue addressed by our amendment is private rooms. The private room incentive payment was an important innovation in HB 33. No one disputes that having a private room is better for residents' quality of life, privacy, and dignity. It is also better for quality of care by reducing exposure to respiratory infections and other communicable diseases and offering a less distracting environment for providing care.

The private room program proved to be very popular once it finally kicked off last December. As of late January, the Department of Medicaid (ODM) had approved nearly 28,000 private rooms for incentive payments, which amounts to more than a third of the 80,911 beds in certified SNFs in Ohio. Thousands of beds were taken out of the system to convert semiprivate rooms into private rooms. Residents all across the state are benefiting from this program, which to our knowledge is unique in the country.

But there is an impediment to further expansion of private rooms to serve even more SNF residents. HB 33 capped the number of private rooms that can be approved by limiting the total dollar amount of the incentive payments in a fiscal year. ODM is only allowed to approve the number of private rooms that would fit under the cap, assuming 50% utilization of approved private rooms by Medicaid residents.

As Director Corcoran testified in committee last week, there is still space under the cap for more private rooms. She also noted, though, that the space depends on the percentage of actual Medicaid utilization – whether it is above or below the assumed 50%. There is a risk that during fiscal year 2026, ODM's ability to approve more private rooms could evaporate because actual utilization turns out to be greater than 50%. Moreover, ODM issued a memo late last year stating that they will cut off incentive payments to all *approved* private rooms if the cap is breached sometime in FY 2026.

To remove these risks and support Ohio's policy of expanding private room availability, our amendment would eliminate the cap and also fix a glitch in the statutory wording that prevents some providers from adding private rooms. We feel this issue needs to be addressed in HB 96 so we don't find ourselves in place where private room approvals and payments are cut off, but the opportunity to address the issue has already passed.

We are not assigning a cost to this change because actual Medicaid utilization and the number of private rooms that would be added over the next two years are both unknown. Experience has shown, though, that only a comparative trickle of private rooms have been added after the original mass approvals. The vast majority of the approvable private rooms already have been approved, so the incremental cost of adding more would be relatively small, if there is a cost at all.

The third policy issue that we feel needs attention is the portion of the SNF payment rate that in theory reimburses providers for the capital costs of their buildings (that is, construction, renovation, and capital equipment). The current rates for capital don't serve that function because they are frozen at 2014 cost levels. HB 33 continued the freeze, but the problems with capital rates were supposed to be addressed shortly after the bill passed. Previous legislation, HB 45 in late 2022, required ODM to bring a proposal for a replacement methodology based on fair rental value to the General Assembly by October 1, 2023. Unfortunately, though, ODM did not comply with the legislative directive, leaving the capital rate unaddressed for another budget cycle.

In the executive version of HB 96, the administration again fails to take on this issue. The capital rate methodology, however, is truly broken. In addition to being based on 2014 costs, the current formula pays every provider in each peer group the same amount regardless of whether their building is spacious or cramped, old or new, well-maintained and upgraded or allowed to deteriorate, or meets any other objective factors measuring the quality of the environment where residents live. The system is simply inequitable. Just as direct care rates are adjusted for acuity, capital rates should be adjusted for the value of the building.

Our amendment would scrap the current capital rate methodology after leaving the freeze in place for another two years while a new system is ramped up. Starting July 1, 2027, the amendment would replace the old rates with a new environmental quality incentive payment. Following the legislative intent evidenced in HB 45, the incentive payment would be based on a fair rental value methodology. In simple terms, this methodology, which has been the state of the art for capital reimbursement across the country for 30 years, takes the value assigned to each facility based on a standardized appraisal and converts it to a per diem "rental" payment.

The amendment also includes language authorizing ODM to adopt rules specifying additional environmental quality factors that are not captured by an appraisal but would have a significant positive impact on residents' quality of life. A stakeholder workgroup would advise ODM on those factors and the dollar value that should be attached to them.

During the FY 2026-2027 biennium, the department would put in place the structure for the new methodology, including the rules, and secure CMS approval of the necessary state plan amendment. Providers across the state would obtain (and pay for) appraisals and submit them to ODM in time to calculate rates under the new system for July 1, 2027. No change to the Medicaid appropriation in HB 96 would be needed because the old, frozen capital rates would continue to apply during the biennium.

This timing also would allow the legislature, in the next budget, to review progress on implementing the environmental quality incentive payment and whether any revisions are needed.

Thank you for your attention to these important topics for Ohio's SNFs. I would be happy to answer any questions you may have at this time. I also am available to meet in person or communicate via email (pvanrunkle@ohca.org) or phone (614-361-5169) regarding these issues.