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. My name is Shane Craycraft. I am a Registered Nurse (RN), a Licensed Nursing Home Administrator and oversee the operations of 6 facilities in southern Ohio. In addition, I am here representing the members of the Ohio Health Care Association (OHCA) as their current Provider Elected President. OHCA is the largest statewide membership organization for long-term services and supports providers, with more than 1,200 members.

Medicaid Payment System Conversion for Skilled Nursing Facilities (SNF)

CMS is moving away from the system that Ohio currently uses. A temporary fix has been in place in Ohio as a patchwork to get us to this biennium. This budget must implement the transition to a system that CMS will support. The system CMS is currently utilizing is the Patient Driven Payment Model, otherwise known as PDPM.

There are some key points about PDPM that should be recognized before we move forward.

- PDPM was designed for short-term residents. The current RUG's IV 57 category being used in the State of Ohio was adapted to long term residents. There is no clean cross walk from one system to the other. (RUG's IV-57 to PDPM).
- Conversion from RUG's IV-57 to PDPM is volatile regarding rates. There are large up and down swings in provider rates, as much as $50-$60/day for the exact same resident set depending on which system is used.
- The rates we are discussing would be effective January 1, 2026. However, the data periods used are the 2nd and 3rd quarters of 2025. In essence, assessments on April 1, 2025, which is less than a month away, will begin to impact rates. That is insufficient time for training and preparation.

PDPM consists of 5 components. There is a Nursing component, the three therapies (Physical, Occupational and Speech) and a Non-Therapy ancillary category that covers expensive services (IV's, parenteral nutrition, wound care, etc.) and high-cost diagnosis (major infections, diabetes, immune disorders, etc.). The proposed budget recommends only using one of the five components of PDPM developed by CMS. It only uses the Nursing component and ignores the other 4 categories.

The decision to use only 1 component out of the 5 creates 2 significant problems:
<u>First is volatility in rate</u>.

Using the Nursing component only creates the broadest ranges of rates in almost all the potential models tested when converting from RUG's IV-57 to PDPM. Facilities could have a $50 per day rate swing to the positive or negative, with no changes to the patient population. It unintentionally creates winners and losers. The current budget seems to recognize this volatility and recommends a yearlong phase in period using 1/3rd PDPM and 2/3rd RUG's IV-57 for the first 6 months of the phase in and then using 2/3rd PDPM and 1/3rd RUGs IV-57 for the second 6 months. Full PDPM implementation would begin in January 1, 2027.
This process will force Assessment Nurses to operate in two systems for a period. And due to the uncertainty of which components of PDPM will be used, will have nurses doing assessments while not knowing what data will be collected for rate determination.

<u>The second problem is accuracy of assessment</u>.
Another primary goal is to create a predictable system by accurately capturing the most seen patient presentations in Ohio. The purpose of PDPM was to create more accurate assessments of residents that would then be used to provide more accurate payment for resident care. The Nursing Component alone of PDPM does not cover many of the standard resident conditions that we see in Ohio. This would lead to inaccurate assessments.
The Nursing Component of PDPM does not cover mental health, dysphagia, cognition treatment, common treatments or coverage of high-cost diagnosis that are all commonly seen in Ohio long term care facilities. Therefore, using only the Nursing component of PDPM would result in inaccurate reflections of resident conditions in the payment system.

OHCA is proposing and amendments to remedy the deficits in the proposed budget.
<u>The first recommendation would be to use 3 of the 5 PDPM components rather than just one</u>.

- The Nursing Component would be used as the foundation for the assessment and would be weighted at 70%.
- The Speech Therapy Component would be used to collect cognition and dysphagia data and would be weighted at 20%.
- The NTA category would be used to cover high-cost procedures and diagnosis and would be weighted at 10%.

This change accomplishes 2 goals. The first is reduce rate volatility in the transition of payment methodologies. Using these three PDPM components is one of the least volatile options related to rate movement from RUG's IV-57 to PDPM that OHCA has processed.
Secondly, this would provide a more accurate assessment and provide a clearer snapshot of the resident and their needs.

<u>The second recommendation is related to the phase in process</u>.
We agree that a phase in period would still be required. What the budget currently proposes, presents a significant challenge related to the timing of the assessments and when PDPM rates will start. For PDPM rates to start on January 1, 2026, data will be pulled from the 2nd and 3rd quarters of 2025. MDS Assessment Nurses will be required to start PDPM assessments on April 1, 2025, in just a few short weeks. They will then have to complete PDPM assessments while

still maintaining RUG's IV-57 assessments at the same time. Since the budget process will not be over, they will also not know if they should be utilizing 1 or 3 of the PDPM components.

The recommendation is to move to a stop gain/stop loss in place of a phase in process. In this scenario, the facility rate could not go below the facility's existing rate (stop loss) and could not rise more than $5 per day until the full PDPM implementation date of January 1, 2027, as stated in the budget.
This solution:

1. Mitigates wild fluctuations in rate related to nothing more than transition to the PDPM payment system.
2. It also eliminates punishment through a reduction of rate for simply changing to a new system and minimally rewards those that are diligently working towards the full transition to a new system.
3. It allows MDS Assessment Nurses to operate within a single system.
4. MDS Assessment Nurses will have time to train. Rather than having PDPM assessments impacting rates starting on April 1, 2025, with a stop loss/stop gain, the assessments negatively impacting rates would not being until April 1, 2026.

For these reasons, we respectfully request that 3 PDPM categories (Nursing, Speech Language Pathology and Non-Therapy Ancillary) be used. We also request that we do not splice two systems together but rather adopt a stop loss/stop gain methodology for the transition year to allow time for training.

Private Rooms

The Private Room legislation has proven to be a very positive tool with regards to resident quality. The reduction in opportunistic infections is beneficial for all residents. COVID emphasized the importance of private rooms for infection control and Ohio is truly cutting edge in this program. We are currently experiencing outbreaks in Ohio facilities in Influenza, RSV, COVID and Norovirus. Private Rooms are an exceptional tool in mitigating the spread of these infections.

HB 33 capped the volume of dollars that could be attributed to this program. This effectively placed a cap on the number of private rooms that could be put into place. The last numbers OHCA has seen indicate approximately 28,000 out of the state of Ohio's 80,911 total beds have been approved under the Private Room program. These numbers would seem to indicate the majority of the CON changes to create more private rooms has already been completed. Any additional expenses beyond the cap would seem to be minimal and well worth the gains in clinical quality.

The proposed amendment is simply to eliminate the cap to allow for more private rooms. It also addresses some language where private room payments and applications would be, or has been, cut off for new applicants.

Fair Rental Value/Capital

Capital costs are a longstanding issue and have not been addressed for more than a decade. Rates for Capital Costs have been frozen since 2014. Congress began addressing this issue in discussions for the last biennium and directed the Ohio Department of Medicaid (ODM) to bring a proposal for a Fair Rental Value to the General Assembly in 2023 (HB45). However, ODM failed to comply with that request.

Capital rates are designed to assist facilities with capital expenditures, renovations, building improvements and similar costs. Obviously, with the capital rates frozen for 11 years, facilities have been limited in completing renovations and upgrades that would benefit and improve the resident's quality of life. The current system is broken and not capable staying current and relevant. It pays the exact same rate to every provider in the same geographical peer group using information that is more than a decade old no matter the value of their property.

Our Amendment would eliminate the current system and replace it with a Fair Rental Value system. Similar systems have been utilized in other states, as well as Ohio. Some form of this system is already in place in Ohio for the ID/DD community.

This new system would use appraisals to determine fair value rates for each facility. To transition to this system, we would recommend a capital rate freeze for this biennium. This would enable the system to be built, the facilities to obtain appraisals and methodologies to be worked out well in advance. It could be built and put into place for the biennium starting July 1, 2027.

Closing

Thank you for the opportunity to testify before you today. If you have any questions, please feel free to contact me.
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