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Testimony of Eli Faes
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Senate Finance Committee

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Good morning, Chair Cirino, Vice Chair Chavez, Ranking Member Hicks-Hudson and members of the Senate Finance Committee. My name is Eli Faes, Public Policy Director with LeadingAge Ohio, and I appreciate the opportunity to share our thoughts on the operating budget for SFY 2026-2027.

LeadingAge Ohio is an association representing nearly 400 members that serve older Ohioans across the buckeye state. In a given year, we employ roughly 35,000 and serve nearly 400,000 older Ohioans. Our members include affordable and market rate senior housing, life plan communities, nursing homes, assisted living, home health, hospice, and palliative care, as well as adult day services. LeadingAge Ohio also supports the PACE Association of Ohio, that represents the four organizations standing up the Program for All-inclusive Care for the Elderly (PACE) across the state of Ohio.

What differentiates our members from their counterparts is that they are guided by mission and values. Over 90% are not-for-profits, over 70% are founded by or tethered to faith-based organizations.

Today I'd like to speak to some areas for your consideration to be changed or included in the substitute version of House Bill 96.

Nursing Facilities: Updating Ohio's PDPM Case Mix Adjustment, Private Rooms, and Environmental Quality Capital Payments

The Ohio Medicaid reimbursement formula includes a number of different components, each dedicated to different costs that nursing homes experience. Some of these are fixed costs, such as the portion that pays for capital expenses like the building or lease payments, or the portion dedicated to key positions like administrators, activities coordinators, and the like. These do not dramatically increase depending on characteristics of the patient population.

The largest component is that which is dedicated to direct care expenses: nurses, nurse aides,

therapists. This is a variable cost: nursing homes that serve individuals with higher acuity conditions will increase the number of direct care staff to meet greater care needs. The Centers for Medicare & Medicaid Services (CMS) uses a case mix adjustment factor, derived from data collected via patient assessments, which it applies to the direct care price to account for this variation of acuity.

In 2019, CMS transitioned from an old case mix calculation method (RUGS IV) to a new one, called the Patient-driven Payment Model, or PDPM, for the Medicare population. PDPM is made up of five sub-parts (nursing, physical therapy, occupational therapy, speech-language pathology, and non-therapy ancillary), and was developed for use with the short-term Medicare population.

Most states, including Ohio, have used an optional state assessment (OSA) that has allowed them to continue to rely on the old case mix methodology while they determine what blend of the PDPM components makes the most sense for their populations. It is now time for Ohio to make the permanent transition to PDPM, and the executive and House budgets propose the simplest method, relying on only one of the five different components of PDPM. The executive budget also phases in PDPM over three years, by gradually increasing the portion of the case mix relying on PDPM for rate settings in January 2026, July 2026 and July 2027.

Our proposal would modify the provision in the following way:

- We suggest using three of the five components of PDPM in determining the new case mix score rather than one. While we agree that the nursing component is the most important, there are two other components that also drive costs to a lesser extent. Individuals with dementia and cognitive impairment require more time for feeding and behavioral management, and the speech / language pathology score captures these individuals. Additionally, the non-therapy ancillary component captures individuals with conditions like diabetes. We propose a blend of 70 percent nursing, 20 percent speech / language pathology and 10 percent non-therapy ancillary, to more accurately capture cost drivers for the Medicaid population. We have submitted an amendment (SC1009) that accomplishes this in a budget neutral way.

Private Rooms

In the last biennium, the legislature approved the creation of an add-on payment for private rooms. Implemented in December 2024, the private room payment is the first of its kind in the country, and already, Ohio has become a model that other states aspire to.

Private rooms not only enhance individual dignity, but they are a key preventative measure for infection prevention and control. Studies of the COVID-19 pandemic noted that the prevalence of private rooms slowed the spread of the disease, a pattern that we've seen repeated in more recent infectious outbreaks like influenza and RSV.

Unfortunately, the House made changes to the private room add-on that we believe misses the mark. It is our belief that they intended to maintain the previous budget's investments in private rooms while restructuring the way spending is controlled. The House-passed version accomplishes this by capping the number of private rooms approved rather than capping the funding. Currently, over 28,000 private rooms have been approved for private room payments by the Department of Medicaid. At any one time, we expect that around half of these will be occupied by a Medicaid-eligible individual, though that figure is still just an estimate. We don't have the utilization data yet.

The House proposed to cap the total number of private rooms at 15,000, presuming that only 2,000 more rooms may be approved, and then only half of them would receive the payment. However, nursing home rooms are not assigned by payor, nor would we ever want them to be. Rather, an individual may enter a nursing home initially on a short-term stay (over 85 percent of stays begin this way) or as private pay, and then later, they may become eligible for Medicaid either because their needs are more long-term than originally anticipated or because they spend down their assets and subsequently qualify for assistance. There are no Medicaid-designated areas of nursing homes. For this reason, the number of rooms that *could be* occupied by Medicaid-eligible individuals will necessarily be significantly higher than those that actually are.

For this reason, we support either raising the number of rooms from 15,000 as was specified in the House-passed budget to 30,000 or reverting to the original $160 million dollar amount cap that is currently in place.

Environmental quality

The capital portion of the reimbursement formula is long overdue for being restructured. The last few budgets have failed to rebase this portion of the formula, so reimbursement is still based on capital cost data from 2014. Furthermore, its structure neither incentivizes nor rewards providers who reinvest in their buildings to enhance the quality of care. Rather, a price is set based on the 25th percentile of capital costs of all providers in a peer group. Any improvements that are made by an operator to distinguish their physical plant – whether it is investment in additional common areas, larger rooms, high-speed internet or exterior grounds – are not rewarded.

We support using the upcoming biennium to develop a proposal to pay for the quality of the environment of care, which includes an appraisal of the building and takes into consideration other factors that may enhance quality of life for residents. This proposal will have no fiscal impact on this biennium. Rather, any recommended changes would be advanced to the SFY 2028-2029 biennium.

Hospice Care in Nursing Homes

Hospice programs are required by federal law to bill Medicaid for the nursing home room and board for residents in their care, and then "pass through" these payments to the nursing home.

Under the current arrangement, Ohio only pays 95% of the cost of nursing facility care, and the hospice pays their nursing home partner 100 percent, absorbing the difference as a financial loss. While we would like to see this rectified completely and require the state to pay hospices the full cost of room & board of their patients, LeadingAge Ohio would support any increase above 95 percent in this budget (amendment SC1048).

Caregiving Workforce

Ohio is a leader among states in innovative strategies to retain talent and drive workforce development. In particular, programs such as Tech Cred and the Individual Micro-credential Assistance Program (IMAP) are effective tools to support growing our workforce in critical areas of need and upskilling existing workers already attached to an employer.

Home health and personal care aides are Ohio's #1 top job, with over 15,000 current openings statewide, representing a 13.7 % vacancy rate, with an additional 2,300 jobs annually being added annually. Nurse assistants, which typically work in nursing homes, are also among Ohio's "top jobs" with just over 7,700 current vacancies, representing a 10.9 % vacancy rate.

LeadingAge Ohio, along with other aging network advocates, believes that a first step towards standardizing and promoting caregiving careers is for the state of Ohio to take an active role in promoting these keystone professions. We support the expansion of the IMAP program to include training in these direct care workforce areas, to usher individuals into caregiving careers as well as upskill those that have already committed to the vocation (amendment SC2110).

Ohio Housing Trust Fund

Previous to establishing the Ohio LIHTC program in the last budget, the Ohio Housing Trust Fund (OHTF) was the principal, though modest, driver for affordable housing development and services in the state. In particular, it offers flexible funding that was leveraged to get project financing to completion, and it also funds critical services that enable low-income renters to remain in the community like home modifications and service coordination. A small number of service coordinators in low-income senior housing connect older Ohioans to important supports like food benefits, transportation services, and home-based care, enabling them to remain in their communities rather than transitioning to higher-cost care settings. Low-cost service coordinators are among the best healthcare investments that the state of Ohio can make, offering the minimum level of preventative services that can make the difference in preventing entrance into the highest-cost care settings: emergency rooms and nursing homes. Defunding the OHTF is short-sighted and will harm the older Ohioans that rely on these service coordinators. We support an amendment that would reverse this House change and institute a study committee to look at the OHTF to inform any future improvements that could be made to the fund.

We believe these initiatives would ensure that all Ohioans have dignity, choice and access to the supports they need as they age. We appreciate the opportunity to share our thoughts and welcome any questions you may have.