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Before the House Finance Committee
Testimony on House Bill 96 As Passed by the House

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Good morning, Chair Romanchuk, Vice-Chair Huffman, Ranking Member Liston, 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.

I'm here today to discuss the House-passed version of HB 96 as it affects our skilled nursing facility (SNF) members. Specifically, I will address our concerns about what the House did or did not do on three specific policy issues.

Our first policy concern with the bill as passed by the House relates to the Medicaid incentive payment for private rooms in SNFs, which only started in December 2024. The House budget caps the number of private rooms that the Department of Medicaid (ODM) can approve or pay for at 15,000. This cap is unworkable because it reverses the General Assembly's policy direction in the last budget, HB 33, to allow Medicaid beneficiaries in SNFs broad access to private rooms up to an annual funding limit of $160 million.

ODM implemented this policy direction in accordance with the statutory language and has approved 28,000 private rooms, far more than the House's cap would allow. These private rooms are currently operational. Residents are in them, and providers are billing for the incentive payment. According to Director Corcoran when she testified in House committee, there is still space to approve additional private rooms under the funding cap in current law.

The House cap would prevent further growth of private rooms, which both the General Assembly and Governor DeWine encouraged just two years ago. Even more challenging is that to implement the House language, ODM would have to rescind approval of nearly half of the existing private rooms. Many SNF operators gave up licensed beds and spent money renovating

their buildings to create private rooms. Canceling private rooms that already are operational would lead to mass relocation of Medicaid residents.

As the legislature and administration agreed in the last budget, HB 33, private rooms are good public policy. 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.

It is not clear to us why the House sought to roll back private rooms only a few months after the program became operational. There may have been confusion about how the private room program works. Fifteen thousand private rooms, where the House set the cap, is approximately half of the estimated 30,662 private rooms that could be approved under the current $160 million cap. The dollar cap assumes that approved rooms are used 50% of the time by Medicaid residents and 50% of the time by residents with other pay sources.

Perhaps the House thought only 15,000 private rooms were needed to serve the assumed number of Medicaid residents under the dollar cap. That would be true only if the rooms were 100% occupied by Medicaid beneficiaries, which is not the case. Current law specifies an assumption of 50% Medicaid utilization, which means if there were only 15,000 private rooms available, only 7,500 Medicaid residents would be assumed to be in them.

The existing statute reflects reality in Ohio SNFs. Residents with a variety of pay sources currently are using private rooms in SNFs. Medicare and Medicare Advantage patients who are in the facility for short-term, post-acute rehabilitation stays typically have private rooms. The same is true of private-pay residents. SNFs also serve residents with VA benefits, private insurance coverage, or hospice elections, all of whom may be in private rooms. The legislature structured and CMS approved Ohio's program with this reality in mind – that residents with various pay sources will utilize private rooms.

The House amendment may have been motivated by a desire to control spending on private room incentive payments. Given this year's tight budget environment, making sure spending on private rooms doesn't exceed the $160 million appropriation is a legitimate goal, but the cap in the House budget is not the right way to meet that goal. Instead of being budget neutral, it would be a cut. The right way to ensure that spending stays within the limit is simply to eliminate the cap on the number of private rooms and restore the spending cap in current law.

The second policy issue that we feel needs to be addressed in HB 96 is updating Ohio's case-mix system for direct care payment rates to reflect federally-mandated changes. The executive budget proposal on this topic raises several concerns that were not resolved in the House-passed budget.

The case-mix system adjusts each SNF's direct care rate to account for the acuity of its residents: their cognitive and health conditions and their service needs relative to other residents. The

system or "grouper" historically used in Ohio and many other states is called Resource Utilization Groups (RUGs). It takes data elements from a nationally-standardized resident assessment required by CMS, the Minimum Data Set (MDS), to determine acuity scores for each resident.

Over the past few years, CMS has phased out RUGs and the version of MDS that supports RUGs and replaced 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. PDPM is a methodology designed for Medicare, not Medicaid. Medicaid residents are very different from Medicare residents. Nonetheless, CMS instructed states using RUGs for Medicaid to move to PDPM by September 30, 2025. After that date, CMS is canceling both RUGs and the assessment instrument currently used to populate RUGs, the Optional State Assessment (OSA).

In HB 33, with the end date still two years away, the General Assembly set up an interim case-mix system that gave providers the choice to freeze their case-mix scores (commonly called "case-mix index" or "CMI") at the March 31, 2023, level or continue completing OSAs and having a new RUGs CMI calculated every 6 months per previous practice. 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 case-mix system to use beginning July 1. The DeWine Administration included their ideas in HB 96. They proposed to convert to PDPM, but to use only one of 5 components of the federal model. They also proposed to phase in the new methodology over 18 months by freezing all SNFs' CMIs for six months, through December 31, 2025. Then during 2026, 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 support some aspects of the administration's proposal but request several adjustments and corrections.

First, there are two technical problems with the language currently in HB 96. One relates to 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 direct care 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 gigantic rate cut for all Ohio SNFs. We suggest adjusting the three peer group prices by the percentage difference between the average CMI under RUGs and PDPM, which means multiplying each peer group's price by about 2.13. This approach would maintain budget neutrality in the transition.

Second, HB 96's language on the 6-month freeze is erroneous and could not be implemented as written. It calls for freezing each facility's quarterly RUGs CMI for June 30, 2025. The problem is that a majority of SNFs will not have a June 30 quarterly score because they froze their CMIs over a year ago and have not had quarterly scores since then. The non-frozen buildings also will not

have quarterly scores when ODM does the July 1, 2025, semi-annual rate-setting because quarterly scores are not finalized until after a 45-day data correction period. We suggest amending this language to use the provider's already-frozen score or, for the non-frozen facilities, the score that normally would have been calculated for the July 2025 rate-setting - the average of the scores from the fourth quarter of 2024 and the first quarter of 2025.

Beyond these technical issues, we agree with the administration's proposed timeline of a 6-month CMI freeze and gradual implementation of PDPM over the following 12 months. We also agree with moving to 100% PDPM as of January 1, 2027. However, we do not agree with the administration's blending approach for the phase-in because it could result in deep direct care rate cuts starting in just 6 months. For example, if moving to full PDPM would reduce a facility's rate by $60 per day, the administration's phase-in would impose a $20 cut on January 1, 2026, and a $40 cut on July 1, 2026. These cuts would be purely because the formula has changed, not because of any change in residents' care needs.

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, when PDPM is implemented, approximately half of the state's SNFs will see rate increases and the other half will see rate cuts, even though everyone is still serving the same residents and delivering the same care as before.

Based on our modeling of the impact of moving to PDPM, some of the increases and cuts would be quite large, up to $50-60 per day. We are particularly concerned about the cuts. A sudden rate reduction of that magnitude would jeopardize a SNF's ability to continue operating. It could lead to closures and the bad outcome of 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 as receiving a windfall if their rates go up by a large amount just because of a change in methodology.

The purpose of the phase-in is 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 believe the transition to PDPM should be a glide path, not a cliff. We suggest limiting both the upside and downside risk – the winners and losers - during the transition to a very manageable $5 per day. Because the stop loss and stop gain would be the same, this approach would be budget neutral. Larger cuts and increases would not occur until January 1, 2027, based on assessments done starting April 1, 2026. By then, the nurses who prepare MDSs would have had 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. Once the phase-in period is over,

SNFs would feel the full impact of moving to PDPM, positive or negative, but hopefully anyone who would be negatively impacted will have time to mitigate the cuts as much as possible.

In addition to the administration's phase-in approach, we also disagree with their proposal to use only one PDPM component to measure acuity of Medicaid residents. Instead of using only the nursing component and ignoring the other pieces of PDPM, we recommend blending three PDPM components to create an acuity measure that better reflects the Medicaid population in SNFs. Moving to a blend is the latest trend in other states that are dealing with this same issue. Under our suggested blend, 70% of the overall CMI would be from the nursing component, with the remainder coming from the speech-language pathology component (20%) and the non-therapy ancillaries component (10%).

These additions would recognize common conditions among Medicaid residents that are not captured by the nursing component alone. Examples of conditions more prevalent among Medicaid residents than Medicare residents are cognitive impairment (dementia) and diabetes. While we agree that the bulk of CMI should come from the nursing component, a panel of national and Ohio PDPM experts recommended adding in a bit of the other two components to make PDPM better-suited for Medicaid residents.

In addition, using the nursing component alone results in a larger spread between winners and losers. Nursing-only generates bigger cuts and bigger increases than the blended model we are proposing.

As part of moving to PDPM, we also propose eliminating 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 ($130 plus around $30 for room and board), let alone the average SNF daily rate of around $275. The low-acuity residents currently are excluded from the CMI calculation, but would be added back in if the $115 rate is eliminated, keeping the change budget-neutral.

The third policy issue, which is not addressed in the executive budget or House version, is the capital component of the SNF payment rate. This rate component is intended to reimburse SNF providers for the capital costs of their buildings (that is, construction, renovation, and capital equipment). The capital reimbursement methodology is broken because the rates have been frozen at 2014 cost levels since 2016 and because the current formula pays every provider in a 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. Just as direct care rates are adjusted for acuity, capital rates should be adjusted for the value of the building.

In late 2022, the General Assembly passed HB 45, which included a requirement for ODM to present a proposal for a new capital methodology based on fair rental value (FRV) to the legislature by October 1, 2023. Unfortunately, though, ODM did not comply with this legislative directive.

To reform the broken capital rate methodology and effectuate the legislative intent to move to a FRV system, we suggest adding FRV to HB 96. It takes time to put the new system in place, so we recommend maintaining the current freeze for another two years while a new system is ramped up. Starting July 1, 2027, the old capital rates would be replaced by a new environmental quality incentive payment based on a FRV 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.

We also suggest 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 develop the structure for the new methodology, including adopting rules and obtaining CMS approval of a Medicaid 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.

This proposal is budget-neutral for the FY 2026-2027 biennium because ODM would continue to pay the frozen capital rates. There would be added cost in the following biennium, but the July 1, 2027, start date would allow the General Assembly to take another look at the new methodology in the next budget. The legislature could review the implementation and cost of the environmental quality incentive payment and determine whether any revisions are needed.

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