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Senate Medicaid Committee

April 29, 2025

Good afternoon, Chair Romanchuk, Vice Chair Huffman, Ranking member Liston and members of the House Finance Committee. We appreciate the opportunity to share our thoughts on the operating budget for SFY 2026-2027, and in particular for today, the nursing home reimbursement proposals contained within it.

LeadingAge Ohio is an association representing nearly 400 members that serve older Ohioans across the buckeye state including 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. 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 will highlight four important reforms for Ohio's nursing homes. Nursing homes are an important part of the continuum for individuals whose needs either cannot be safely met in community, or who lack caregiver support that makes community-based care feasible.

Quality-based payment

The Governor's budget maintained quality incentive payment (QIP), one component of the nursing home formula that has been particularly effective in driving quality of care for Ohio nursing homes. From 2020 to 2025, Ohio nursing home performance on the four key measures included in the QIP improved performance by driving down incidence of pressure ulcers (43.6%), urinary tract infections (63.2 %), incidence of catheter lines being left in (63.6 %) and residents experiencing decreased mobility (35.4 %).

In July of last year, five additional measures were added to the QIP calculation (activities of daily living, prescriptions of antipsychotic medications, falls, nurse staffing and census), and we are

already seeing the improvement in performance on these measures.

Ohio is a leader among states in the portion of its payment formula tied to quality measures, and we are pleased to see this continue.

Updating Ohio's case mix adjustment

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 ratesettings in January 2026, July 2026 and July 2027.

Our proposal would make two modifications to the executive proposal:

- First, 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.

- Second, rather than phase-in of the new case mix over three years, we suggest that we move forward with implementation but not penalize providers for care assessments that have already been completed. Because of the delay in assessments being collected and verified, both July 2025 and January 2026 case mix would be built off of data completed before the budget language is passed. We agree with the Administration's six-month freeze to rates, and following that, we support a period when providers are not penalized as a result of the transition and have sufficient time to adjust to the new system.

  Obviously, there will be a cost associated with this, so we are recommending that during the transition period, no provider see more than a $5 increase in their reimbursement as a result of the case mix adjustment as a cost-containment measure. We estimate the additional cost of this would be $16 million all-funds for each FY 2026 and 2027 ($5.7 million per year state share).

Private rooms enhance quality & reduce spread of infection

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 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-passed language 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 raising the number of rooms from 15,000 as was specified in the House-passed budget to 30,000.

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.

I've already shared Ohio's success in driving quality with payment: we know that incentives work. We believe that we could apply the same logic to the physical environment that we have to clinical quality of care by rewarding those providers that invest in upkeep, renovations and modernization of their physical plant.

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.

We appreciate the opportunity to share these recommendations to continue to advance high-quality care in nursing homes, and make Ohio a great place to age for all levels of care needs.