Senate Medicaid Committee
Testimony on HB 96 – FY26-27 State Operating Budget
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Current Medicaid Payment Methodology Concerns

Chairman Romanchuk, Vice Chair Huffman, Ranking Member Liston, and Members of the Senate Medicaid Committee, I thank you for the opportunity to provide testimony on House Bill 96. My name is Dave Mannion, and I am the CEO of Copeland Oaks and Crandall Medical Center located in Sebring, OH.

I am testifying today regarding the inequities of the Quality Incentive Payment (QIP), which comprises a major portion of the daily Medicaid rate paid to Crandall Medical Center. Crandall is a 150 bed, all private room, dually certified skilled nursing facility (SNF) as part of the Copeland Oaks Continuing Care Retirement Community. Crandall has a long history of high quality care, has always been a leader in providing the highest levels of direct care hours in the state, a consistent 4 and 5 star CMS facility, and has even been recognized by Newsweek Magazine as one of the top nursing facilities in the state for the last 3 years in a row. Our resident and family satisfaction surveys also reflect our rich tradition of high quality care, provided in an environment of Christian love and compassion. In spite of being nearly twice the size of the average Ohio skilled nursing facility, Crandall just finished its annual state survey and received only 4 minor citations, less than half the average number of citations for all SNF's.

The last Ohio biennium budget generously acknowledged the urgent necessity for increased Medicaid reimbursement to Ohio's skilled nursing facilities. However, a glaring inequity did not make that a reality for Crandall Medical Center. As part of the last budget package, facilities that scored in the lowest 25th percentile in a newly designed point system based on nine resident quality measures would be penalized by receiving zero dollars in the QIP portion of their Medicaid rate. The Quality Incentive Payment is a very significant portion of the rate and is generally between thirty five and fifty five dollars per day. At our facility, a loss of forty five dollars per day equates to over one million dollars annually. Crandall spends every dollar taken in on our resident service model and relies on donations in addition. That's one million dollars stripped from available funds for resident care. If care was sub-standard, that's certainly a painful penalty to incentivize better quality care; but this simply not the case as has been proven by a 50 year history of quality care, generous staffing, good surveys, high resident and family satisfaction, 4 and 5 star CMS ratings and very positive feedback by state Ombudsmen when in our building. The gist of the aforementioned inequity lies in the fact that Crandall is home to a significantly older population than what the typical skilled facility would serve, with most of our residents coming from within our retirement community.

The state-wide average SNF has 25% of its population aged 85 and over, while Crandall is over twice that at 58%. This equates to a census of approximately 29 for the average facility, while Crandall cares for 70. The state-wide facility average % over 90 years of age stands at around 20%, while Crandall averages nearly twice that at 36%, equating to a population of 18 – residents over the age of 90, while Crandall cares for 41.

- **The quality points are awarded on the following measures:**
  - **Increasing ability to perform Activities of Daily Living or "ADL's"**
  - **Ability to move worsened**
  - **Number of falls with major injury**
  - **Number of high risk pressure ulcers**
  - **Number of urinary tract infections**
  - **Number of catheters used**
  - **Number of antipsychotic meds used**
  - **Total nurse staffing**
  - **Occupancy greater than 75%**
- **Nurse staffing levels and antipsychotic meds prescribed may be fair quality measuring tool for all skilled nursing residents over 65. (Unless the facility specializes in antipsychotic behaviors)**
- **The incidence level for falls requiring a trip to the hospital is 75% higher for a person over age 85 vs. an 80-84 year old, and nearly 3 times that of a 75-79 year old. The statewide average age for a nursing home resident is 78. In Crandall - 80% of our residents are at least 80 years old, nearly 60% are at least 85, with nearly 40% over age 90, including 3 over 100 years old.**
- **Activities of Daily Living (bathing, dressing, toileting, and transferring, eating, continence) are in a state of rapid decline for residents over age 85. In fact, past studies have shown that a resident over 85 is 3 times more likely to need help with ADL's than a resident aged 75 to 84. Imagine what that number turns into over age 90!**
- **Ability to walk independently. (This is the only measure that reflects a minor reduction in point penalty based on age and other factors – but not enough to help most facilities).**
- **Along with increased longevity, especially in frail elderly patients, there is a higher rate of pressure ulcers due to a higher rate of incontinence and cognitive impairment with dementia - coinciding with immobility.**
- **According to the National Library of Medicine (NLM), "Urinary Tract Infections are common amongst the oldest old". Of note, with those over age 85 – cognitive impairment, ADL disability and incontinence are independent predictors. From ages 65-85 the incidence rate for a female UTI is 10%, Over age 85, the rate increases to 30%**
- **Similarly – the need for catheters increases dramatically for those over the age of 85.**

While the sole intention of the Quality Incentive Payment system is to increase quality, in some instances it promotes the opposite effect. Crandall treats the most severely aged and vulnerable demographic of our populace. Eliminating all QIP funding penalizes facilities serving those most at risk in order to reward facilities serving a younger, less physically and cognitively impaired populace; hence paying them more for residents that require less daily assistance and care. As long as the current measures are the determining factor for receiving the QIP payment, I would advocate that points be added for facilities with such a dramatic number of residents in the most advanced age groups.

Each facility CMS iQIES report categorizes residents by age group compared to statewide averages. If a facility has more than twice the percentage of their resident population aged 85 and over, the facility should receive 3 quality points. This is similar to the 3 points awarded for occupancy of 75%.

Our facility is home to 15 residents aged 95 to 108, members of "The Greatest Generation". Some are WW2 and Korean War Veterans; people that sacrificed so much to give the world freedom, now are becoming residents some facilities would avoid as a threat to their QIP funding. I know this is not your intention.

I know there is no perfect system of measuring quality and that your efforts are solely focused on improvement of care. I would ask that you consider an amendment we have submitted through our State Senator Al Cutrona to make this inaugural system of payment a little better aligned with your cause. Since all of the measures are dramatically impacted by resident age, the amendment will level the playing field for skilled nursing facilities because a facility with a younger population has less risk of incidents of the quality measures impacted above. There are very minimal allowances for age variance in the current scoring system. This measure helps insure adequate resources for our most frail and vulnerable residents.

On behalf of those I serve, thank you very much for your time and consideration and the opportunity to testify before you today. I would be happy to answer any questions you might have.

Dave Mannion
CEO
Copeland Oaks & Crandall Medical Center