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Testimony Before the House Health and Human Services Subcommittee

House Bill 33
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Good morning, Chair Carruthers, Ranking Member Liston, and members of the subcommittee. I am Pete Van Runkle from the Ohio Health Care Association (OHCA). I appreciate the opportunity to appear before you again, this time to discuss skilled nursing facilities (SNFs) in relation to the state budget.

As I mentioned last month, OHCA is a trade association that represents providers of long-term services and supports (LTSS). We count among our membership assisted living communities, home care and hospice agencies, providers who serve people with intellectual and developmental disabilities, SNFs, and a host of businesses that furnish goods and services to those health care providers. The majority of our members are SNFs, which is why we are here today.

As you heard in full committee testimony from the state agencies, House Bill 33 as introduced does not address funding for SNFs in any way. That is the case notwithstanding language in House Bill 45 from last December that expressed clear legislative intent both to rebase Medicaid rates for SNFs in this budget using 2022 cost report data and to consider a reimbursement incentive to give Medicaid residents the privacy and dignity of private rooms.

While his budget is silent on rebasing and SNF rates in general, the Governor and the Administration have acknowledged this legislative intent in the State of the State address and on various occasions afterward. Just last week, at the inaugural meeting of the Governor's task force on SNFs, the Governor said "no doubt" SNFs need more funding. He also restated his commitment for the task force to look at quality of care and life in our SNFs.

Reimbursement and quality are tied together. The common thread that binds them is workforce. I will elaborate on that tie and what we are proposing for it later in my testimony, but first I would like to give some background behind the statement of intent in House Bill 45.

The story actually starts with the last budget bill, House Bill 110 of the 134th General Assembly, when the legislature added a provision creating a temporary joint committee, the Nursing Facility

Payment Commission. This provision was the legislature's response to concerns we and others raised in the last budget process about various aspects of the 17-year-old formula for SNF rates. We contended, and contend today, that the formula was flawed at the outset and has become more broken in the intervening years since its creation in 2005.

The commission's charge was to take a deep dive into SNF reimbursement at a stage in the legislative session when it was possible to do so without the pressures of a budget bill. The commission, which included Representative Hoops as one of the House members, spent considerable time last summer thoroughly examining the SNF rate formula, rebasing, the quality incentive, private rooms, the impact of reimbursement on quality of care and life, and a variety of other issues. The commission process ultimately resulted in House Bill 45, with its statements of intent to rebase rates and to address private rooms in this budget and its creation of a "bridge" to those reforms by appropriating ARPA dollars as a short-term workforce fix.

Let's look a little more deeply at rebasing. Rebasing is a common concept in SNF reimbursement systems across the country. Rebasing recalculates rates to reflect changes in operating costs over time, as documented in annual cost reports that providers certify to the state. Under current law, which we are asking to change, Ohio rebases once every 5 years. This rebasing frequency is less often than is typical. Most states rebase every year or two. Another common feature is an adjustment factor for inflation in years between rebasings. Ohio does not currently have such a feature. The combination of relatively infrequent rebasing, lack of an interim inflation factor, and fundamental flaws in Ohio's reimbursement formula has caused our rates to lag behind our neighbors, as shown in Table 1.

Table 1
Current SNF Rates - Ohio and Surrounding States

State	Current Rate
Ohio	$232.07
Michigan	$251.69
Kentucky	$244.31
Pennsylvania	$290.44
Indiana	$272.64
West Virginia	$296.98

Another key issue relative to rebasing that we discussed with the commission is comparing rate to cost. It is critical that the Medicaid rate at least get close to covering a provider's costs of providing care. Otherwise, the facility cannot continue to operate.

Since its inception, Ohio's formula has not reimbursed even the average cost of providing care to SNF residents. There are reasons for that, which we will cover later. But the immediate problem that led to creation of the commission and informed the intent statement in House Bill 45 is that

today, without rebasing, rates have fallen extremely far behind cost. Table 2 shows what has happened to the rate-cost gap over the years since the current formula took effect.

Table 2
Ohio SNF Cost-Rate Comparison Over Time

Fiscal Year	Average Cost - Preceding CY	Average Rate July 1 of FY	Gap
2023	301.16	231.73	-69.43
2022	278.27	226.44	-51.83
2021	250.60	209.14	-41.47
2020	244.44	202.12	-42.32
2019	237.62	195.90	-41.72
2018	229.28	194.41	-34.87
2017	224.24	192.20	-32.05
2016	219.71	177.33	-42.39
2015	218.09	175.06	-43.03
2014	214.86	174.97	-39.90
2013	214.13	173.34	-40.79
2012	212.74	166.20	-46.54
2011	197.12	176.57	-20.54
2010	184.35	176.11	-8.24
2009	177.91	165.93	-11.98
2008	175.56	164.12	-11.43
2007	172.74	154.60	-18.13

The gap shown above is an average of $69 for every day of care to a Medicaid resident in Ohio – 14 million days in a year – based on 2021 costs. It is nearly a billion dollars of underfunding each year. Although the 2022 cost reports are not in yet, we know the gap grew even more last year, probably to more than $80 per day. By surveying 284 SNFs, we found that their 2022 direct care costs increased 4.85% and their ancillary and support costs grew 6.78% over 2021.

The gap grew so large because the last rebasing, which determined the rates the state still pays today, used 2019 costs. Those costs in no way reflect what providers are experiencing today and have experienced for the past three years. COVID-19, the workforce crisis, and general inflation combined to drive pre-pandemic costs up sharply. Table 3 shows per diem cost increases between 2019 and 2022 for the two main SNF cost centers, direct care and ancillary and support, which contain all of the labor costs.

Table 3
Ohio SNF Cost Changes 2018-2022

Year	Average Direct	Percent Change	Average Ancillary/Support	Percent Change
2018	$120.04		$83.39	
2019	$122.44	1.8%	$85.84	2.9%
2020	$137.52	12.6%	$95.25	11.0%
2021	$148.65	8.1%	$103.33	8.5%
2022 (est)	$155.86	4.9%	$110.36	6.8%

Since the beginning of the pandemic, the table shows that per-patient-day direct care costs have grown by 27% and ancillary and support costs by 28%. None of those cost increases are included in the current rates.

In the past when inflation was low, not rebasing for a couple of years or even longer – while not the best policy - had a less dramatic impact. But with the cost increases we have seen the last three years, the deep systemic flaw of rebasing only every 5 years without any inflation factor in the interim becomes glaring. The massive discrepancy today between costs and rates has SNF providers struggling to survive, even with occasional infusions of money from pandemic-related government programs. Many providers throughout the state are on the brink financially.

The financial struggle has a major adverse impact on quality of services. The Governor was not wrong to point out that serious problems exist in some of Ohio's SNFs. We too are aware of those quality issues and are very concerned about them. Although it is not the only explanation for some facilities having unacceptably poor quality, chronic underfunding is a key reason and in my opinion, the leading reason.

Let's examine the connection between Medicaid reimbursement and quality more carefully, starting with a couple of important facts. First, Medicaid pays for the care of 65% of SNF residents, making it the predominant payer. Second, close to 70% of the cost of operating a SNF is labor. If Medicaid does not pull its weight, providers do not have the money to pay for labor.

The quality connection runs through workforce, which is dependent on funding. No one seriously questions that quality is related to workforce, or in the parlance of SNFs, staffing. It is not just a numbers game, but numbers have a lot to do with it.

The Governor and Director McElroy pointed out, correctly, the Ohio ranks 39th in overall stars in the federal star-rating system. Star ratings are made up of three components: survey stars based on inspection results; stars for staffing levels; and stars for clinical quality measures. The federal Centers for Medicare and Medicaid Services (CMS) normalizes the survey stars because there are radical differences in the survey culture and stringency in different states. So every state has around the same average number of survey stars.

Where the states are differentiated is the staffing and quality measures stars. Ohio is 15th on the clinical quality measures, above average. On staffing, however, we are 47th. That is what drags down our overall rating. According to Bureau of Labor Statistics data, Ohio's SNFs lost 13.1% of their workforce from early 2020, when the pandemic began, to the second quarter of 2022, the most recent period available.

Ohio's low staffing ranking compared to the rest of the nation is borne out by the observed quality problems. Almost all of the most serious issues result from inadequate staffing, either numbers or competency or both. In some cases, it is because of the presence of temporary staff, who we refer to as "agency." These workers are not familiar with the patients and have no particular commitment to the facility or incentive to deliver good care. It is no coincidence that quality problems started to multiply the staffing crisis intensified and agency use skyrocketed. The average SNF's cost for agency staff grew an estimated 67% from 2021 to 2022 and an astounding 670% since 2019, the year used for the last rebasing. No provider chooses to use agency – it is more expensive and poorer quality. The vast expansion of agency in Ohio's SNFs happened because providers had no choice to staff their buildings. They could not find enough workers otherwise.

During the commission hearings last year, Scripps Gerontology Center presented another way of looking at the connection between reimbursement and staffing and, ultimately, quality. Scripps showed that there is an inverse relationship between staffing levels and dependence on Medicaid funding. In other words, the more Medicaid patients a facility had, the lower its staffing tended to be. We at OHCA found the same inverse relationship between Medicaid dependence and star ratings: SNFs with more Medicaid tended to have lower star ratings. Medicaid does not pay enough to fund adequate staffing, which leads to reduced quality.

Inability to staff buildings also leads to Ohio seniors losing access to SNF care. Since the pandemic began, 31 SNFs in Ohio have closed officially, and I am aware of at least three others that have not made it onto the state's list yet. Beyond that, an untold number of facilities are limiting admissions or not taking them at all because they do not have enough workers to take care of additional residents.

This subcommittee is well-familiar with the workforce crisis in long-term services and supports and its root in Medicaid rates that do not support competitive wages. SNFs are hardly immune from this systemic problem.

The statewide average wage for nursing assistants (STNAs) per the 2021 cost reports was $17.18 an hour. This figure is not the true average base wage, as it includes overtime, shift differentials, and other things providers did to try to cope with the staffing shortage. Providers could afford even this level of wages, which is well below the $20 per hour that we have been discussing as the market standard, only because of one-time COVID-19 stimulus cash that now is ending. We are concerned that absent rebasing, providers will not be able to sustain the wage increases they've already given. The impact on staffing is obvious.

As we consider how to improve quality of care and life in Ohio's SNFs, the answer has to start with rebasing, both now and in the future, to give providers the cash to compete in the marketplace for workers. Additional staff will help Ohio's standing on metrics like the staffing stars, but more importantly, it will give additional eyes to see call lights, additional hands to help residents with eating, mobility, bathing, and treatments, and additional ears to hear alarms when someone tries to leave the building.

We propose amending House Bill 33 to implement the General Assembly's expressed intent to rebase in this budget. We further propose that the rebasing amendment require using the median cost instead of the 25th percentile of cost. The 25th percentile is a serious system flaw that has played a major part in putting us in the situation we are in today, with such a large discrepancy between rates and costs. The median at least gets us to the middle instead of the bottom quarter. Ohio simply should not fund care for our seniors and people with disabilities at the lowest common denominator.

To avoid being in same position in the future, with growing costs outstripping stagnant rates, we propose changing from a 5-year to a 2-year rebasing schedule. More frequent rebasing is a long-term solution to shore up the SNF workforce and to prevent the need for crisis responses.

The Governor recognized that the legislature intends to rebase rates and added that rebasing should be tied to quality. We agree. That is why we proposed last fall, and continue to propose today, that 60% of any added money from rebasing go to the quality incentive component of the rate. This move would give Ohio by far the largest quality incentive of any state, making us a leader in this area. Not only would rebasing enhance the ability of all SNFs to secure the staffing necessary for quality, it would direct more funding to those providers who already have demonstrated that they can deliver quality.

Additionally, we propose expanding the dimensions of quality that are part of the incentive program. Currently, the quality incentive is based on four measures that are used in the federal start-rating system that I mentioned earlier. The legislature added a fifth measure, occupancy, for the one-time funding appropriated in House Bill 45. We propose to make occupancy a permanent part of the system in the first year of the budget and then to add, in the second year, three more clinical outcome measures that also are in the star-rating system. By July 1, 2024, Ohio's program would include all 7 quality measures for long-stay patients that the federal system uses, plus occupancy.

We further propose to retain permanently another reform to the quality incentive that was in House Bill 45: eliminating arbitrary barriers to participation in the program. This approach gives every SNF operator the incentive to improve their performance while not taking away critically-needed funding to make that happen. Every facility would receive an incentive that reflects how well they did on the specified measures. The incentive could be anywhere from nothing, if a facility got no points, to around $80 per day if they qualified for the maximum number of points.

We also recommend the legislature adopt another way to tie reimbursement to quality, a financial incentive for offering private rooms to Medicaid residents. Private rooms were discussed extensively in the commission process last year, resulting in intent language in House Bill 45 directing the Department of Medicaid to bring forward a private room legislative proposal. Based on Director Corcoran's response to a question on private rooms in full committee, we are concerned that ODM's full plate of other initiatives may prevent them from developing a proposal. As a result, we will offer language for a private room incentive to this subcommittee.

The quality-of-life benefits of private rooms have been obvious for a long time, and forward-thinking SNF providers have moved in that direction, as has CMS. It took the pandemic to shine a spotlight on the benefits for quality of care, namely for preventing spread of infections – not only COVID-19, but also pre-existing communicable diseases such as flu that can have severe negative consequences for people who already are medically compromised.

While not directly related to reimbursement, we have a final proposal that also is directed at improving quality. We recommend that the legislature insert last session's House Bill 466, which would regulate staffing agencies, into the budget. House Bill 466 was vetted in the House and favorably reported by the Commerce and Labor Committee, so we feel it is ripe for inclusion in the budget. The intent of House Bill 466 is to ensure that staffing agencies operate according to set standards, supply workers who are appropriately credentialed and prepared to provide high-quality care, and do not "gouge" SNFs, diverting even more money that could be better spent on actual employees. It is time for Ohio to join the parade of other states that have enacted staffing agency regulations.

Again, I thank you for the opportunity to speak with you today. I would be happy to answer any questions you may have now or through follow-up at pvanrunkle@ohca.org or 614-361-5169.