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Before the House Finance Committee
Testimony on House Bill 96 As Introduced

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Good morning, Chair Stewart, Vice-Chair Dovilla, Ranking Member Sweeney, 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 budget for only one of our member constituencies, skilled nursing facilities (SNFs). Specifically, I will address three policy issues relating to payment rates and also the prohibition in the executive budget on leasing a SNF from a real estate investment trust (REIT).

Medicaid reimbursement for SNFs is a perennial topic in every budget bill. HB 96 is no exception. I would like to start, though, by expressing our sincere gratitude for the outstanding work of the House and Senate in last session's budget, HB 33, to raise Medicaid rates and help offset the extreme cost increases SNFs saw during the early years of this decade, particularly in the cost of labor.

Experience with HB 33, however, shines a light on several areas where reimbursement policy changes are needed. We are proposing an amendment (HC0386, attached) that addresses three of those areas.

First is Ohio's case-mix system, which 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 or 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. Ohio uses the RUG-IV-57 model of RUGs.

More recently, CMS began to phase out RUGs and the version of MDS that supports RUGs and replace 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, and instructed states that were using RUGs for Medicaid to move to PDPM.

CMS delayed the phase-out of RUGs and the related MDS version during the pandemic, but afterward set a hard date of September 30, 2025, for states to transition. After that date, both RUGs and the MDS version currently used to populate RUGs, the Optional State Assessment (OSA), will no longer be available.

In HB 33, with the end date still two years away, the General Assembly put in place an interim case-mix system that gave providers the choice to freeze their case-mix scores (commonly called "case-mix index" or "CMI") where they were on March 31, 2023, 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 system to use beginning July 1. In the as-introduced version of HB 96, the DeWine Administration offers an idea. We support some aspects of the proposal but request several adjustments.

The administration proposes to use only one of the 5 case-mix-adjusted components of PDPM, the nursing component, and leave out the other 4. They would begin to phase in the nursing component throughout calendar year 2026, after a 6-month CMI freeze that ends December 31, 2025. Starting January 1, 2027, the nursing component would make up 100% of each facility's CMI.

Two things are important to know about the transition to PDPM. One is that PDPM was designed for short-stay Medicare residents who are in a SNF for post-acute rehabilitation and typically have a very different medical and cognitive profile than longer-stay Medicaid residents. The other is that 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, many of the increases and cuts would be quite large, up to $50-60 per day. We are particularly concerned about the cuts. Sudden rate reductions of that magnitude would jeopardize the ability of affected SNFs to continue operating and could lead to closures and unfortunately 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 to be receiving a windfall if their rates go up by a large amount just because of a change in methodology.

The problem of winners and losers is why the administration is proposing a phase-in. We agree that a phase-in is needed, but the administration's approach doesn't solve the problem. We also disagree with their proposal to use only one PDPM component to measure the acuity of Medicaid residents.

Instead of using only the nursing component and ignoring the other pieces of PDPM, HC0386 would blend three PDPM components to create an acuity measure that better reflects the Medicaid population in SNFs. Under this approach, 70% of 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 that are more frequent in Medicaid residents compared to Medicare residents are cognitive impairment (dementia) and diabetes, among others. While we agree that the bulk of CMI should come from the nursing component, we were advised by a group of national and Ohio PDPM experts that it is important to add in a bit of the other two components to make PDPM better-suited for Medicaid residents.

In addition, using the nursing component alone maximizes the winners and losers in terms of impact on their payment rates. Nursing-only generates bigger cuts and bigger increases than the blended model we are proposing.

The phase-in is intended 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 agree with the administration's proposed timeline of a 6-month CMI freeze and gradual implementation of PDPM over the following 12 months. HC0386 would make a technical correction to the language in HB 96 on the 6-month freeze, which cannot be implemented as currently written.

For the 12-month phase-in, HC0386 includes two changes. One would require ODM to adjust the prices used for setting direct care rates to account for 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 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 a gigantic rate cut. Our amendment would adjust the three 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 even things out globally, although not for each facility.

To address the impact on individual SNFs, HC0386 would use a different phase-in methodology than the administration proposed, while leaving the timetable intact. In HB 96 as introduced, 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 agree with moving to all PDPM as of January 1, 2027, but do not agree with the blending approach for the phase-in because it would result in rate cuts starting January 1, 2026. For instance, if full PDPM would cut a facility's rate by $60 per day, the administration's phase-in would impose a $20 cut on January 1 and a $40 cut on July 1. CMI is calculated from MDS assessments that were done in the past. The PDPM CMI for January 1, 2026, would be based in part on assessments done before HB 96 passes and before providers knew what the new system would look like.

HC0386 would prevent any rate cuts during the phase-in period. The first cuts would occur January 1, 2027, based on assessments done starting April 1, 2026. That means the nurses who prepare MDSs would 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.

The amendment also would limit rate increases for "winners" to $5 per day. Once the phase-in period is over, SNFs would feel the full impact of moving to PDPM, positive or negative, but hopefully providers who would be negatively impacted will adjust sufficiently either to eliminate or significantly mitigate the cuts. This phase-in policy would have some incidental cost, which we estimate to be $16 million all funds ($5.6 million state share) in each of fiscal years 2026 and 2027, because it allows a small amount of "gain" during the phase-in.

The last change HC0386 would make to the administration's PDPM plan would eliminate 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, let alone the average SNF daily rate of around $270. These residents currently are excluded from the CMI calculation because they are paid at the low rate. Under our amendment, they would be included in CMI, which would have the effect of lowering rates slightly for SNFs serving low-acuity residents.

The second policy issue addressed in HC0386 is availability of private rooms in SNFs. 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.

The private room program proved to be very popular once it finally kicked off last December. As of late January, the Department of Medicaid (ODM) had approved nearly 28,000 private rooms for incentive payments, which amounts to more than a third of the 80,911 beds in certified SNFs

in Ohio. Thousands of beds were taken out of the system to convert semiprivate rooms into private rooms. Residents all across the state are benefiting from this program, which to our knowledge is unique in the country.

But there is an impediment to further expansion of private rooms to serve even more SNF residents. HB 33 capped the number of private rooms that can be approved by limiting the total dollar amount of the incentive payments in a fiscal year. ODM is only allowed to approve the number of private rooms that would fit under the cap, assuming 50% utilization of approved private rooms by Medicaid residents.

Director Corcoran testified in Medicaid Committee that there is still space under the cap for more private rooms. She also noted, though, that the space depends on the percentage of actual Medicaid utilization – whether it is above or below the assumed 50%. There is a risk that during fiscal year 2026, ODM's ability to approve more private rooms could evaporate because actual utilization turns out to be greater than 50%. Moreover, ODM issued a memo late last year stating that they will cut off incentive payments to all *approved* private rooms if the cap is breached sometime in FY 2026.

To remove these risks and support Ohio's policy of expanding private room availability, our amendment would eliminate the cap and also fix a glitch in the statutory wording that prevents some providers from adding private rooms. We feel this issue needs to be addressed in HB 96 so we don't find ourselves in place where private room approvals and payments are cut off, but the opportunity to address the issue has already passed.

There may or may not be a cost to this change because actual Medicaid utilization and the number of private rooms that would be added over the next two years are both unknown. If utilization is 50% or less, more private rooms can be added below the cost cap. If it is greater than 50%, there would be some additional cost, although we believe it would be minimal. Only a comparative trickle of private rooms have been added in the 5 months since the original mass approvals. The vast majority of the approvable private rooms already have been approved. A reasonable guess of the maximum cost exposure over the biennium might be $22.5 million all funds ($7.9 million in state share). But that number is totally speculative, and there may be no cost impact at all.

The third policy issue that HC0386 would address is the portion of the SNF payment rate that in theory reimburses providers for the capital costs of their buildings (that is, construction, renovation, and capital equipment). The current rates for capital don't serve that function because they are frozen at 2014 cost levels. HB 33 continued the freeze, but the problems with capital rates were supposed to be addressed shortly after the bill passed.

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 to the legislature by October 1, 2023. Unfortunately, though, ODM did not comply with the legislative directive, leaving the capital rate unaddressed for another budget cycle.

In the executive version of HB 96, the administration again fails to take the broken capital rate methodology. In addition to being based on 2014 costs, the current formula pays every provider in each 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. The system is simply inequitable. Just as direct care rates are adjusted for acuity, capital rates should be adjusted for the value of the building.

HB0386 would scrap the current capital rate methodology after leaving the freeze in place 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. Following the legislative intent from HB 45, the incentive payment would be based on a fair rental value 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.

The amendment also includes language 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 put in place the structure for the new methodology, including the rules, and secure CMS approval of the necessary 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. No change to the Medicaid appropriation in HB 96 would be needed because the old, frozen capital rates would continue to apply during the biennium.

This timing also would allow the legislature, in the next budget, to review progress on implementing the environmental quality incentive payment and whether any revisions are needed.

Another serious concern we have about HB 96 is the DeWine Administration's proposal to prohibit a SNF operator from leasing the real estate from a REIT. The language is specific to REITs, not any other type of business entity that owns the building where a SNF operates. It applies to any new lease of a SNF from a REIT after the bill's effective date. We are proposing another amendment (HC0632, also attached) to remove this language.

We strongly oppose the REIT prohibition. In a state that supposedly is "open for business," the administration's proposal would slam the door in the face of one specific type of business that is commonplace in Ohio and elsewhere around the country. So far in the budget process, the administration has offered no rational basis for singling out REITs in this manner.

A REIT is a specific type of business entity, defined in the Internal Revenue Code, that invests in real estate. REITS own all types of buildings, although typically a given REIT concentrates on property used in one or more specific business sectors such as offices, warehouses, data centers, retail, or residential. Health care is one of those sectors. Some REITs are publicly traded while others are privately held. Around 1,100 REITs exist in the United States, of which 225 are publicly traded. Institutional and individual investors frequently hold positions in REITs as an alternative to equities and fixed income.

For the thousands of businesses, including SNF operators, that lease buildings or space from REITs, the REIT is a financing mechanism. It is no different than other methods of commercial financing such as banks, private equity firms, or other businesses or individuals who own or have a financial interest in real estate and receive periodic payments from the business that uses the building. The administration's proposed prohibition on leasing from REITs would cut off a financing option used by many SNF operators at a time when commercial banks are tightening down because of uncertainty about Medicaid rates.

Reportedly, the REIT prohibition in HB 96 is modeled on one piece of a larger health care bill the Massachusetts legislature passed in December, following the collapse of the Steward *hospital system*. Steward was based in Massachusetts and happened to lease its hospital buildings from a REIT. One of them was in Ohio. Steward did not operate SNFs.

The only clue as to why the administration is seeking to expand this radical prohibition to SNFs came during ODH Director Vanderhoff's testimony in the Health Committee last month. He mentioned a few SNFs that the department closed in the relatively recent past. He said there was a "high probability" that the same problems would occur anytime a SNF operator leases from an "out-of-state owner," e.g., a REIT. (As a side note, one of the main health care REITs is based in Toledo, so not out of state.) Dr. Vanderhoff offered no evidence to support a wholesale ban on leasing from REITs while continuing to allow leasing from any other type of business entity and loan financing through banks or other lenders.

The proposed ban would create multiple market dislocations. The language in HB 96 prohibits ODH from licensing a SNF operator if they enter into a new lease with a REIT. While existing leases would be grandfathered, a REIT could not replace a poorly-performing operator with a better one. They – and the facility's residents - would be stuck with the bad operator. An operator who wants to build a new SNF or acquire an existing SNF would be denied an important source of financing that is available and widely used today. A SNF owner who wishes to sell a building would be denied access to a pool of potential purchasers, as would an owner/operator who wants to get out of the ownership business but continue to operate the buildings.

All of these dislocations would happen because the administration apparently thinks leasing from a REIT – any and all leases from any and all REITs – somehow automatically results in extremely poor quality, so poor that it results in the SNFs being closed down.

This theory is false.

After HB 96 was introduced and we discovered the REIT language, we began to research REIT ownership of SNFs in Ohio. There is no publicly-available list, but through intensive searching, we identified 103 REIT-owned SNFs. We believe this group encompasses most if not all Ohio facilities with REIT involvement. Using the most recent available data, we compared the performance of REIT-owned buildings against the entire Ohio SNF population on key quality metrics.

The following table shows that on all but one of these widely-used metrics, the REIT-owned facilities outperformed the statewide average.

Measure	REIT-Owned SNFs	All Ohio SNFs
5-star status	21%	18%
1-star status	11%	16%
Ohio quality points	32.3	30.9
CMS long-stay quality measures	4.62	4.45
CMS short-stay quality measures	3.25	3.02
Adjusted total nurse staffing	3.36	3.55

Clearly, leasing from a REIT is not a recipe for poor care, as the administration seems to be suggesting.

Building owners are not responsible for the quality of care, operators are. The operator provides care and services to the facility's residents on a daily basis. The building owner, whether it is a REIT or someone else, is simply a landlord. It is no different than the myriad businesses that operate in leased space. The success of the business is driven by the business owner (the operator), not the landlord. It is true that unfavorable lease terms can create difficulties for a business and even lead to closure or relocation. But that is true of only a small minority of businesses operating under leases and also applies to businesses that "can't pay the mortgage."

Governor DeWine has been very clear, over the past two years, about his interest in the quality of services provided in Ohio's SNFs. He is right to take interest. But the focus should be on how facilities are operating, not how they are financed.

The answer is already in place.

Over the last two years, the General Assembly acted in HB 33 and again in SB 144 to require much greater scrutiny of the qualifications of operators who take over Ohio facilities (so-called "CHOPs"). The legislation applies even-handedly to potential operators based in Ohio and those based in other states. The applicant for a CHOP license must provide full transparency about ownership of both the operating entity and the real estate. The new operator must be able to demonstrate operational experience and cannot have a track record of problems like facility closures, license revocations, or bankruptcies.

In addition to regulating which new or expanding operators, the recently-enacted CHOP law addresses the real estate owner. The legislature included language imposing a penalty if a new owner acquires a building and raises the rent or other financial obligations of the operator within 12 months after the acquisition. This language deals with concerns about owners potentially stripping resources from operators. In addition, if a CHOP involves a building that will be leased, a 5-year surety bond of $10,000 per bed is required for the operator to receive a license.

This legislation is operational and enforced vigorously by the Department of Health. The "bad operator" in the case we believe Dr. Vanderhoff is referring to took over before the legislature enacted the CHOP reforms. The REIT in that case was not the problem. It is a major, publicly-traded company that continues to finance numerous, high-quality SNFs in Ohio and elsewhere. In the case at issue, the REIT replaced the problem operator and advanced significant funding to fix the issues with the facilities, but ODH closed them anyway.

During proceedings in the Health Committee, committee members asked if we could work on a compromise with the administration. While we believe the legislature already has put the necessary statutory changes in place, we are certainly willing to talk with the administration about an alternative solution. We had a preliminary discussion last week.

In the meantime, though, we feel the existing provisions in HB 96 are inappropriate and harmful to SNF residents and operators and should be stripped out of the bill. Accordingly, we respectfully request your support of HC0632. If an alternative solution is developed through our discussions with the administration, it can be added to the bill in the Senate.

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