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Senate Finance Committee
Am. Sub. House Bill 110
Health, Aging, and Medicaid Issues
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Good morning, Chair Dolan, Vice Chair Gavarone, Ranking Member Sykes, and members of the committee. I am Pete Van Runkle from the Ohio Health Care Association. OHCA is Ohio's largest association representing long-term services and supports (LTSS) providers: assisted living; home care; hospice; intellectual and developmental disabilities; and skilled nursing services. We appreciate the opportunity to appear before you again today to discuss the budgets for the Departments of Aging and Medicaid on behalf of our members who provide LTSS funded by those agencies, which include home and community-based services (HCBS) and skilled nursing care. I also will cover a provision in the Department of Health's portion of House Bill 110.

I'd like to start with an overarching theme that you heard earlier today relative to services for people with intellectual and developmental disabilities: workforce. As an organization representing the continuum of LTSS providers, we know from our members that lack of available workforce overshadows all of them equally. Ohio's skilled nursing facilities (SNFs), assisted living communities, home care agencies, and hospices are desperate to find staff to care for their patients and residents, just as you heard about ID/DD providers.

Turning to HCBS specifically, let's define HCBS providers for this discussion. They are providers who receive Medicaid payments for services to Ohioans who have a level of care that would qualify them for SNF coverage, but who choose nursing or personal care (or other services) in their own home or an assisted living community. There are different Medicaid programs that fund these services. In many cases, they are Medicaid waiver programs (Assisted Living Waiver, PASSPORT, Ohio Home Care, MyCare Ohio Waiver). In addition, Ohio's state plan Medicaid program, which is not a waiver, covers home health and hospice services.

What all of these providers have in common, aside from extreme workforce challenges, is they depend on Medicaid for operational revenue. Because Medicaid payments are historically very low, they do not support the wages and benefits needed today to attract staff. While this problem is economy-wide, health care is different because our members serve people who need the services to survive and, in the case of HCBS, to stay in their homes, whether that home is a personal residence or an assisted living community.

Providers' inability to find staff because of low reimbursement has consequences for Ohioans. Agencies cannot take on new caseload or must reduce their existing caseload when they do not have enough staff to deliver care in everyone's home. In some cases, they stop taking Medicaid patients at all. Assisted Living Waiver providers routinely limit how many Medicaid beneficiaries they will take. Many assisted living communities do not participate in the waiver at all, resulting denial of access and a waiting list for services. In every case, a senior who needs help is not getting it.

Medicaid HCBS have been starved of resources for years. The staffing and access problems are long-standing because of low reimbursement rates, but the workforce impact of COVID-19 has made them much worse. Partly because they are not in statute and controlled by the legislature, Medicaid rates for HCBS providers for the most part have been stagnant in good times and bad. Occasionally there are small increases, other times there are cuts. For instance, in 2020, some PASSPORT services and assisted living received a small, 3.25% increase resulting from legislative action, but home health was left out. Overall, though, rates have come nowhere near keeping up with the cost of providing services and have kept the wages of direct care workers too low to attract sufficient staff.

Thus we turn to the legislature for help.

COVID-19 has played a huge part in the challenges HCBS providers face. They have borne higher costs for things like personal protective equipment (PPE), testing, overtime, wage increases, and bonuses while seeing their workforce further depleted by illness and individual decisions to leave the field for COVID-19-related reasons. At the same time, HCBS providers have seen steep declines in their revenue – their ability to pay those higher costs - because people choose not to receive services in their homes or to move into assisted living because of fear of COVID-19 and the restrictions it has spawned such as quarantine and visitation.

We appreciate and support the Executive Budget proposal of a 4% increase for nursing and aide services delivered by waiver and home health providers, but feel it is insufficient given the historic underfunding of HCBS and the impact of COVID-19 on workforce. We asked the House to fund a 5% increase in each year of the biennium and to add language to effectuate this increase (the Executive Budget did not contain language on the 4% increase). Unfortunately, the House did not include this funding, which we estimate at $42.9 million state share over the biennium.

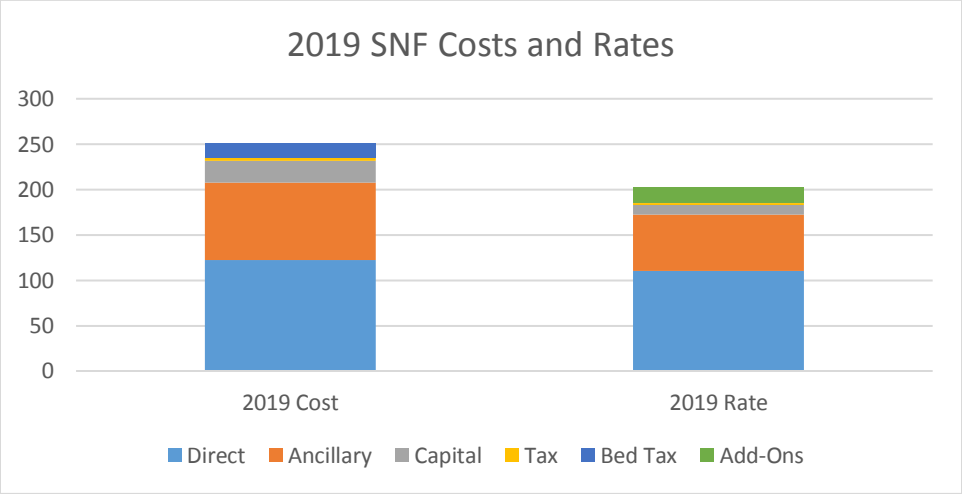
Our request to this committee and to the Senate is to add the language and the appropriation to help HCBS providers secure the necessary workforce and to ensure older Ohioans can receive the services they need in the settings of their choice.

We believe that instead of a culture of allowing rates to stagnate over a long period of time, which got Ohio's HCBS system to where it is now, the legislature should establish the principle that rates are to be adjusted regularly to reflect increases in the cost of providing services,

particularly labor costs, which make up far and away the bulk of HCBS providers' expenses.

Turning to SNFs, they are on the brink. One OHCA member, a multi-facility operator who also offers assisted living, home health, and hospice, recently reported that they lost $9 million in 2020. Another multi-facility company, which also provides multiple services, reports that they are losing $1 million per month. A third operator detailed $9 million in lost revenue between March 2020 and March 2021, with $6.8 million in increased costs.

This stems from multiple factors. To begin with, SNFs nationally were underwater by 0.3% before COVID-19, according to the Medicare Payment Advisory Commission. Medicaid is the predominant reason. In 2019, as shown in the chart below, Ohio's Medicaid rates averaged $202 per day compared to costs of $250 per day, including the bed tax – a loss of $48 per day on every Medicaid day.



Then COVID-19 hit. SNF census, which drives revenue, was decimated. Occupancy in Ohio facilities fell from 81.7% in 2019 to 68.7% by early 2021. Medicaid census declined even more. At the same time as these devastating revenue losses, COVID-19 drove cost increases to SNFs of $25 per day or more. Like all providers, SNFs are suffering grievously from the staffing crisis. They have had to raise wages far beyond what is supported by the Medicaid rate and are using unheard-of amounts of agency staff at highly inflated prices, but that is still not enough. SNFs are forced to deliver only basic-level care and to turn away admissions because they do not have enough staff.

Our SNF members are afloat today only because of a massive influx of federal funding under the CARES Act, either directly or through the state. Members report that this money will run out in anywhere from 3-6 months, creating great anxiety about their futures.

HB 110 contains two major pieces that relate to Medicaid reimbursement for SNFs: rebasing and quality incentives. Existing law requires rebasing rates every 5 years to account for changes in operating costs. State Fiscal Year 2022 is the fifth year, so the law requires rebasing for July 1,

2021, rates using 2019 costs. It should be noted that rebasing is not done individually, but uses the 25th percentile of large peer groups of facilities to set a price for each rate component.

The quality incentive under ORC 5165.26 has been in place since January 1, 2020, but sunsets June 30, 2021. The current quality incentive averages $9.35 per day ($12.63 for the 689 of the total 931 SNFs that actually received the incentive).

The Executive Budget proposed to avoid rebasing until after the biennium, but did extend and add to the quality incentive. The House restored rebasing, but funded it far below the level required by the documented cost increases from 2014 to 2019. The House language also permits the Department of Medicaid to delay rebasing until June 30, 2022, even though it is needed now. The House added more money to the quality incentive, but included language (possibly by mistake) that would deny incentive payments to hundreds of SNFs.

OHCA supports both rebasing and quality incentives. The correct approach, in our view, is full rebasing to give every SNF in Ohio baseline funding needed to provide quality care to their residents, with the incentive as an add-on calibrated to each center's performance on the statutorily-specified metrics. Quality incentives are not a substitute for rebasing because they do not recognize the cost increases SNFs have sustained over the past 7 years. The House budget, which allocates much more funding to the incentive than to rebasing, does not adequately address this reality.

As COVID-19 subsides, SNFs eventually may be able to reduce expenditures for things like PPE and for COVID units, but it will take years for census to recover, and labor costs never will return to pre-COVID levels. Failure to rebase now and to do so in accordance with existing statute jeopardizes the very existence of facilities in all parts of Ohio. This is particularly true because the quality incentive in the House budget completely leaves out more than 300 SNFs across the state – even assuming the additional restrictions in the House-passed language were drafting errors. The blow would fall hard on Ohio's rural communities, where a SNF may be the largest local employer and may provide the only access to care for miles around.

OHCA's request is that the Senate complete the job the House started by fully funding rebasing and making it effective, as under current statute, July 1, 2021. We also support additional funding for the quality incentive and redrafting the incentive language to ensure appropriate distribution of the dollars.

These measures would go a long way to ensuring the stability of a health care service that so many of Ohio's seniors and their families depend on.

We also appreciate the opportunity to address one specific issue relating to the Department of Health's language proposals in Am. Sub. House Bill 110 that is very concerning to our SNF and assisted living members.

The Executive Budget contained a new, non-fiscal provision that would give the Director of Health virtually unfettered authority to issue summary orders against licensed skilled nursing facilities and residential care facilities (assisted living) at essentially the Director's whim. Although OHCA advocated in the House of Representatives to remove this provision, the House left it in the bill with some minor changes.

Under current Ohio law, the Director's main enforcement authority against facilities with regulatory violations is to revoke its license to operate, obviously a very stringent penalty. This penalty applies to both SNFs and assisted living communities. By law, it requires notice and a hearing before it can be imposed.

The Director of Health has many other enforcement options against SNFs, depending on the seriousness of the situation. These actions, which are recommendations to the US Centers for Medicare and Medicaid Services (CMS), include the following:

- Terminating the facility's ability to participate in Medicare and Medicaid, which is tantamount to closing the building.
- Imposing fines of up to $22,000 per day.
- Inserting temporary management.
- Denying payment for new admissions.
- Requiring certain corrective action (called a directed plan of correction).

The Director can and does use these enforcement authorities quite liberally. Millions of dollars of fines are imposed annually, and the Director typically revokes the license of a handful of facilities each year.

The key point about all of these enforcement actions is none of them can be applied summarily by the Director acting alone. In cases of immediate jeopardy, which are the most serious deficiencies, a SNF can be terminated from Medicare and Medicaid and have other sanctions imposed before a hearing is afforded, but even then, the facility is given an opportunity (which may be as short as two days) to correct the deficiencies. Most importantly, the decision is not solely that of the Director, but CMS reviews the recommendation before the penalty is imposed and determines it is appropriate under applicable law.

In the most urgent situations, current Ohio statute (ORC 3721.08) allows the Director to go to court to take action against a SNF or assisted living community where dangerous conditions exist:

> [I]f, in the judgment of the director of health, real and present danger exists at any home, the director may petition the court of common pleas of the county in which the home is located for such injunctive relief as is necessary to close the home, transfer one or more occupants to other homes or other appropriate care settings, or otherwise eliminate the real and present danger. The court shall have the jurisdiction to grant such injunctive relief upon a showing that there is real and present danger.

This authority is very broad – closing the facility, moving out residents, or taking any other action to eliminate the danger. The court can act very quickly through a temporary restraining order, but it is critical to note that this statute includes the check and balance of judicial involvement. The Director must convince a judge that the situation requires extraordinary action, and it is the judge, not the administrative official, who issues the order.

In HB 110, the Director seeks to expand upon this existing Ohio law by adding a new section 3721.081 that would authorize the Director to do everything the existing judicial remedy statute allows, but to do it through a summary administrative order without any checks or balances. There would be no limits on what the Director could order. There would be no hearing before the order is imposed and no reviewing entity to determine if the Director is acting appropriately. Remember this is an order that could severely harm or even shut down a business that houses and employs scores of Ohioans. If the business does not comply with the Director's order, she could impose a summary, administrative fine of up to $100,000.

We are not aware of any other business in Ohio that is subject to such unbounded authority on the part of an administrative agency. The proposed language would give the Director this immense power based only on the Director's personal opinion that immediate action is necessary to protect resident health and safety.

In discussions with Director McCloud during the House process, she gave two examples of situations in which she would have liked to have had the power to issue orders. In neither case, from what we were able to discern, did Health Department surveyors feel there was immediate jeopardy – even though they cite immediate jeopardy more than 100 times a year. The department certainly did not think the situation was bad enough to go to court for immediate action. But the Director nonetheless wants to have ultimate power in her hands with no checks or balances.

The House made a few tweaks to the language as proposed by the Executive. These include such things as 24-hour advance notice (but not a hearing), reducing the maximum administrative fine for noncompliance with the order to $100,000, and allowing a facility to recover damages in an after-the-fact administrative hearing if the Director exceeded her authority (which is hard to imagine given its breadth).

These tweaks do nothing to address the fundamental problem with the proposed statute: it gives one administrative official essentially unlimited power over an Ohio business based on that official's opinion without review by anyone else or any opportunity for the business to be heard.

Current law already gives the Director authority to take immediate, decisive action when there is a clear and present danger – by going to court and proving the case. The argument that this action requires time and effort on the part of state employees simply doesn't hold water when balanced against the potential harm to a health care provider and their residents and staff.

Proposed section 3721.081 is unnecessary and inappropriate. We respectfully request that it be removed from the bill.

Thank you very much for your attention to our suggestions for improving the budget as it relates to LTSS. I would be happy to answer any questions from the committee.