

Written Testimony of



**Delivered by
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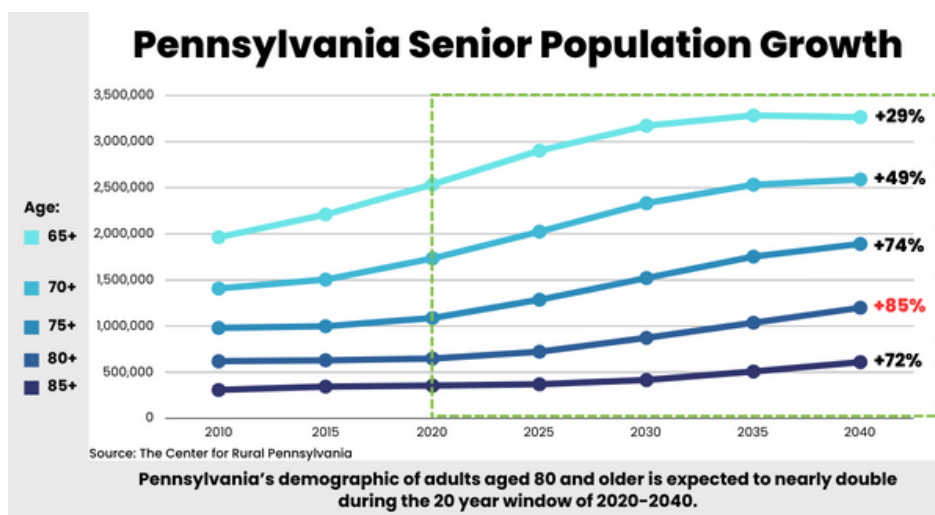
May 15, 2026

Chairman Rowe, members of the House Republican Policy Committee, thank you for the opportunity to testify today on the current crisis facing long term care providers in Pennsylvania. Specifically, I would like to highlight the reimbursement challenges confronting our members and the impact those challenges are having on their ability to deliver high-quality care.

My name is Angela Zaydon, and I am the Director of Government Affairs for the Pennsylvania Health Care Association or PHCA. We represent providers who care for older Pennsylvanians and adults with disabilities across the Commonwealth. We are proud to represent government-run, nonprofit, and for-profit nursing homes, as well as personal care homes and assisted living communities. I appreciate the opportunity to discuss an issue that goes directly to access, quality, workforce stability, and the long-term sustainability of nursing home care in Pennsylvania.

Pennsylvania Background and Medicaid

The central point of my testimony is straightforward: Pennsylvania has an aging population, and its long-term care system—particularly nursing homes—remains materially underfunded. To understand the why and the how, it is first important to understand the reimbursement system that pays for long term care in Pennsylvania, a mandated benefit in the Medicaid program.



Nearly 70% of nursing home residents rely on Medicaid to pay for their care. That figure is central to this discussion because Medicaid reimbursement directly affects both the financial stability of nursing homes and the quality of care available to most residents. In Pennsylvania, as in many states, Medicaid has long been a challenging payer for long-term care because it has consistently failed to cover the cost of providing care. That is especially true in states with a Budget Adjustment Factor (BAF) and where increased funding allocations have not been made to Medicaid base rates for all providers, including skilled nursing facilities, such as in Pennsylvania.

That Medicaid percentage only increases in more urban areas. That means when Medicaid underpays, the financial damage is not marginal. It cuts into the core operating revenue facilities rely on to pay staff, maintain services, and care for residents with increasingly complex needs.

Skilled nursing facilities have little ability to absorb that underpayment because they cannot offset the gap through other payers, and residents still require the same essential daily care regardless of whether reimbursement is adequate. The result is a persistent Medicaid shortfall that places ongoing pressure on facilities, staffing and access to care.

It is also important to note that, under federal Medicaid law, nursing facility services are not optional; they are a required benefit that states must provide for individuals age 21 and older who need that level of care. By contrast, home-and-community-based services (HCBS), while critically important, are generally offered through optional Medicaid authorities and depend on sufficient workforce and provider capacity, as well as an individual's ability to be served safely in the community. HCBS is a part of the long-term care continuum, but it cannot replace the need for nursing facility care, particularly for individuals with the most complex needs. As Pennsylvania's population ages, that need will only increase. If nursing facilities are not funded in a way that supports long-term sustainability, continued closures and lost capacity will further erode a critical safety net for our most vulnerable residents.

The second highest payor for long term care is Medicare, and while this committee and our General Assembly do not control Medicare policy, it is important to understand the interplay between these two payors to fully grasp the challenges our providers face. Medicare, on average, pays for about 10-15% of all residents that reside in an average nursing home in Pennsylvania. Medicare, unlike Medicaid, has historically been a positive payer.

The Medicaid shortfall, which is the delta between costs and reimbursement, was historically offset by better than average margins on Medicare. Medicare pays for the short term, post acute residents that are looking for rehabilitation following a hospital stay and will go home. Although that was never Medicare's intended function, Medicare margins historically helped offset Medicaid underpayment and partially mitigated its effect on providers.

However, over the last 10-15 years, the Medicare margins have shrunk due to a myriad of factors. That margin loss of what was used to compensate for the Medicaid shortfall, now no longer does to the extent that it used to. This has only exacerbated the shortfall on the Medicaid side. While Medicare was never intended to act as a buffer for poor Medicaid reimbursement, in reality, that's exactly what it did. Today, that is no longer the case and that is part of the reason we are where we are today.

The Budget Adjustment Factor (BAF) and the Impact

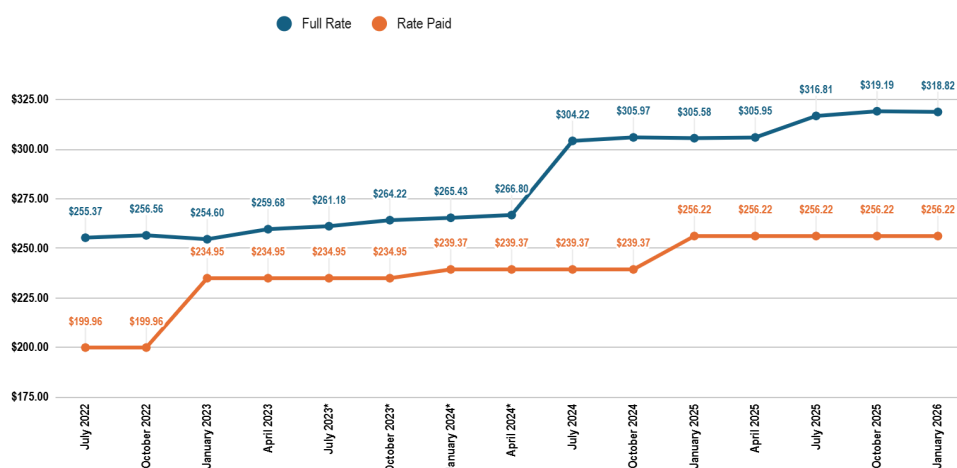
Compounding this Medicaid shortfall is a feature that is relatively uncommon in long-term care reimbursement: the Budget Adjustment Factor, or BAF. We are only one of five states in the entire country, the others being Nevada, Maryland, New Hampshire, and Idaho, that have a BAF in place, and it has been proven challenging in all of them.

Pennsylvania already has a Medicaid rate-setting system that is supposed to reflect reasonable, allowable audited costs and resident acuity. Facilities file annual cost reports. Rates are adjusted to account for how clinically complex residents are and how much care they require. In other words, the system already has a way to determine what providers should be paid. But then the BAF steps in and cuts those calculated rates down to fit the budgeted appropriation rather than the allowable auditable costs for care. That means providers are not truly being paid the rate the state itself says is appropriate.

Pennsylvania's long term care providers have operated under a BAF-adjusted reimbursement system since the 2005-06 budget, when the policy was first adopted in response to rapidly rising nursing facility costs. At the time, the BAF was intended as a one year budget-management tool to moderate spending growth and promote efficiency. But whatever its original purpose, the BAF has now remained in place for two decades and has evolved from a temporary cost-control mechanism into a structural reduction in payment. Efficiency has limits. Nursing facilities are subject to extensive care, staffing, and regulatory requirements, and they cannot reduce costs indefinitely without affecting access, operations, workforce stability, or quality. At some point, a mechanism intended to encourage efficiency stops trimming excess and starts cutting into the core resources needed to deliver safe and reliable care.

The BAF acts as a mathematical "haircut" on Medicaid reimbursement. The budget pie of funding has remained the same size, but the slices have gotten smaller. For seven of the eight years during the Wolf Administration, nursing homes received flat funding. Nursing homes were again flat-funded in the most recent enacted state budget, even as underlying costs continued to rise.

Below is a chart that illustrates the cap between the rate that providers are currently paid (orange) and the rate the system says they should be paid (blue).



The Department of Human Services maintains that there are less people receiving care paid for by Medicaid in our long term care facilities as they stated during the Appropriations Committee hearings. On its face, that is accurate. However, that isn't the whole story. We have had over 30 closures in Pennsylvania in recent years, which reduces the number of people receiving care and services. Additionally, there has been a significant increase in home and community based services paid for by Medicaid, which again, is NOT a mandated benefit. This has also reduced the number of people in nursing homes. Fewer residents in facilities does not mean the need has disappeared; it means capacity has been reduced and care has shifted across the system.

Absent a supplemental budget or additional funding, a BAF'd payment structure is the only way that the Department of Human Services can afford to pay all the providers, by discounting the rate. Today the BAF sits at .80, which means that providers are effectively receiving more than 20% less than what allowable costs would otherwise say they should be paid if the system was

fully funded. All the while, providers are expected to increase wages, improve quality and absorb an ever growing population of older adults with increasingly complex needs.

If you compare Pennsylvania in terms of the rate paid to skilled nursing centers with that of our neighboring states, we fall woefully short. If this trend continues, Pennsylvania risks losing high-quality providers that are committed to resident care and long-term investment in the Commonwealth, while creating conditions that may attract operators less focused on care quality and long-term stability.

When the BAF fluctuates, the consequences extend beyond fiscal uncertainty and directly affect residents, families, and caregivers. The real world, day to day impact on providers is that they cannot responsibly commit to long term wage increases, retention bonuses, capital improvements, or operational investments when their primary revenue source is subject to quarterly shocks. A provider could be receiving one rate on the last day of the quarter, and then, on the very next day, through no change or fault of its own, that rate drops. The reason is not reduced need or lower costs inside the building; it is that statewide utilization and costs continued to climb while the dollars remained flat, thereby reducing the rate paid for the same population and level of need. That is not a stable business environment and it certainly is not a stable care environment.

As the gap between cost and payment widens, facilities are forced to limit admissions, leaving seniors stuck in hospitals or on waiting lists. In rural areas, this could lead to closures which create health care deserts forcing families to search well beyond their communities for care for a loved one. Residents today require more complex care than they did in 2005, yet the BAF treats nursing care as an adjustable budget line item rather than a clinical necessity.

Why 2026 is Critical for Skilled Nursing Facilities

So let's talk about 2026 and why this is such a pivotal year for the BAF and long term care. The BAF is set to expire on June 30, 2026. Given the financial ramifications, it is highly unlikely that the Department will choose to let the BAF expire. Rather, much like previous years, they will come to the General Assembly to renew the BAF, normally for another multi year duration. That is why the General Assembly has a meaningful opportunity in 2026 to improve the funding trajectory for long-term care and strengthen outcomes for current residents as well as future Pennsylvanians who will depend on this system.

When presented with the BAF renewal, we urge the legislature to require a meaningful BAF floor that escalates each year of the renewal until it is phased out. We need to stop the reimbursement erosion and volatility that our providers have faced for the last 20 years. A BAF floor helps create predictable funding. That allows providers to plan finances effectively based on resident care needs, directly driving quality improvement. A BAF floor creates clinical realism by helping rates better keep pace with rising care costs and resident acuity. A BAF floor strengthens long term sustainability by reducing the number of providers forced to close their doors due to unpredictable and insufficient reimbursements. And it enhances fiscal responsibility by allowing a greater flow of appropriated dollars through the payment system, reducing the need for large emergency year over year funding increases and creating more predictability for both providers and the Commonwealth.

The BAF was never meant to be a permanent feature of nursing home reimbursement. Yet two decades later, it remains in place and has become less a policy tool than a budget-cutting device. If the Commonwealth is serious about protecting access to care and supporting quality,

the BAF should be floored at a meaningful level with the intention of elimination over the next 3 years.

That erosion is not theoretical. It has real and severe consequences. While providers' full case-mix, audited rates continued to reflect rising resident acuity and higher costs, the amount they actually paid falls far short. For the January 2026 quarter, the average non-public facility case-mix rate was \$327.42 per day, while the average rate actually paid after application of the BAF was \$263.13. That is over a \$64 per day shortfall for each Medicaid resident. For a 100-bed facility with 70% Medicaid occupancy, the estimated annual deficit is over \$1.6 million.

Due to federal requirements, Pennsylvania is transitioning to a new way of calculating a facility's CMI (acuity) scores called the Patient Driven Payment Model (PDPM). The phase-in began on April 1, 2026 and will be fully implemented by January 1, 2027. The PDPM system classifies residents into case-mix categories based on clinical characteristics, resident assessments, resident diagnosis and predicted resources needed to care for a resident during their stay. On average, the 'resident care need scores' (i.e. acuity or level of sickness) under PDPM are higher than under the prior system.

In the DHS rate modeling, the average nursing home Medicaid payment rate statewide was higher using PDPM. Assuming flat funding, DHS estimated that the BAF was projected to be 0.74602 in July 2025 and 0.74422 in October 2025. These initial (BAF) floor cost projections were based on information provided to nursing facilities and the associations by DHS. Based on the previous method of calculations, PHCA had projected that the cost to create a .90 Budget Adjustment Factor (BAF) Floor would be approximately \$450 million in state monies. Based on the DHS modeling, we anticipated the Medicaid rates to increase significantly with the transition to PDPM, and with flat funding, the BAF would erode substantially. It was later discovered that there were substantial flaws within the DHS rate modeling that we relied on to develop the BAF Floor cost projections. In the PDPM modeling, DHS used the total NF acuity scores based on the old system instead of the PDPM scores. The acuity scores under PDPM are higher than the acuity scores under the old system (RUGs), therefore lowering the resident care adjusted costs used in rate setting. The net result to the system are rates that are lower than anticipated which is why the BAF floor cost projections for FY26-27 for a .09 are now \$250 million rather than the original estimate of \$450 million. This does not mean that nursing homes were paid more, it simply means that the cost to the state to implement a .90 BAF floor is less than originally thought.

We have seen operational bed capacity—set up and staffed beds—has contracted by over 10 percent since 2016. For those that remain open, this creates an immense uncertainty among SNFs, making staffing, investments, and planning impossible. At the same time, providers are facing intensifying pressure from every direction. Residents in nursing homes are sicker and more clinically complex than they were just a few years ago. Labor costs remain elevated. Providers continue to struggle with recruitment and retention and are often forced to rely on expensive agency staffing. Inflation has increased the cost of supplies, food, utilities, and operations. Yet when the state-calculated rate rises to reflect those realities, the BAF suppresses the payment anyway. The result is instability by design.

The current structure also creates inequities. Because the BAF effectively caps the total reimbursement pool, providers are pushed into competition with one another for limited dollars. This can disadvantage facilities that operate efficiently and serve a high proportion of Medicaid residents. In practice, the very facilities doing the most to care for low-income Pennsylvanians can be among those hit hardest.

Data Supporting the Need for Increased Medicaid

This is no longer just a provider complaint. It is increasingly supported by research. A 2026 JAMDA study examining 9,473 freestanding nursing homes in 44 states found that higher Medicaid payment rates were associated with a greater likelihood of 4-star or 5-star ratings in overall, health inspection, and staffing domains. The same study concluded that inadequate Medicaid payment rates undermine nursing home quality and force facilities to subsidize Medicaid losses with profits from other sources. That is exactly the problem Pennsylvania providers are confronting.

That study is especially important for this discussion because it reframes that Medicaid funding not simply as a line item expense, but as a quality lever. If the Commonwealth wants stronger staffing, better inspections, and more stable performance, payment adequacy matters. **Policy cannot demand quality improvement on one hand while systematically undercutting the revenue needed to support it on the other.**

The danger ahead is even greater. In other words, as the payment system more accurately reflects resident needs, the BAF could simply ratchet down and wipe out the benefit. That would further reduce the percentage of the full rate that providers actually receive.

This is why a one-time rate increase, while helpful, is not enough. The underlying mechanism remains broken. If additional appropriations simply flow into a system where the BAF continues to erode the state-calculated rate, providers are still left with uncertainty and instability. What nursing homes need is not just more dollars, but a payment structure that allows appropriated dollars to reach the bedside predictably.

Two Sensible Pathways for Success

First, a meaningful floor of .90 on the BAF. We propose a 0.90 floor so that facilities are not paid less than 90% of their state-calculated Medicaid case-mix rate. That would restore some measure of predictability and limit the damage caused by quarterly erosion. It is never going to be cheaper than it is in 2026. The industry asked for this in 2025 and the cost in 2026 has more than doubled. The cost trajectory isn't going to change and 2027 will simply cost more. The precise fiscal note may evolve, but the policy rationale does not: providers should not be subject to an endlessly falling reimbursement haircut that bears no relationship to the cost of care.

Second, a phase out approach over the standard three-year renewal period that starts with a .90 floor in year one, followed by a higher floor in year two and three, with complete phase-out in year four. If Pennsylvania already has a rate-setting methodology based on audited costs and acuity, then that methodology should mean something. A reimbursement system should reimburse. It should not calculate one rate and pay another simply because the appropriation falls short.

Conclusion

Pennsylvania has to ask itself the critical question about its budget priorities as a Commonwealth with the understanding that nursing home care is a mandated benefit of the Medicaid program. A famous quote that we should all keep in mind is this: "The true measure of any society can be found in how it treats its most vulnerable members." If we are not adequately funding care for our seniors, what is that saying about Pennsylvania. This is a question of

priorities and to this point we have seen Pennsylvania's. Nursing homes are caring for Pennsylvanians with the most intensive long-term care needs. They are not optional providers. They are an essential part of the healthcare continuum. Yet under current policy, they remain the only sector in Pennsylvania subjected to this kind of blunt budget adjustment mechanism. That is not sustainable, and it is not fair.

When nursing homes are underfunded, the consequences are borne by residents, families, and workers. Facilities delay capital improvements. Staffing remains strained. Admissions can become harder. In some communities, providers close, and families are left scrambling to find care farther from home.

Pennsylvania should not continue balancing its nursing home budget on the backs of frail older adults, people with disabilities, and the workers who care for them. The legislature has the opportunity **this year** to seriously change the trajectory of nursing homes in our Commonwealth for years to come by flooring the BAF and phasing it out in favor of our most vulnerable citizens.

Thank you again for the opportunity to provide testimony on this complex yet very important topic. I welcome your questions.