SC1009

Am. Sub. H. B. No. 96
As Passed by the House

_____ moved to amend as follows:

In line 351 of the title, after "5163.05," insert "5165.152,"

After line 111909, insert:

"**Sec. 5165.01.** As used in this chapter:

(A) "Affiliated operator" means an operator affiliated with either of the following:

(1) The exiting operator for whom the affiliated operator is to assume liability for the entire amount of the exiting operator's debt under the medicaid program or the portion of the debt that represents the franchise permit fee the exiting operator owes;

(2) The entering operator involved in the change of operator with the exiting operator specified in division (A)(1) of this section.

(B) "Allowable costs" are a nursing facility's costs that the department of medicaid determines are reasonable. Fines paid under sections 5165.60 to 5165.89 and section 5165.99 of the Revised Code are not allowable costs.

(C) "Ancillary and support costs" means all reasonable

costs incurred by a nursing facility other than direct care costs, tax costs, or capital costs. "Ancillary and support costs" includes, but is not limited to, costs of activities, social services, pharmacy consultants, habilitation supervisors, qualified intellectual disability professionals, program directors, medical and habilitation records, program supplies, incontinence supplies, food, enterals, dietary supplies and personnel, laundry, housekeeping, security, administration, medical equipment, utilities, liability insurance, bookkeeping, purchasing department, human resources, communications, travel, dues, license fees, subscriptions, home office costs not otherwise allocated, legal services, accounting services, minor equipment, maintenance and repairs, help-wanted advertising, informational advertising, start-up costs, organizational expenses, other interest, property insurance, employee training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted under section 5165.02 of the Revised Code, for personnel listed in this division. "Ancillary and support costs" also means the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the nursing facility's cost report for the cost reporting period ending December 31, 1992.

(D) "Applicable calendar year" means the calendar year immediately preceding the first of the state fiscal years for which a rebasing is conducted.

(E) For purposes of calculating a critical access nursing facility's occupancy rate and utilization rate under this chapter, "as of the last day of the calendar year" refers to the

occupancy and utilization rates during the calendar year identified in the cost report filed under section 5165.10 of the Revised Code.

(F)(1) "Capital costs" means the actual expense incurred by a nursing facility for all of the following:

(a) Depreciation and interest on any capital assets that cost five hundred dollars or more per item, including the following:

(i) Buildings;

(ii) Building improvements;

(iii) Except as provided in division (D) of this section, equipment;

(iv) Transportation equipment.

(b) Amortization and interest on land improvements and leasehold improvements;

(c) Amortization of financing costs;

(d) Lease and rent of land, buildings, and equipment.

(2) The costs of capital assets of less than five hundred dollars per item may be considered capital costs in accordance with a provider's practice.

(G) "Capital lease" and "operating lease" shall be construed in accordance with generally accepted accounting principles.

(H) "Case-mix score" means a measure determined under section 5165.192 of the Revised Code of the relative direct-care resources needed to provide care and habilitation to a nursing

facility resident.

(I) "Change of operator" includes circumstances in which an entering operator becomes the operator of a nursing facility in the place of the exiting operator.

(1) Actions that constitute a change of operator include the following:

(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;

(b) A change in operational control of the nursing facility, regardless of whether ownership of any or all of the real property or personal property associated with the nursing facility is also transferred;

(c) A lease of the nursing facility to the entering operator or termination of the exiting operator's lease;

(d) If the exiting operator is a partnership, dissolution of the partnership, a merger of the partnership into another person that is the survivor of the merger, or a consolidation of the partnership and at least one other person to form a new person;

(e) If the exiting operator is a limited liability company, dissolution of the limited liability company, a merger of the limited liability company into another person that is the survivor of the merger, or a consolidation of the limited liability company and at least one other person to form a new person.

(f) If the operator is a corporation, dissolution of the corporation, a merger of the corporation into another person

that is the survivor of the merger, or a consolidation of the corporation and at least one other person to form a new person;

(g) A contract for a person to assume operational control of a nursing facility;

(h) A change of fifty per cent or more in the ownership of the licensed operator that results in a change of operational control;

(i) Any pledge, assignment, or hypothecation of or lien or other encumbrance on any of the legal or beneficial equity interests in the operator or a person with operational control.

(2) The following do not constitute a change of operator:

(a) Actions necessary to create an employee stock ownership plan under section 401(a) of the "Internal Revenue Code," 26 U.S.C. 401(a);

(b) A change of ownership of real property or personal property associated with a nursing facility;

(c) If the operator is a corporation that has securities publicly traded in a marketplace, a change of one or more members of the corporation's governing body or transfer of ownership of one or more shares of the corporation's stock, if the same corporation continues to be the operator;

(d) An initial public offering for which the securities and exchange commission has declared the registration statement effective, and the newly created public company remains the operator.

(J) "Cost center" means the following:

(1) Ancillary and support costs;

(2) Capital costs;

(3) Direct care costs;

(4) Tax costs.

(K) "Custom wheelchair" means a wheelchair to which both of the following apply:

(1) It has been measured, fitted, or adapted in consideration of either of the following:

(a) The body size or disability of the individual who is to use the wheelchair;

(b) The individual's period of need for, or intended use of, the wheelchair.

(2) It has customized features, modifications, or components, such as adaptive seating and positioning systems, that the supplier who assembled the wheelchair, or the manufacturer from which the wheelchair was ordered, added or made in accordance with the instructions of the physician of the individual who is to use the wheelchair.

(L)(1) "Date of licensure" means the following:

(a) In the case of a nursing facility that was required by law to be licensed as a nursing home under Chapter 3721. of the Revised Code when it originally began to be operated as a nursing home, the date the nursing facility was originally so licensed;

(b) In the case of a nursing facility that was not required by law to be licensed as a nursing home when it originally began to be operated as a nursing home, the date it first began to be operated as a nursing home, regardless of the

date the nursing facility was first licensed as a nursing home.

(2) If, after a nursing facility's original date of licensure, more nursing home beds are added to the nursing facility, the nursing facility has a different date of licensure for the additional beds. This does not apply, however, to additional beds when both of the following apply:

(a) The additional beds are located in a part of the nursing facility that was constructed at the same time as the continuing beds already located in that part of the nursing facility;

(b) The part of the nursing facility in which the additional beds are located was constructed as part of the nursing facility at a time when the nursing facility was not required by law to be licensed as a nursing home.

(3) The definition of "date of licensure" in this section applies in determinations of nursing facilities' medicaid payment rates but does not apply in determinations of nursing facilities' franchise permit fees.

(M) "Desk-reviewed" means that a nursing facility's costs as reported on a cost report submitted under section 5165.10 of the Revised Code have been subjected to a desk review under section 5165.108 of the Revised Code and preliminarily determined to be allowable costs.

(N) "Direct care costs" means all of the following costs incurred by a nursing facility:

(1) Costs for registered nurses, licensed practical nurses, and nurse aides employed by the nursing facility;

(2) Costs for direct care staff, administrative nursing

staff, medical directors, respiratory therapists, and except as provided in division (N)(8) of this section, other persons holding degrees qualifying them to provide therapy;

(3) Costs of purchased nursing services;

(4) Costs of quality assurance;

(5) Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted under section 5165.02 of the Revised Code, for personnel listed in divisions (N)(1), (2), (4), and (8) of this section;

(6) Costs of consulting and management fees related to direct care;

(7) Allocated direct care home office costs;

(8) Costs of habilitation staff (other than habilitation supervisors), medical supplies, emergency oxygen, over-the-counter pharmacy products, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, audiologists, habilitation supplies, and universal precautions supplies;

(9) Costs of wheelchairs other than the following:

(a) Custom wheelchairs;

(b) Repairs to and replacements of custom wheelchairs and parts that are made in accordance with the instructions of the physician of the individual who uses the custom wheelchair.

(10) Costs of other direct-care resources that are specified as direct care costs in rules adopted under section

5165.02 of the Revised Code.

(O) "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

(P) "Effective date of a change of operator" means the day the entering operator becomes the operator of the nursing facility.

(Q) "Effective date of a facility closure" means the last day that the last of the residents of the nursing facility resides in the nursing facility.

(R) "Effective date of an involuntary termination" means the date the department of medicaid terminates the operator's provider agreement for the nursing facility.

(S) "Effective date of a voluntary withdrawal of participation" means the day the nursing facility ceases to accept new medicaid residents other than the individuals who reside in the nursing facility on the day before the effective date of the voluntary withdrawal of participation.

(T) "Entering operator" means the person or government entity that will become the operator of a nursing facility when a change of operator occurs or following an involuntary termination.

(U) "Exiting operator" means any of the following:

(1) An operator that will cease to be the operator of a nursing facility on the effective date of a change of operator;

(2) An operator that will cease to be the operator of a nursing facility on the effective date of a facility closure;

(3) An operator of a nursing facility that is undergoing

or has undergone a voluntary withdrawal of participation;

(4) An operator of a nursing facility that is undergoing or has undergone an involuntary termination.

(V)(1) Subject to divisions (V)(2) and (3) of this section, "facility closure" means either of the following:

(a) Discontinuance of the use of the building, or part of the building, that houses the facility as a nursing facility that results in the relocation of all of the nursing facility's residents;

(b) Conversion of the building, or part of the building, that houses a nursing facility to a different use with any necessary license or other approval needed for that use being obtained and one or more of the nursing facility's residents remaining in the building, or part of the building, to receive services under the new use.

(2) A facility closure occurs regardless of any of the following:

(a) The operator completely or partially replacing the nursing facility by constructing a new nursing facility or transferring the nursing facility's license to another nursing facility;

(b) The nursing facility's residents relocating to another of the operator's nursing facilities;

(c) Any action the department of health takes regarding the nursing facility's medicaid certification that may result in the transfer of part of the nursing facility's survey findings to another of the operator's nursing facilities;

(d) Any action the department of health takes regarding

the nursing facility's license under Chapter 3721. of the Revised Code.

(3) A facility closure does not occur if all of the nursing facility's residents are relocated due to an emergency evacuation and one or more of the residents return to a medicaid-certified bed in the nursing facility not later than thirty days after the evacuation occurs.

(W) "Franchise permit fee" means the fee imposed by sections 5168.40 to 5168.56 of the Revised Code.

(X) "Inpatient days" means both of the following:

(1) All days during which a resident, regardless of payment source, occupies a licensed bed in a nursing facility;

(2) Fifty per cent of the days for which payment is made under section 5165.34 of the Revised Code.

(Y) "Involuntary termination" means the department of medicaid's termination of the operator's provider agreement for the nursing facility when the termination is not taken at the operator's request.

(Z) ~~"Low case-mix resident" means a medicaid recipient residing in a nursing facility who, for purposes of calculating the nursing facility's medicaid payment rate for direct care costs, is placed in either of the two lowest case-mix groups, excluding any case-mix group that is a default group used for residents with incomplete assessment data.~~

~~(AA)~~ "Maintenance and repair expenses" means a nursing facility's expenditures that are necessary and proper to maintain an asset in a normally efficient working condition and that do not extend the useful life of the asset two years or

more. "Maintenance and repair expenses" includes but is not limited to the costs of ordinary repairs such as painting and wallpapering.

~~(BB)~~ (AA) "Medicaid-certified capacity" means the number of a nursing facility's beds that are certified for participation in medicaid as nursing facility beds.

~~(CC)~~ (BB) "Medicaid days" means both of the following:

(1) All days during which a resident who is a medicaid recipient eligible for nursing facility services occupies a bed in a nursing facility that is included in the nursing facility's medicaid-certified capacity;

(2) Fifty per cent of the days for which payment is made under section 5165.34 of the Revised Code.

~~(DD)(1)~~ (CC)(1) "New nursing facility" means a nursing facility for which the provider obtains an initial provider agreement following medicaid certification of the nursing facility by the director of health, including such a nursing facility that replaces one or more nursing facilities for which a provider previously held a provider agreement.

(2) "New nursing facility" does not mean a nursing facility for which the entering operator seeks a provider agreement pursuant to section 5165.511 or 5165.512 or (pursuant to section 5165.515) section 5165.07 of the Revised Code.

~~(EE)~~ (DD) "Nursing facility" has the same meaning as in the "Social Security Act," section 1919(a), 42 U.S.C. 1396r(a).

~~(FF)~~ (EE) "Nursing facility services" has the same meaning as in the "Social Security Act," section 1905(f), 42 U.S.C. 1396d(f).

~~(GG)~~ (FF) "Nursing home" has the same meaning as in section 3721.01 of the Revised Code.

~~(HH)~~ (GG) "Occupancy rate" means the percentage of licensed beds that, regardless of payer source, are either of the following:

(1) Reserved for use under section 5165.34 of the Revised Code;

(2) Actually being used.

~~(II)~~ (HH) "Operational control" means having the ability to direct the overall operations and cash flow of a nursing facility. "Operational control" may be exercised by one person or multiple persons acting together or by a government entity, and may exist by means of any of the following:

(1) The person, persons, or government entity directly operating the nursing facility;

(2) The person, persons, or government entity directly or indirectly owning fifty per cent or more of the operator;

(3) An agreement or other arrangement granting the person, persons, or government entity operational control.

~~(JJ)~~ (II) "Operator" means a person or government entity responsible for the operational control of a nursing facility and that holds both of the following:

(1) The license to operate the nursing facility issued under section 3721.02 of the Revised Code, if a license is required by section 3721.05 of the Revised Code;

(2) The medicaid provider agreement issued under section 5165.07 of the Revised Code, if applicable.

~~(KK)(1)~~ (JJ)(1) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in any of the following regarding a nursing facility:

(a) The land on which the nursing facility is located;

(b) The structure in which the nursing facility is located;

(c) Any mortgage, contract for deed, or other obligation secured in whole or in part by the land or structure on or in which the nursing facility is located;

(d) Any lease or sublease of the land or structure on or in which the nursing facility is located.

(2) "Owner" does not mean a holder of a debenture or bond related to the nursing facility and purchased at public issue or a regulated lender that has made a loan related to the nursing facility unless the holder or lender operates the nursing facility directly or through a subsidiary.

~~(LL)~~ (KK) "Per diem" means a nursing facility's actual, allowable costs in a given cost center in a cost reporting period, divided by the nursing facility's inpatient days for that cost reporting period.

~~(MM)~~ (LL) "Person" has the same meaning as in section 1.59 of the Revised Code.

~~(NN)~~ (MM) "Private room" means a nursing facility bedroom that meets all of the following criteria:

(1) It has four permanent, floor-to-ceiling walls and a full door.

(2) It contains one licensed or certified bed that is occupied by one individual.

(3) It has access to a hallway without traversing another bedroom.

(4) It has access to a toilet and sink shared by not more than one other resident without traversing another bedroom.

(5) It meets all applicable licensure or other standards pertaining to furniture, fixtures, and temperature control.

~~(OO)~~ (NN) "Provider" means an operator with a provider agreement.

~~(PP)~~ (OO) "Provider agreement" means a provider agreement, as defined in section 5164.01 of the Revised Code, that is between the department of medicaid and the operator of a nursing facility for the provision of nursing facility services under the medicaid program.

~~(QQ)~~ (PP) "Purchased nursing services" means services that are provided in a nursing facility by registered nurses, licensed practical nurses, or nurse aides who are not employees of the nursing facility.

~~(RR)~~ (QQ) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider.

~~(SS)~~ (RR) "Rebasing" means a redetermination of each of the following using information from cost reports for an applicable

calendar year that is later than the applicable calendar year used for the previous rebasing:

(1) Each peer group's rate for ancillary and support costs as determined pursuant to division (C) of section 5165.16 of the Revised Code;

(2) Each peer group's rate for capital costs as determined pursuant to division (C) of section 5165.17 of the Revised Code;

(3) Each peer group's cost per case-mix unit as determined pursuant to division (C) of section 5165.19 of the Revised Code;

(4) Each nursing facility's rate for tax costs as determined pursuant to section 5165.21 of the Revised Code.

~~(TT)~~ (SS) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider.

(1) An individual who is a relative of an owner is a related party.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in both the provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.

(3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or

direct the actions or policies of an organization.

(4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all of the following conditions are met:

(a) The supplier is a separate bona fide organization.

(b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the provider and there is an open, competitive market for the types of goods or services the supplier furnishes.

(c) The types of goods or services are commonly obtained by other nursing facilities from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by nursing facilities.

(d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.

~~(UU)~~ (TT) "Relative of owner" means an individual who is related to an owner of a nursing facility by one of the following relationships:

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted parent, child, or sibling;

(4) Stepparent, stepchild, stepbrother, or stepsister;

(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;

(6) Grandparent or grandchild;

(7) Foster caregiver, foster child, foster brother, or foster sister.

~~(VV)~~ (UU) "Residents' rights advocate" has the same meaning as in section 3721.10 of the Revised Code.

~~(WW)~~ (VV) "Skilled nursing facility" has the same meaning as in the "Social Security Act," section 1819(a), 42 U.S.C. 1395i-3(a).

~~(XX)~~ (WW) "State fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.

~~(YY)~~ (XX) "Sponsor" has the same meaning as in section 3721.10 of the Revised Code.

~~(ZZ)~~ (YY) "Surrender" has the same meaning as in section 5168.40 of the Revised Code.

~~(AAA)~~ (ZZ) "Tax costs" means the costs of taxes imposed under Chapter 5751. of the Revised Code, real estate taxes, personal property taxes, and corporate franchise taxes.

~~(BBB)~~ (AAA) "Title XIX" means Title XIX of the "Social Security Act," 42 U.S.C. 1396 et seq.

~~(CCC)~~ (BBB) "Title XVIII" means Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq.

~~(DDD)~~ (CCC) "Voluntary withdrawal of participation" means an operator's voluntary election to terminate the participation of a nursing facility in the medicaid program but to continue to provide service of the type provided by a nursing facility.

Sec. 5165.15. Except as otherwise provided by sections 5165.151 to 5165.158 and 5165.34 of the Revised Code, the total

per medicaid day payment rate that the department of medicaid shall pay a nursing facility provider for nursing facility services the provider's nursing facility provides during a state fiscal year shall be determined as follows:

(A) Determine the sum of all of the following:

(1) The per medicaid day payment rate for ancillary and support costs determined for the nursing facility under section 5165.16 of the Revised Code;

(2) The per medicaid day payment rate for capital costs determined for the nursing facility under section 5165.17 of the Revised Code;

(3) ~~The~~ Except as otherwise provided in this division, the per medicaid day payment rate for direct care costs determined for the nursing facility under section 5165.19 of the Revised Code~~;~~. For the period beginning January 1, 2026, and ending December 31, 2026, the per medicaid day payment rate for direct care costs for each nursing facility shall instead be the following:

(a) If the nursing facility's rate for direct care costs on December 31, 2025, is greater than the rate determined for the nursing facility under section 5165.19 of the Revised Code, the greater of the following;

(i) The rate determined for the nursing facility under section 5165.19 of the Revised Code;

(ii) The nursing facility's rate for direct care costs on December 31, 2025, minus five dollars.

(b) If the nursing facility's rate for direct care costs on December 31, 2025, is less than the rate determined for the

nursing facility under section 5165.19 of the Revised Code, the lesser of the following:

(i) The rate determined for the nursing facility under section 5165.19 of the Revised Code;

(ii) The sum of the nursing facility's rate for direct care costs on December 31, 2025, and five dollars.

(4) The per medicaid day payment rate for tax costs determined for the nursing facility under section 5165.21 of the Revised Code;

(5) If the nursing facility qualifies as a critical access nursing facility, the nursing facility's critical access incentive payment paid under section 5165.23 of the Revised Code.

(B) To the sum determined under division (A) of this section, add sixteen dollars and forty-four cents.

(C) To the sum determined under division (B) of this section, add the per medicaid day quality incentive payment rate determined for the nursing facility under section 5165.26 of the Revised Code.

(D) If the nursing facility qualifies as a low occupancy nursing facility, subtract from the sum determined under division (C) of this section the nursing facility's low occupancy deduction determined under section 5165.23 of the Revised Code. "

After line 112019, insert:

"Sec. 5165.19. (A)(1) Semiannually, except as provided in division (A)(2) of this section, the department of medicaid shall determine each nursing facility's per medicaid day payment

rate for direct care costs by multiplying the facility's semiannual case-mix score determined under section 5165.192 of the Revised Code by the cost per case-mix unit determined under division (C) of this section for the facility's peer group.

(2) Beginning January 1, 2024, during state fiscal years 2024 and 2025, the department shall determine each nursing facility's per medicaid day payment rate for direct care costs by multiplying the cost per case-mix unit determined under division (C) of this section for the facility's peer group by the case-mix score specified in division (A)(2)(a) or (b) of this section, as selected by the nursing facility not later than October 1, 2023. If the nursing facility does not make a selection by October 1, 2023, the case-mix score specified in division (A)(2)(a) of this section shall apply. The case-mix score may be either of the following:

(a) The semiannual case-mix score determined for the facility under division (A)(1) of this section;

(b) The facility's quarterly case-mix score from March 31, 2023, which shall apply to the facility's direct care rate from January 1, 2024, to June 30, 2025.

(3) For the period beginning July 1, 2025, and ending December 31, 2025, the department shall determine each nursing facility's per medicaid day payment rate for direct care costs by multiplying the cost per case-mix unit determined under division (C) of this section for the facility's peer group by the following case-mix score:

(a) If the facility's case-mix score during fiscal year 2025 is the case-mix score specified in division (A)(2)(b) of this section, that case-mix score;

(b) If the facility's case-mix score during fiscal year 2025 is the semiannual case-mix score determined for the facility under division (A)(1) of this section, the semiannual case-mix score determined under that division for the semiannual period beginning July 1, 2025.

(B) For the purpose of determining nursing facilities' rates for direct care costs, the department shall establish three peer groups.

(1) Each nursing facility located in any of the following counties shall be placed in peer group one: Brown, Butler, Clermont, Clinton, Hamilton, and Warren.

(2) Each nursing facility located in any of the following counties shall be placed in peer group two: Allen, Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Stark, Summit, Trumbull, Union, and Wood.

(3) Each nursing facility located in any of the following counties shall be placed in peer group three: Adams, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot.

(C)(1) ~~The~~ Except as provided in division (C)(4) of this section, the department shall determine a cost per case-mix unit

for each peer group established under division (B) of this section. The cost per case-mix unit determined under this division for a peer group shall be used for subsequent years until the department conducts a rebasing. To determine a peer group's cost per case-mix unit, the department shall do both of the following:

(a) Determine the cost per case-mix unit for each nursing facility in the peer group for the applicable calendar year by dividing each facility's desk-reviewed, actual, allowable, per diem direct care costs for the applicable calendar year by the facility's annual average case-mix score determined under section 5165.192 of the Revised Code for the applicable calendar year;

(b) Subject to division (C)(2) of this section, identify which nursing facility in the peer group is at the seventieth percentile of the cost per case-mix units determined under division (C)(1)(a) of this section.

(2) In making the identification under division (C)(1)(b) of this section, the department shall exclude both of the following:

(a) Nursing facilities that participated in the medicaid program under the same provider for less than twelve months in the applicable calendar year;

(b) Nursing facilities whose cost per case-mix unit is more than one standard deviation from the mean cost per case-mix unit for all nursing facilities in the nursing facility's peer group for the applicable calendar year.

(3) The department shall not redetermine a peer group's cost per case-mix unit under this division based on additional

information that it receives after the peer group's per case-mix unit is determined. The department shall redetermine a peer group's cost per case-mix unit only if it made an error in determining the peer group's cost per case-mix unit based on information available to the department at the time of the original determination.

(4) The department shall multiply each cost per case-mix unit determined under division (C)(1) of this section by the peer group average case-mix score in effect on December 31, 2025, divided by the peer group average blended case-mix score determined under section 5165.192 of the Revised Code for the semiannual period beginning January 1, 2026. The product determined under this division for each nursing facility's peer group shall be the cost per case-mix unit used to determine each nursing facility's per medicaid day payment rate for direct care costs under division (A)(1) of this section for the period beginning January 1, 2026, and ending on the day before the department's next rebasing conducted after that date takes effect."

In line 112027, strike through "and is not a low case-mix resident"

In line 112042, strike through "in rules authorized"; after "by" insert "division (A)(2)(d) of"

In line 112047, delete "nursing index"

In line 112050, after "program" insert ";

(d) In applying the grouper methodology specified by division (A)(2)(c) of this section, the department shall utilize the following blend of case-mix indexes from the methodology:

(i) Seventy per cent of the nursing case-mix index;

(ii) Twenty per cent of the speech-language pathology case-mix index;

(iii) Ten per cent of the non-therapy ancillaries case-mix index"

In line 112107, strike through "Modify the grouper methodology specified in division"

Strike through line 112108

In line 112109, strike through "(i)"

In line 112113, reinsert "changes to"

In line 112114, delete "nursing index used by"

In line 112115, reinsert "makes"

In line 112116, reinsert "after"; delete "on"

In line 112118, delete "(ii)"; strike through the balance of the line

Strike through line 112119

In line 128845, after "5163.05," insert "5165.152,"

Delete lines 134656 through 134674 (Remove Section 333.280)

Update the title, amend, enact, or repeal clauses accordingly

The motion was _____ agreed to.

SYNOPSIS

Nursing facility direct care costs and case-mix scores

R.C. 5165.01 and 5165.15; R.C. 5165.152 (repealed)

Modifies the Medicaid nursing facility funding direct care costs formula as follows:

--For calendar year 2026, specifies that instead of the regular direct care costs formula, a facility's direct care costs rate is the greater or lesser of: (1) the facility's current direct care costs rate, or (2) the facility's direct care costs rate on December 31, 2025, plus or minus $5 (based on comparing its December 31, 2025, rate to its current rate).

Case-mix scores

R.C. 5165.19 and 5165.192

For purposes of calculating a nursing facility's direct care costs: prescribes the case-mix score to use in calculations from July 1 through June 30, 2026; specifies the cost per case-mix unit calculation for the semiannual period from January 1, 2026, through the next rebasing.

Regarding the case-mix score used as a multiplier to calculate a nursing facility's direct care costs:

--Removes the exclusion of Medicaid recipients who are low case-mix residents from a component of the case-mix score calculation (i.e. all Medicaid residents will be counted for purposes of calculating a facility's case-mix score);

--Prescribes how ODM must blend case-mix indexes when using the grouper methodology to determine case-mix scores, and removes ODM's authority to adopt different procedures by rule;

--As such, requires ODM to incorporate in rules changes to the CMS grouper methodology, rather than incorporating the full methodology by rule;

--Removes Executive provisions providing for a gradual implementation of the CMS patient-driven payment model for direct care cost case-mix scores.