IN THE SUPREME COURT OF OHIO

STATE OF OHIO *EX REL.* LEADINGAGE OHIO, *et al.,*	)	**CASE NO. 2024-1075**
Plaintiffs/Relators,	)	**ORIGINAL ACTION IN MANDAMUS**
v.	)	
THE OHIO DEPARTMENT OF MEDICAID, *et al.,*	)	
Defendants/Respondents.	)	

RELATORS' MERIT BRIEF

BARNES & THORNBURG LLP
Counsel of Record:
David Paragas (0043908)
41 S. High Street, Suite 3300
Columbus, Ohio 43215
Phone: (614) 628-1407
David.Paragas@btlaw.com

Kian Hudson (admitted *pro hac vice*)
11 South Meridian Street
Indianapolis, Indiana 46204
Phone: (317) 229-3111
Kian.Hudson@btlaw.com

ROLF GOFFMAN MARTIN LANG LLP
Aric D. Martin (0065765)
Joseph F. Petros III (0088363)
31105 Bainbridge Road, Suite 4
Cleveland, Ohio 44139
Phone: (216) 514-1100
Fax: (216) 626-7623
Martin@RolfLaw.com
Petros@RolfLaw.com

Attorneys for Relators

FROST BROWN TODD LLP
Counsel of Record:
Frank J. Reed
One Columbus, Suite 2300
10 West Broad Street
Columbus, OH 43215
freed@fbtlaw.com

Ryan W. Goellner
Nathaniel L. Truitt
3300 Great American Tower
301 East Fourth Street, Suite 3300
Cincinnati, OH 45202
rgoellner@fbtlaw.com
ntruitt@fbtlaw.com

Attorneys for Respondents

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INTRODUCTION

This case turns on a simple question of statutory interpretation: ***Does "rate" mean "rate," or does "rate" mean "price"?*** The express language of House Bill 33 (the budget legislation enacted in 2023; hereinafter, the "Budget Legislation") requires Respondents, when calculating quality incentive reimbursement rates for nursing facilities, to include 60% of the amount by which each nursing facility's "**rate for direct care costs** … changed as a result of the rebasing" that ODM conducts to update its data regarding nursing facilities' costs of providing care. R.C. 5165.26(E)(1)(a) (emphasis added).

Though this language is unambiguous, Respondents openly admit that they are refusing to follow it. They acknowledge that they are not including 60% of the change in the "rate for direct care costs," but are instead including only 60% of the change in the "cost per case-mix unit" (commonly known as the "price"). And this misapplication of the statute has severe consequences: Ohio law defines a nursing facility's "rate for direct care costs" as the **product** of the "price" multiplied by that facility's "case-mix score." Accordingly, the rebasing-caused change in the rate is substantially larger than the rebasing-caused change in the price. Respondents' refusal to follow the statute as written has thus resulted in quality incentive payments that are multiples lower than they should be.

The three elements for mandamus relief are easily satisfied in this case: (1) a clear legal right to the requested relief; (2) a corresponding clear legal duty on the part of the defendant/respondent to provide it; and (3) the lack of an adequate remedy in the ordinary course of the law. *State ex rel. Lane v. Pickerington*, 130 Ohio St.3d 225, 2011-Ohio-5454, 957 N.E.2d 29, ¶ 10. This is not a case involving an unclear or ambiguous statute. The statute's mandatory calculation formula is clear; Respondents' obligation to implement it is clear; and Relators have exhausted the administrative process and have no further legal remedy. Relators are therefore

entitled to a peremptory writ of mandamus directing Respondents to implement the Budget Legislation as written: ODM must calculate the total amount to be spent on quality incentive payments using 60% of the change in each facility's "rate"—not 60% of the change in "price."

STATEMENT OF FACTS

A. Ohio's Statutory Framework for Nursing Facility Medicaid Payment Rates

In Ohio, the methodology for setting Medicaid payment rates for nursing facilities is set by the General Assembly in statute, Revised Code chapter 5165. The predecessors of the current statutes on nursing facility rates go back to 1980 and have been amended numerous times over the intervening years, typically through budget legislation, as the legislature has adjusted the state's Medicaid rate-making policy. For many years, the statutory scheme has covered virtually every detail of rate calculation and implementation, leaving little to the discretion of ODM, the agency charged by law with administering the statutory rate structure as the legislature has prescribed it.

Medicaid reimbursement for nursing facility care in Ohio is made up of two components: a "base rate" and a "quality incentive payment rate." R.C. 5165.15, R.C. 5165.26. The "base rate" is received by all eligible Medicaid nursing facility providers based on the cost of providing care and is not dependent on facilities' performance on quality metrics. *Id.* The "quality incentive payment rate" is received only by providers who achieve certain quantifiable quality standards and is calculated pursuant to Revised Code section 5165.26.

Currently, the statutory methodology for calculating both the base rate and the quality incentive payment rate includes several cost-related components, each based on aggregated cost data for expenses incurred in caring for nursing facility residents. Because facilities' costs change over time, ODM is required every few years to update its data regarding nursing facilities' costs of providing care through a process called "rebasing." R.C. 5165.36, 5165.19, 5165.01(SS)(3).

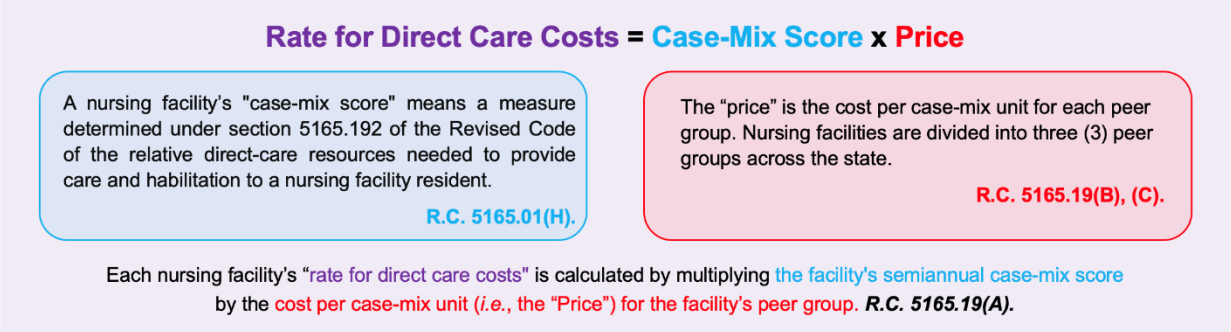
Increased costs reflected in rebasing serve as the basis for increases in the Medicaid reimbursement rates that Ohio pays to nursing facilities.

For purposes of this case, the critical cost-related component at issue is the "rate for direct care costs." This is a statutorily defined term, and it is calculated for each nursing facility by multiplying the facility's semiannual "case-mix score" by the "cost per case-mix unit" (commonly referred to as the "price") for the facility's peer group.[1] R.C. 5165.19(A). (*See* Figure 1, below.) Specifically, the statute provides that 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** … by the **cost per case-mix unit** … for the facility's peer group." R.C. 5165.19(A)(1) (emphasis added). Indeed, in each of the three affidavits submitted by Respondents, each affiant specifically agrees with this definition of "rate": "At a high level, a facility's **Rate** for direct care costs is the product of the peer group's **Price** (cost per case-mix unit) and the facility's **Case-mix score** (an acuity scale, see R.C. 5165.01(H)). *See* R.C. 5165.19(A)(1).'" Corcoran ¶ 15 (emphases in original); *see also* Beatty ¶ 16 (same); Schlagheck ¶ 16 (same).[2]

[1] A "peer group" is a grouping of nursing facilities that share similarities based upon their respective metropolitan statistical areas. The use of peer groups is intended to ensure that the "price" reflects the differing costs of providing care to residents depending upon the location of a nursing facility (*i.e.*, the cost of providing care in urban areas and in rural areas differs). R.C. 5165.19(B).

[2] This brief cites to Volume I of Respondent's Evidence Submission (the Affidavit of ODM Director Maureen Corcoran) as "Corcoran ¶ __." It cites to Volume II of Respondent's Evidence Submission (the Affidavit of ODM Deputy Director and Chief of Policy Patrick Beatty) as "Beatty ¶ __." And it cites to Volume III of Respondent's Evidence Submission (the Affidavit of former ODM Deputy Director Joan Schlagheck) as "Schlagheck ¶ __."

Figure 1



A nursing facility's "case-mix score" is the result of an individualized calculation ODM makes for each facility that reflects the clinical acuity of the facility's residents (and by extension, the cost of providing care to that facility's residents). *See* R.C. 5165.192. As the statute itself puts it, the "case-mix score" is "a measure … of the relative direct care resources needed to provide care and habilitation to a nursing facility resident." R.C. 5165.01(H).

The "cost per case-mix unit" (*i.e.*, the "price") is a dollar figure representing the cost of providing direct care services to a single hypothetical nursing facility resident in a certain geographic area of the state. *See* R.C. 5165.19(C). The statute directs ODM to calculate this figure for each of three different geographic "peer groups" that are organized by county; within each group, all facilities have the same "price." *See* R.C. 5165.19(B)–(C).

It is essential to distinguish between a nursing facility's "rate for direct care costs" (which per the statute is the product of **multiplication**) and a nursing facility peer group's "price" (which per the statute is one of the two **factors** in the multiplication that produces the rate for direct care costs). Figure 1, above, illustrates this relationship. The "rate for direct care costs" and the "price" are two specifically defined statutory terms. ODM has erroneously conflated these terms in calculating nursing facilities' quality incentive rates.

B. Budget Legislation Amendments to Nursing Facility Medicaid Reimbursement

In an effort to boost the incentive to provide high-quality care, the Budget Legislation purposefully shifts total Medicaid reimbursement for nursing facilities more toward the quality incentive payment rate by mandating that 60% of the increase in funding from "rebasing" be allocated toward the quality incentive payment rate, with 40% of the increase allocated toward the base rate. To do so, the Budget Legislation amends the formula for determining the "total amount to be spent on quality incentive payments" that is contained in section 5165.26(E) as follows:

> (E) The total amount to be spent on quality incentive payments … for a fiscal year shall be determined as follows:
>
> (1) Determine the following amount for each nursing facility:
>
> (a) The amount that is five and two-tenths per cent of the nursing facility's base rate for nursing facility services provided on the first day of the state fiscal year plus one dollar and seventy-nine cents **plus sixty per cent of the per diem amount by which the nursing facility's rate for direct care costs determined for the fiscal year under section 5165.19 of the Revised Code changed as a result of the rebasing conducted under section 5165.36 of the Revised Code**.
>
> (b) Multiply the amount determined under division (E)(1)(a) of this section by the number of the nursing facility's medicaid days for the calendar year preceding the fiscal year for which the rate is determined.
>
> (2) Determine the sum of the products determined under division (E)(1)(b) of this section for all nursing facilities for which the product was determined for the state fiscal year.
>
> (3) To the sum determined under division (E)(2) of this section, add one hundred twenty-five million dollars.

R.C. 5165.26(E) (emphasis added).

Correspondingly, as to the base rate, section 333.300 of the Budget Legislation specifies:

> For fiscal years 2024 and 2025, the Department of Medicaid shall include in each nursing facility's base rate **only forty per cent of**

the increase in its rate for direct care costs due to the rebasing conducted pursuant to section 5165.36 of the Revised Code.[3]

2023 Ohio Laws File 8 (Am. Sub. H.B. 33) Section 333.300 (uncodified). Critically, the same term—"rate for direct care costs"—is used in both R.C. 5165.26(E)(1)(a) and section 333.300 of the Budget Legislation. Taken together, these two statutory provisions make clear how the increase in each nursing facility's "**rate for direct care costs**" as a result of rebasing is to be divided: 60% toward the quality incentive payment rate, and 40% toward the base rate.

C. ODM's Egregious Misinterpretation of the Budget Legislation

ODM has refused to follow the Budget Legislation's unambiguous statutory command and has adopted an incorrect calculation formula that significantly shortchanges the increase in the quality incentive payment rate. In calculating the "total amount to be spent on quality incentive payments," ODM did not take 60% of the amount by which each nursing facility's "**rate for direct care costs**" changed due to rebasing, as required under R.C. 5165.26(E). Instead, ODM merely took 60% of the amount by which each peer group's "**price**" changed as a result of rebasing. (Relators' Aff. ¶ 25; Beatty ¶ 26). [4] As explained above, the "price" is only one of two factors that, when multiplied, produce each nursing facility's "rate for direct care costs." (*See* Figure 1). As a

[3] The statute defines a nursing facility's "base rate" to mean its total payment rate *other than* its quality incentive payment rate. *See* R.C. 5165.26(A)(1) ("'Base rate' means the portion of a nursing facility's total per medicaid day payment rate determined under divisions (A) and (B) of section 5165.15 of the Revised Code."); R.C. 5165.15(A)–(B) (providing that a nursing facility's "total per medicaid day payment rate" is the sum of several subsidiary rates, including the "per medicaid day payment rate for direct care costs determined for the nursing facility under section 5165.19 of the Revised Code"); R.C. 5165.15(C) (providing that a nursing facility's "total per medicaid day payment rate" also includes "the per medicaid day quality incentive payment rate determined for the nursing facility under section 5165.26 of the Revised Code").

[4] This brief cites to the Affidavits of Christopher Murray, Peter VanRunkle, and Susan Wallace included in Relators' Submission of Evidence collectively as "Relators' Aff. ¶ __." These Affidavits use the same paragraph numbering, so the same paragraph citation applies to each of the three Affidavits. This brief cites to the Affidavit of Joseph F. Petros III included in Relators' Submission of Evidence as "Petros Aff. ¶ __."

result of ODM's error, the amount of the increase in quality incentive payments is much smaller than it is supposed to be under the statute. (Relators' Aff. ¶ 27).

Remarkably, even though ODM made this error when calculating the quality incentive payment rate, it did not make the same error when calculating the base rate, even though that statutory section uses the same exact term—"rate for direct care costs." ODM **correctly** included in each facility's base rate 40% of the change in each nursing facility's total "**rate for direct care costs**"—*i.e.*, 40% of the full **product** of each nursing facility's "case-mix score" and "price." (Relators' Aff. ¶¶ 28–29; Corcoran ¶ 31; Schlagheck ¶ 22; Beatty ¶ 27). The upshot of this erroneous inconsistency: a much greater proportion of the resulting funding increase is going toward the base rate than is going toward the quality incentive rate, undermining the General Assembly's considered choice to emphasize quality. (Relators' Aff. ¶ 30). Furthermore, because the quality incentive component is being shortchanged, ODM is depriving Ohio's nursing facilities—and thus the vulnerable residents of those facilities—of Medicaid funding that the legislature has specifically *required* ODM to spend. (Relators' Aff. ¶ 31).

Though Respondents had shared with Relators and others their projections as to what they thought the *overall cost* of the Budget Legislation's quality incentive and nursing home reimbursement provisions would be to the Medicaid program, they never shared the calculations they were using to arrive at those numbers, or the rebasing adjustments that went into those calculations, until on or around July 13, 2023—after the Budget Legislation had been signed into law and a mere two weeks before they posted nursing facilities' reimbursement rates to their online portals. (Relators' Aff. ¶ 32; Corcoran ¶ 30). Upon seeing that ODM was performing the calculation incorrectly, Relators submitted a formal rate reconsideration request urging ODM to

correct its rate calculations. (Relators' Aff. ¶ 34).[5] Notably, a rate reconsideration request is the sole statutory and regulatory method for providers and associations to challenge rate calculation errors administratively. *See* R.C. 5165.38; Ohio Administrative Code 5160-3-24.

Despite the clear language of the statute, ODM denied Relators' Rate Reconsideration Request and continues to insist upon its erroneous calculation formula. (Relators' Aff. ¶ 35).[6] As discussed in greater detail below, the key portion of ODM's response illustrates the conspicuousness of the agency's error:

> The amendment to Ohio Revised Code, 5165.26(E), in HB 33 requires the addition of 60% of the amount by which the nursing facility's rate for direct care costs changed **as a result of rebasing** to the quality pool of funds. As noted above, **the change to the rate as a result of rebasing is a change to the price**. Sixty percent was properly applied to the change in price.

App. 9 (second emphasis added).

It is simply not true that "the change to the rate as a result of rebasing is a change to the price." As explained above, the statutory language makes it abundantly clear that the rate and the price are two different things. The price is a **component** of the rate; it is **not the same thing** as the rate. (*See* Figure 1). **ODM's inexplicable conflation of these two precisely defined statutory terms has now led to this mandamus petition.**

Because Relators have no further administrative or legal remedy, they now turn to this Court to issue a writ of mandamus compelling ODM to comply with the law as written.

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[5] Relators' Rate Reconsideration Request is included in the Appendix attached to this brief at App. 1–7 and is included in Relators' Submission of Evidence.

[6] ODM's response denying Relators' Rate Reconsideration Request is included in the Appendix attached to this brief at App. 8–10 and is included in Relators' Submission of Evidence.

ARGUMENT

Proposition of Law No. 1: A Writ of Mandamus Is the Proper Remedy for the Failure of a State Agency to Comply with a Statutory Duty.

This Court has original jurisdiction in mandamus actions. Ohio Constitution, Article IV, section 2(B)(1)(b); R.C. 2731.02. And this Court has long recognized that "mandamus will lie when a public officer or agency is under a clear legal duty to perform an official act, the relator is being denied a private right or benefit by the officer's or agency's failure to perform that official act, and the relator has no plain and adequate remedy in the ordinary course of the law." *State ex rel. McCarley v. Dep't of Rehab. & Correction*, 175 Ohio St. 3d 460, 2024-Ohio-2747, 244 N.E.3d 1114, ¶ 15, citing *State ex rel. Pressley v. Indus. Comm.*, 11 Ohio St.2d 141, 228 N.E.2d 631, 648 (1967). Accordingly, a writ of mandamus is proper upon demonstration of (1) a clear legal right to the requested relief; (2) a corresponding clear legal duty on the part of the defendant/respondent to provide it; and (3) the lack of an adequate remedy in the ordinary course of the law. *State ex rel. Lane*, 130 Ohio St.3d 225, 2011-Ohio-5454, 957 N.E.2d 29, ¶ 10. All three of those factors are easily satisfied here.

Proposition of Law No. 2: Relators Have a Clear Legal Right to the Requested Relief, and ODM Has a Corresponding Clear Legal Duty to Provide It

a. Relators Have Standing to Bring This Petition.

As an initial matter, Relators note that they all have standing to bring this petition and that they all are entitled to the requested mandamus relief. "To have standing in a mandamus case, a relator must be 'beneficially interested' in the case." *State ex rel. Ames v. Portage Cty. Bd. of Revision*, 166 Ohio St.3d 225, 2021-Ohio-4486, 184 N.E.3d 90, ¶ 10, quoting *State ex rel. Hills & Dales v. Plain Local School Dist. Bd. of Edn.*, 158 Ohio St.3d 303, 2019-Ohio-5160, 141 N.E.3d 189, ¶ 9. "[T]he applicable test is whether [a] relator[] would be directly benefited or injured by a

judgment in the case." *Id.*, quoting *State ex rel. Sinay v. Sodders*, 80 Ohio St.3d 224, 226, 1997-Ohio-344, 685 N.E.2d 754.

Relators LeadingAge, OHCA, and the Academy, are "beneficially interested" in this case and have standing to bring this petition as trade associations on behalf of their nursing facility members. "[A]n association has standing on behalf of its members when '(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit.'" *State ex rel. Am. Subcontractors Assn. v. Ohio State Univ.*, 129 Ohio St.3d 111, 2011-Ohio-2881, 950 N.E.2d 535, ¶ 12, quoting *Ohio Contractors Assn. v. Bicking*, 71 Ohio St.3d 318, 320, 643 N.E.2d 1088 (1994).

Here, all three trade associations' members include nursing facilities that have received—and, absent this Court's action, will continue to receive—quality incentive payments that are lower than the Budget Legislation requires under Revised Code section 5165.26. (Relators' Aff. ¶¶ 3–5). Accordingly, their members would have standing to sue in their own right. The interests the trade associations seek to protect in this lawsuit are also germane to their organizations' purposes, which include advocating for the interests of their member nursing facilities and the populations they serve. (Relators' Aff. ¶ 6). Finally, neither the claim asserted nor the relief requested in this lawsuit requires the participation of each individual member, given that ODM's error is in the calculation of the statewide "total amount to be spent on quality incentive payments." R.C. 5165.26(E).

b. The Statute Clearly Requires ODM to Take 60% of Each Nursing Facility's "Rate for Direct Care Costs"—Not 60% of Each Peer Group's "Price"—in Calculating the "Total Amount to Be Spent on Quality Incentive Payments."

The question before the Court is quite narrow and quite simple: **Does "rate" mean "rate," or does "rate" mean "price"?** The sole issue is whether the term "rate for direct care costs" in Revised Code section 5165.26(E)(1)(a) actually means "rate for direct care costs" (as Relators

contend), or whether it instead means "cost per case-mix unit" (also known as the "price," as Respondents contended in their rate reconsideration response).

The answer is as simple as the question. This Court has consistently held: "It is a cardinal rule of statutory construction that where the terms of a statute are clear and unambiguous, the statute should be applied without interpretation." *Wilson v. Lawrence*, 150 Ohio St.3d 368, 2017-Ohio-1410, 81 N.E.3d 1242, ¶ 11, quoting *Wingate v. Hordge*, 60 Ohio St.2d 55, 58, 396 N.E.2d 770 (1979). "When the statutory language is plain and unambiguous, and conveys a clear and definite meaning, we must rely on what the General Assembly has said, and give effect only to the words the legislature used, making neither additions to, nor deletions from, the statutory language." *Id.* (quotation marks and citations omitted).

There can be no doubt that Relators are entitled to the relief sought and that ODM has a legal duty to provide it. Unlike Ohio's Medicaid payments for other types of healthcare providers, Medicaid payments for Ohio nursing facilities are mandatory and spelled out in statute; it is not left to the discretion of ODM or to administrative regulation. ODM is statutorily required to calculate and provide nursing facility payments precisely as directed under Revised Code chapter 5165—including quality incentive payments under Revised Code section 5165.26. That section unambiguously mandates that "the department of medicaid **shall** determine each nursing facility's per medicaid day quality incentive payment rate as follows…." R.C. 5165.26(B) (emphasis added). "It is axiomatic that when it is used in a statute, the word 'shall' denotes that compliance with the commands of that statute is *mandatory*." *Dept. of Liquor Control v. Sons of Italy Lodge 0917*, 65 Ohio St.3d 532, 534, 605 N.E.2d 368 (1992) (emphasis in original).

It is also important to note that Ohio courts are not obliged to give any deference to a state agency's interpretation of the law. As this Court recently confirmed, "it is the role of the judiciary,

not administrative agencies, to make the ultimate determination about what the law means. Thus, the judicial branch is *never* required to defer to an agency's interpretation of the law." *TWISM Enters. v. State Bd. of Registration for Prof'l Eng'rs & Surveyors*, 2022-Ohio-4677, 172 Ohio St. 3d 225, 223 N.E.3d 371, ¶ 3 (2022) (emphasis in original).

As to the statutory formula for calculating the "total amount to be spent on quality incentive payments," the Budget Legislation expressly requires ODM to take "sixty per cent of the per diem amount by which the nursing facility's **rate for direct care costs** determined for the fiscal year under section 5165.19 of the Revised Code changed as a result of the rebasing conducted under section 5165.36 of the Revised Code." R.C. 5165.26(E)(1)(a). Each nursing facility's **individualized** "rate for direct care costs" is determined under section 5165.19 by **multiplying** the facility's semiannual "case-mix score" by its peer group's "price" (*i.e.*, the peer group's "cost per case-mix unit"). There is simply no textual basis for ODM's erroneous conclusion that 60% of the change in the "rate for direct care costs" actually means 60% of the change in the "price."

ODM's error is further highlighted by its inconsistency. Despite the fact that the same term—"rate for direct care costs"—is used in both R.C. 5165.26(E)(1)(a) and section 333.300 of the Budget Legislation, ODM is not giving that term the same meaning under each section. In calculating facilities' base rates under section 333.300, ODM correctly included 40% of the change in the "rate for direct care costs"—*not* the change in the "price." (Relators' Aff. ¶¶ 28–29; Corcoran ¶ 31; Schlagheck ¶ 22; Beatty ¶ 27). Yet inexplicably, in calculating quality incentive rates under R.C. 5165.26(E)(1)(a), ODM incorrectly included 60% of the change in "price" instead of the change in the "rate for direct care costs." (Relators' Aff. ¶ 25; Beatty ¶ 26). As a result of this inconsistent and nonsensical approach, the increase in the quality incentive rate ended up being *less* than the increase in the base rate—directly contrary to what the General Assembly mandated.

The error in ODM's interpretation is also underscored by the fact that the "price" is a generalized number that applies to all nursing facilities in a given peer group. Section 5165.26, on the other hand, directs ODM to "[d]etermine for **each** nursing facility … sixty per cent of the per diem amount by which **the nursing facility's** rate for direct care costs … changed." R.C. 5165.26(E)(1). If the General Assembly intended that the calculation be applied to the peer group price (as ODM insists), it would not have needed to require ODM to perform separate calculations for every facility. Instead, it would have written the statute to perform the calculation using peer group prices (which would have required 3 calculations instead of 900+).

There is no legal basis to conclude that the General Assembly meant anything other than what it wrote. The statutory language could not be clearer. It therefore must be applied as written.

c. ODM's Response to Relators' Request for Rate Reconsideration Confirms that the Agency's Approach Is Unsupported and Internally Inconsistent.

To date, ODM's *only* response consists of a two-paragraph argument in ODM's response to Relators' Request for Reconsideration. The agency's argument begins on page 2 and reads, in its entirety, as follows:

> Pursuant to Ohio Revised Code, 5165.01(SS), rebasing for direct care costs is a redetermination of the peer group cost per case-mix unit, also known as the price. Rebasing is not a redetermination of the rate for an individual facility. Therefore, the change to the rate as a result of rebasing is a change to the price and 60% of the change in price is to be added to the quality pool of funds.
>
> Your reconsideration request focuses on the term, "rate," without consideration of the remainder of the sentence that focuses on the change as a result of rebasing. The plain language of the statute does not require the addition of 60% of the **funding generated by rebasing** to the quality pool of funds. Rather, as noted in division (E)(1)(a) above, the quality pool of funds includes sixty percent of the amount by which the nursing facility's rate for direct care costs changed **as a result of rebasing.** Had the General Assembly wanted 60% to apply to the funding generated by rebasing, it would have

> included that language in the statute. It did not. Instead, it required that 60% of the change in price be applied to the quality pool of funds.

App. 9 (emphasis in original).

A point-by-point analysis of ODM's argument lays bare the agency's illogical and self-contradictory interpretation.

> *ODM: Pursuant to Ohio Revised Code, 5165.01(SS), rebasing for direct care costs is a redetermination of the peer group cost per case-mix unit, also known as the price. Rebasing is not a redetermination of the rate for an individual facility.*

The statute does indeed provide that "'Rebasing' means a redetermination of," among other things, "[e]ach peer group's cost per case-mix unit" (*i.e.,* a redetermination of the peer group's price). R.C. 5165.01(SS). This is irrelevant, however, because section 5165.26 does not refer to "rebasing" in the abstract; it expressly refers to the "amount by which the nursing facility's **rate for direct care costs** … **changed as a result of the rebasing**." R.C. 5165.26(E)(1)(a). Rebasing re-determines the price for each peer group, and the statute recognizes that each individual facility's "rate for direct care costs" changes ***as a result of*** that redetermination because each facility's "rate for direct care costs" is equal to the price multiplied by the facility's "case-mix score." R.C. 5165.19(A)(1). In other words, the "rate" for each facility in a peer group will **necessarily** change due to a rebasing-caused redetermination of the peer group's price.

> *ODM: Therefore, the change to the rate as a result of rebasing is a change to the price and 60% of the change in price is to be added to the quality pool of funds.*

This is incorrect. The change in the "rate" is the change in the "rate"—it is not the same thing as the change in the "price." The explicit statutory definitions make it crystal clear that an individual facility's "rate for direct care costs" is not the same thing as the "price" for that facility's peer group. The Budget Legislation specifically requires ODM to use the change in an individual

"nursing facility's rate for direct care costs" that results from rebasing—not merely the change in the overall peer group's "price" that results from rebasing. ODM is obviously aware of this distinction because it correctly used the change in each nursing facility's "rate for direct care costs" in calculating the base rates, but chose not to do so in calculating the quality incentive rates. There is nothing in the statute that would suggest that ODM should interpret this identical language differently in these two contexts.

> *ODM: Your reconsideration request focuses on the term, "rate," without consideration of the remainder of the sentence that focuses on the change as a result of rebasing. The plain language of the statute does not require the addition of 60% of the* ***funding generated by rebasing*** *to the quality pool of funds.*

The plain language of the statute does indeed require the addition of 60% of the funding generated by rebasing. The statute is clear as to what it requires. ODM must calculate for each nursing facility 60% of the amount "by which the nursing facility's rate for direct care costs changed … as a result of the rebasing." R.C. 5165.26(E)(1). The General Assembly correctly recognized that this "change" would inevitably be an **increase** in each facility's "rate for direct care costs," and it directed ODM to then sum together the facility-specific figure "for all nursing facilities." R.C. 5165.26(E)(2).

> *ODM: Rather, as noted in division (E)(l)(a) above, the quality pool of funds includes sixty percent of the amount by which the nursing facility's rate for direct care costs changed* ***as a result of rebasing****.*

Remarkably, this ODM sentence correctly states Relators' point: the pool of funds for quality incentive payments includes 60% of the amount by which each "nursing facility's rate for direct care costs changed"—not merely 60% of the amount by which **each peer group's price** changed—"as a result of rebasing."

> *ODM: Had the General Assembly wanted 60% to apply to the funding generated by rebasing, it would have included that language in the statute. It did not.*

> *Instead, it required that 60% of the change in price be applied to the quality pool of funds.*

This directly contradicts ODM's (correct) immediately preceding statement, that the General Assembly required ODM to take "sixty percent of the amount by which the nursing facility's **rate for direct care costs** changed as a result of rebasing"—not 60% of the change in **price**. Indeed, section 5165.26 **nowhere mentions price (or "cost per case-mix unit") at all**.

After making the above faulty statutory arguments, ODM's response to Relators' Rate Reconsideration Request concludes with several assertions that may shed light on why ODM is insisting upon such a clearly erroneous interpretation of the statute:

> *ODM: The funds appropriated from the General Assembly to the department align with the department's calculation. Specifically, the Legislative Budget Office (LBO) estimated the nursing home provisions would increase costs for Medicaid services by $627,600,000 in FY 2024 and $747.600,000 in FY 2025. The statutory language, when applied as the department did, produced this monetary result. The fiscal assessment by the LBO of the cost of the full nursing facility HB 33 budget package matches the result of a change in price. It does not match a change in the rate. The total expenditures estimated by the LBO were known to all parties during the budget process. No concerns were raised.*
>
> *Applying terms in the manner you have suggested would result in an expenditure of $285.6 million more per year than was authorized by the General Assembly.*

The implied reasoning here is faulty for several reasons.

First, there is no specific nursing facility allocation provided by the General Assembly. The General Assembly has allocated $36 billion to ODM, and it has allocated those funds on an agency-wide basis; there is no portion of that allocated amount that is specifically designated for a "nursing facility" budget (or for any other provider type or program within ODM).

Second, there is no cap on what amount of the overall ODM budget may be allocated to nursing facilities. The statute provides a mandatory methodology for determining the *rates* that will be paid to nursing facilities, but not a floor or a limit to what overall *dollar amount* will be

provided, which is obviously dependent upon numerous factors, such as the number of Medicaid residents served, the lengths of their stays, and the services provided to them.

Third, Respondents have provided no evidence that ODM will hit its *agency-wide*, biennial appropriation limit of $36 billion. Indeed, official figures show that ODM's spending is hundreds of millions of dollars *under* budget. *See* ODM, Budget Variance Reports, https://medicaid.ohio.gov/stakeholders-and-partners/reports-and-research/budget-variance-reports/. Regardless, while Ohio law does prohibit state agencies from *actually* spending more than is appropriated to them (*see* R.C. 131.33(A)), it does not authorize state agencies to refuse to make particular *statutorily mandated* expenditures at the beginning of a fiscal period simply because they project their overall appropriation may not cover all their anticipated spending (including discretionary spending) for the entire period. It is important to note that, while other parts of the Medicaid budget are discretionary, the calculation and payment of nursing facility reimbursement rates, including quality incentive payments, are mandatory and must be made as directed under Revised Code chapter 5165. *See* R.C. 5165.26(B).

Fourth, ODM's reference to budgetary projections provided by the Legislative Budget Office ("LBO")—which ODM insists are consistent with ODM's position—provides no support for ODM's contradictory interpretation of the statute. The LBO's projections relied entirely on calculations *ODM* provided; ODM's invocation of the LBO's projections is thus nothing more than a tautology. And regardless, the LBO is not the General Assembly, and LBO projections are not the law. ODM was obligated to follow the clear text of the statute. It has refused to do so.

d. Ohio Courts Consistently Grant Mandamus Petitions Against Agencies that Fail to Execute Mandatory Expenditures.

This Court and the state's courts of appeals have consistently held that a government body cannot refuse to make a statutorily required expenditure simply because it may result in hardship

to other, discretionary parts of its budget. This Court has expressly "refused to excuse a governmental body from fulfilling its mandatory duty based upon a claim of hardship." *State ex rel. Durkin*, v. *Youngstown City Council*, 9 Ohio St.3d 132, 134 (1984); *see also State ex rel. Foster v. Bd. of County Commrs*., 16 Ohio St.2d 89, 91, 242 N.E.2d 884 (1968); *State ex rel. Motter v. Atkinson*, 146 Ohio St. 11, 15, 63 N.E.2d 440 (1945). In *State ex rel. Moorehead, v. Reed*, 177 Ohio St. 4, 6, 201 N.E.2d 594 (1964), this Court held that required expenditures must be made even if "there are no unappropriated or unencumbered funds out of which the additional funds could be appropriated, and…to comply with…[the court's] request would work an undue hardship and burden on other offices and agencies." *Id.* at 6; *accord State ex rel. Clarke v. Lawrence Cty. Bd. of Comm'rs*., 141 Ohio St. 16, 46 N.E.2d 410 (1943). In *State ex rel. Motter*, this Court rejected as a defense that there was not enough money to cover the relator's request and at the same time keep open and operate other offices. 146 Ohio St. at 14. Courts of appeals have held likewise. *See, e.g., State ex rel. Cottrill v. Meigs Cty. Bd. of Mental Retardation & Dev. Disabilities*, 86 Ohio App.3d 596, 602-603, 621 N.E.2d 728 (4th Dist.1993), *State ex rel. Smith v. Culliver*, 186 Ohio App.3d 534, 2010-Ohio-339, 929 N.E.2d 465, ¶ 36 (5th Dist.), *State ex rel. Stacey v. Halverstadt*, 7th Dist. Columbiana No. 87-C-30, 1987 WL 18846, at *2–3 (Oct. 23, 1987).

In *State ex rel. Cottrill*, the Fourth District considered an appeal of a writ of mandamus ordering the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD, now Department of Developmental Disabilities) to provide certain statutorily mandated funding to the Meigs County Board of Mental Retardation and Developmental Disabilities (MRDD). Like ODM in this case, ODMRDD argued that it should not be compelled to provide the funding because it would be "impossible," given its other budget constraints. The court rejected ODMRDD's argument, explaining that, "although there are other programs on which ODMRDD

might prefer to spend those funds, that spending is discretionary but the programs MRDD sought funds for were mandated programs." *Id.* at 603. The court continued:

> We note here, parenthetically, that the legislature does a lot more mandating than it does appropriating. This court does not fault ODMRDD, or the Meigs County MRDD, and recognizes that each agency is trying to do the best it can under the current appropriation. In a similar vein, this court can only do what it can under the current state of the law. We further recognize that our decision here will not resolve the underlying problem and that an ultimate resolution awaits legislative action. Nonetheless, we must apply the law as it is now.

Id.

The same reasoning applies here. To the extent ODM believes that performing the quality incentive calculation pursuant to the unambiguous language of the Budget Legislation will cause its overall appropriation for the 2024–2025 fiscal period to be insufficient to cover all its mandatory and discretionary expenses (a conjecture the evidence forecloses, not supports), it has several available recourses under Ohio law. If a state agency runs out of money (appropriations) for a particular program, it may either stop any spending for that program (if the program is discretionary), it may exercise one of the existing statutory options through the Controlling Board (which are more flexible for Medicaid because of the state's Health and Human Services Reserve Fund), or it may request a supplemental appropriation from the General Assembly. What ODM *cannot* do, however, is simply refuse to make a statutorily required expenditure—or rewrite a statute to accommodate its policy views and budgetary objectives.

Proposition of Law No. 3: Relators Lack an Adequate Remedy in the Ordinary Course of the Law.

Relators have exhausted their administrative remedies by filing a rate reconsideration request pursuant to Revised Code section 5165.38 and Administrative Code section 5160-3-24. Relators' Rate Reconsideration Request was denied. Relators do not have any further

administrative remedy or remedy at law pursuant to division (B) of Administrative Code section 5160-3-24, which provides:

> ODM's decision at the conclusion of the rate reconsideration process is final and shall not be subject to any administrative proceedings under Chapter 119 or any other provision of the Revised Code or Administrative Code.

This Court has expressly held that, "when nursing homes and their trade association seek to challenge a state agency's denial of requests for reconsideration of Medicaid reimbursement rates…the exclusive avenue of relief available to the nursing homes is to pursue a writ of mandamus." *Ohio Academy of Nursing Homes v. Ohio Dept. of Job & Family Servs.*, 114 Ohio St.3d 14, 2007-Ohio-2620, 867 N.E.2d 400, ¶ 1. This is especially true where, as here, mandatory relief is necessary to compel ODM to affirmatively calculate the total amount to be spent on quality incentive payments as required by statute. *See State ex rel. Arnett v. Winemiller*, 80 Ohio St.3d 255, 259, 685 N.E.2d 1219 (1997). Accordingly, Relators' only avenue to compel ODM to comply with its statutory duties in calculating the quality incentive payment rates for the July 1, 2023 rate-setting and any subsequent rate-setting is to seek mandamus relief from this Court. For the foregoing reasons, the Court should grant that relief.

Proposition of Law No. 4: Respondents' Affidavits Do Not Comply with S.Ct.Prac.R. 12.06 and Must Be Stricken Because They Are Not Based on Personal Knowledge.

In advance of the presentation of evidence, Relators' counsel reached out to Respondents' counsel on November 6, 2024, as required under Rule 12.06, to present a proposed agreed statement of facts and offering to collaborate on any appropriate revisions. (Petros Aff. ¶ 3). On November 14, 2024, Respondents' counsel responded that Respondents were declining to stipulate to **any** facts. (Petros Aff. ¶ 5). Relator's counsel replied on November 15, 2024 to confirm that Respondents would not stipulate to any of the facts in the proposed stipulation, and Respondents' counsel did not respond. (Petros Aff. ¶¶ 6–7).

Respondents instead submitted affidavits from Director Maureen Corcoran, Deputy Director and Chief of Policy Patrick Beatty, and Deputy Director Joan Schlagheck. Astonishingly, given the history of the parties' dispute, those affidavits do not comply with Rule 12.06's express requirement that affidavits be made on personal knowledge. In language identical to Rule 12.02(B)(2) governing affidavits submitted with the complaint, Rule 12.06(A) requires that affidavits submitted in the presentation of evidence "shall be made on personal knowledge, setting forth facts admissible in evidence, and showing affirmatively that the affiant is competent to testify to all matters stated in the affidavit." This Court has reiterated on numerous occasions that affidavits stating that the statements and claims contained therein are "true and correct" based on the affiant's "personal knowledge and information," "personal information and knowledge," or "best of her knowledge and belief" do not fully comply with the rule because it is not clear which allegations are based on personal knowledge and which allegations are based simply on information or belief. *See State ex rel. Commt. for Charter Amendment for an Elected Law Director v. Bay Village*, 115 Ohio St.3d 400, 2007-Ohio-5380, 875 N.E.2d 574, ¶ 13; *State ex rel. Evans v. Blackwell,* 111 Ohio St.3d 437, 2006-Ohio-5439, 857 N.E.2d 88, ¶ 32; *State ex rel. Hackworth v. Hughes,* 97 Ohio St.3d 110, 2002-Ohio-5334, 776 N.E.2d 1050, ¶ 24.

Here, all three of Respondents' affidavits state: "The evidence set forth in this affidavit is based on my personal knowledge, or the statements are true to the best of my knowledge and belief." (Corcoran ¶ 2; Beatty ¶ 2; Schlagheck ¶ 2). As in the cases cited above, it is not clear which statements are based on their personal knowledge, and which statements are based simply on information or belief. Respondents' affidavits therefore are not admissible in evidence, do not comply with Rule 12.06, and must be stricken and should not be considered.

<u>Proposition of Law No. 5:</u> Respondents' Affidavits Do Not Satisfy Their Duty to Show that Their Position Is Warranted Under the Law.

Even if Respondents' affidavits were based on personal knowledge and were in compliance with Rule 12.06, they only further confirm that Respondents are not following the law as written and have no legal justification for their position. A few points are noteworthy:

a. Respondents Admit They Are Including 60% of the Change in Price—Not 60% of the Change in Rate.

Respondents admit that they are not implementing the Budget Legislation as written. Specifically, they admit that they are not including in the quality incentive pool 60% of the increase in each facility's "rate" as a result of rebasing, but only 60% of the increase in the "price" as a result of rebasing. Patrick Beatty expressly confirms: "The ODM calculation was a result of diverting 60% of the increase to Price (as a result of rebasing) to the quality incentive pool." (Beatty ¶ 26).

b. Respondents Deny Basic Principles of Multiplication.

Respondents attempt to defend their refusal to follow the statute by refusing to acknowledge that rebasing results in a change to the "rate"—thereby denying basic principles of multiplication. The following three paragraphs from Director Corcoran's affidavit, which appear in direct sequence, aptly illustrate Respondents' bewildering position:

> 15. At a high level, **a facility's Rate for direct care costs is the product of the peer group's Price (cost per case-mix unit) and the facility's Case-mix score** (an acuity scale, see R.C. 5165.01(H)). See R.C. 5165.19(A)(1).
>
> 16. Rebasing is a redetermination, at least once every five years, of the direct care, ancillary and support, capital, and tax components of the rate. See R.C. 5165.01(SS). **In rebasing direct care costs, the Ohio Department of Medicaid conducts a redetermination of the Price, a key component for determining a facility's reimbursement rate for direct care costs**.

> 17. Since 2006, when the Ohio Department of Medicaid (formerly the Office of Medicaid at the Ohio Department of Job and Family Services) initiated its pricing system for nursing facility reimbursement, rebasing direct care costs has always applied only to determining the new direct care Price (cost per case-mix unit); i.e., **rebasing has no direct effect on a facility's rate for direct care costs.**

(Corcoran ¶¶ 15–17, emphasis added). In short, Director Corcoran admits that rebasing is a change to the "price," and admits that the "rate" is equal to the "price" multiplied by the "case-mix score"—but nevertheless insists, contrary to the laws of multiplication, that "rebasing has no direct effect on a facility's rate for direct care costs." Respondents refuse to accept simple arithmetic.

c. Respondents' Statements Confirm They Are Correctly Including 40% of the Change in "Rate" when Calculating the Base Rate.

Despite Respondents' insistence to the contrary, their statements confirm that, in contrast to their calculation of the quality incentive pool, they are indeed correctly including 40% of the change in "rate" when calculating the base rate. Corcoran and Schlagheck state that "40% of the increase went to the new Price, **which is then multiplied by nursing facilities' case-mix scores** to calculate their rate for direct care costs." (Corcoran ¶ 31, Schlagheck ¶ 22, emphasis added). Beatty states that "ODM allocates 40% of the increase in Price—which only occurs due to the rebasing calculation process—towards the actual new Price, **which in turn gets multiplied by each facility's case-mix score.**" (Beatty ¶ 27, emphasis added). Accordingly, for the base rate calculation, Respondents are correctly including 40% of the increase in "price" **multiplied by each facility's case-mix score**. In contrast, Respondents are **not** multiplying by each facility's case-mix score when calculating the total amount to be spent on quality incentive payments. (Beatty ¶ 26). So, while 40% of the increase in "price" multiplied by each facility's case-mix score (*i.e.*, 40% of the increase in each facility's "rate") is being included in the base rate, only 60% of the "price" is being included in the quality incentive pool.

d. This is the First Biennium in which Respondents Have Been Required to Perform This 60/40 Calculation.

To the extent Respondents try to suggest that this is the way they have always done things in years past (as is intimated, for example, in paragraph 17 of Director Corcoran's affidavit), it must be noted that this is the first time they have been required to perform this 60/40 split between quality incentive rate and base rate. Specifically, Respondents have never before been required to devote a percentage of the increase in each facility's "rate" as a result of rebasing to the quality incentive pool. Respondents cannot say they are performing this calculation as they have done before, because **the calculation has never been done before**.

e. Respondents Did Not Share Their Calculations with Relators Until July 13, 2023.

ODM's affidavits do not dispute that—until on or around July 13, 2023—ODM never told Relators about their nonsensical interpretation of the statutory language, and never shared with Relators the calculation method they were using to arrive at their overall cost estimates. Instead, Respondents' affidavits emphasize that they shared with Relators their projections regarding the *overall cost* of the Budget Legislation's quality incentive and nursing home reimbursement provisions. Those top-line estimates, however, did not reveal ODM's methodology or their mistaken view of the final statutory language—and ODM's affidavits do not contend otherwise. The fact is that it was not until on or around July 13, 2023—after the Budget Legislation had been signed into law and a mere two weeks before they posted nursing facilities' reimbursement rates to their online portals—that ODM disclosed the atextual "formula ODM was using for allocating the 60/40 split in funding." (Corcoran ¶ 30).

Regardless, the content of any communications between Respondents and Relators—none of whom are legislators—has no significance whatsoever for the meaning of the statute the General Assembly enacted. The General Assembly makes the law—not Respondents, and not Relators.

And the law the General Assembly enacted requires ODM to include 60% of the amount by which "the nursing facility's rate for direct care costs … changed as a result of the rebasing." R.C. 5165.26(E)(1)(a). Respondents have no excuse for flouting this unequivocal statutory command.

CONCLUSION

The statutory language at issue is unambiguous. It requires ODM to use 60% of each nursing facility's "rate for direct care costs"—not 60% of each peer group's "price"—in calculating the "total amount to be spent on quality incentive payments." ODM's failure to apply the language of the Budget Legislation as written has resulted in fewer dollars going to quality incentive payments than the legislature required. It has also resulted in more of the increase in funding from rebasing going toward the base rate than toward the quality incentive rate—the opposite of what the legislature intended and mandated. ODM is not entitled to rewrite the statute to accommodate its own funding preferences—especially when it would cause such profound consequences, and when the statute is so unmistakably clear.

For these reasons, Relators respectfully request that this Court issue a peremptory writ of mandamus ordering Respondents to calculate and pay all nursing facility quality incentive payments, dating from July 1, 2023 forward, as required by the plain language of Revised Code section 5165.26. In particular, Relators request that the Court order Respondents to use the "rate for direct care costs," rather than the "price," in performing the calculation under division (E)(1)(a) of section 5165.26 for the July 1, 2023 rate-setting and any subsequent rate-setting. Relators ask that the Court order Respondents to perform this calculation, and make any payments due or past due pursuant thereto, within a reasonable time and no later than thirty (30) days after the issuance of the writ. Relators further request an award of their costs, expenses, and reasonable attorneys' fees incurred in this action, and any other relief the Court deems just and equitable.

Respectfully submitted,

BARNES & THORNBURG LLP

/s David Paragas
David Paragas (0043908)
41 S. High Street Suite 3300,
Columbus, Ohio 43215
Phone: (614) 628-1407
Fax: (614) 628-1433
David.Paragas@btlaw.com

Kian Hudson (admitted *pro hac vice*)
11 South Meridian Street
Indianapolis, Indiana 46204
Phone: (317) 229-3111
Kian.Hudson@btlaw.com

ROLF GOFFMAN MARTIN LANG LLP

/s Aric D. Martin
Aric D. Martin (0065765)
Joseph F. Petros III (0088363)
31105 Bainbridge Road, Suite 4
Cleveland, Ohio 44139
Phone: (216) 514-1100
Fax: (216) 626-7623
Martin@RolfLaw.com
Petros@RolfLaw.com

Attorneys for Relators

IN THE SUPREME COURT OF OHIO

STATE OF OHIO *EX REL.* LEADINGAGE OHIO, *et al.,*	)	**CASE NO. 2024-1075**
Plaintiffs/Relators,	)	**ORIGINAL ACTION IN MANDAMUS**
v.	)	
THE OHIO DEPARTMENT OF MEDICAID, *et al.,*	)	
Defendants/Respondents.	)	

RELATORS' APPENDIX

BARNES & THORNBURG LLP
Counsel of Record:
David Paragas (0043908)
41 S. High Street, Suite 3300
Columbus, Ohio 43215
Phone: (614) 628-1407
David.Paragas@btlaw.com

Kian Hudson (admitted *pro hac vice*)
11 South Meridian Street
Indianapolis, Indiana 46204
Phone: (317) 229-3111
Kian.Hudson@btlaw.com

ROLF GOFFMAN MARTIN LANG LLP
Aric D. Martin (0065765)
Joseph F. Petros III (0088363)
31105 Bainbridge Road, Suite 4
Cleveland, Ohio 44139
Phone: (216) 514-1100
Fax: (216) 626-7623
Martin@RolfLaw.com
Petros@RolfLaw.com

Attorneys for Relators

FROST BROWN TODD LLP
Counsel of Record:
Frank J. Reed
One Columbus, Suite 2300
10 West Broad Street
Columbus, OH 43215
freed@fbtlaw.com

Ryan W. Goellner
Nathaniel L. Truitt
3300 Great American Tower
301 East Fourth Street, Suite 3300
Cincinnati, OH 45202
rgoellner@fbtlaw.com
ntruitt@fbtlaw.com

Attorneys for Respondent

August 9, 2023

Delivered via email

Director Maureen Corcoran
Ohio Department of Medicaid
Fiscal Operations - LTC Rate Methodology Unit
P.O. Box 182709
Columbus, Ohio 43215-3414

Re: Request for rate reconsideration due to error in calculation of the rate

Submitted on behalf of all SNFs eligible to receive a quality incentive payment as part of their rate for the period beginning July 1, 2023

Dear Director Corcoran:

The Ohio Health Care Association, the Academy of Senior Health Sciences, and LeadingAge Ohio request reconsideration of the Medicaid rates for skilled nursing facilities (SNFs) for the state fiscal year beginning July 1, 2023. These rates were posted to the facilities' online portals beginning the evening of August 1, 2023.

A. Basis for Request

This request is made pursuant to section 5165.38 of the Revised Code and rule 5160-3-24 of the Administrative Code, which confer standing on associations representing SNFs to request rate reconsideration. As provided in section 5165.38, we request reconsideration because the rates were not calculated in accordance with Chapter 5165. of the Revised Code, as specifically described below.

The rate calculation not only fails to comport with statute and the legislative intent embodied in the statute, it also runs counter to Governor DeWine's policy direction, expressed beginning with his State of the State address in early 2023 and running through his post-budget press conference, that funding for SNFs be tied tightly to quality. The rate calculation upends this policy by minimizing the proportion of funding going to quality to an amount far below what was intended.

B. Interested Parties

We make this request on behalf of all SNFs eligible to receive a quality incentive payment under section 5165.26 of the Revised Code as part of their rate for the period beginning July 1, 2023.

C. Request for Expedited Processing

We request expedited processing of this request because of the large number of providers affected (approximately 822) and the administrative burden to providers, the Department of Medicaid (ODM), and managed care plans if the rates are not corrected quickly and as a result require retroactive adjustment.

D. ODM's initial rate calculations are based on an error in applying the language of the newly-revised quality incentive payment statute

As provided in section 5165.38, we request reconsideration because the rates were not calculated in accordance with Chapter 5165. of the Revised Code. ODM's rate calculations are based on an error in applying the language of the newly-revised quality incentive payment statute. Specifically, ODM did not calculate the value per quality point used in determining the quality incentive for each SNF in accordance with division (B)(5) of section 5165.26 of the Revised Code. The value per point is erroneous because ODM did not correctly determine the total amount of funding to be allocated to quality incentive payments under division (E) of section 5165.26, which is one of two elements in calculating the value per point.

Section 5165.26(B)(5) requires ODM to determine the value per quality point by dividing the total dollars available for the quality incentive by the product of the average number of quality points that all SNFs received for the relevant time period multiplied by those SNFs' Medicaid days.

Also amended by HB 33, division (E) of section 5165.26 specifies the number of dollars available for the quality incentive:

> (E) The total amount to be spent on quality incentive payments under division (B) of this section for a fiscal year shall be determined as follows:
>
> (1) Determine the following amount for each nursing facility:
>
> (a) The amount that is five and two-tenths per cent of the nursing facility's base rate for nursing facility services provided on the first day of the state fiscal year plus one dollar and seventy-nine cents plus sixty per cent of the per diem amount by which the nursing facility's rate for direct care costs determined for the fiscal year under section 5165.19 of the Revised Code changed as a result of the rebasing conducted under section 5165.36 of the Revised Code.
>
> (b) Multiply the amount determined under division (E)(1)(a) of this section by the number of the nursing facility's medicaid days for the calendar year preceding the fiscal year for which the rate is determined.

> (2) Determine the sum of the products determined under division (E)(1)(b) of this section for all nursing facilities for which the product was determined for the state fiscal year.
>
> (3) To the sum determined under division (E)(2) of this section, add one hundred twenty-five million dollars.

In performing the calculation under division (E) for the July 1, 2023, rates, ODM erroneously determined the amount required by the second part of division (E)(1)(a) - the part that refers to moving 60% of the funding from rebasing under section 5165.36 into the quality incentive.

Instead of calculating 60% of the per diem amount by which each nursing facility's **direct care rate** changed, as required by the statute, ODM mistakenly calculated the amount by which the **direct care cost per case-mix unit** (commonly referred to as the "direct care price") changed for each nursing facility's peer group. ODM omitted the step of multiplying by case-mix score, which is what converts each facility's price into its rate.

This error was highly material, because the increase in the direct care rate is not the same as the increase in the direct care price. Instead, the rate is the product of the price and the facility's case-mix score. The rate is significantly more than the price because case-mix scores among Ohio SNFs are on average close to 3, so the rate increase is nearly triple the price increase.

Division (E)(1)(a) makes it extremely clear that the legislature intended ODM to use the rate, not the price, through the words, "the per diem amount by which the nursing facility's **rate for direct care costs** determined for the fiscal year under section 5165.19 of the Revised Code changed as a result of the rebasing conducted under section 5165.36 of the Revised Code."

Division (A)(1) of section 5165.19, which the legislature incorporated into section 5165.26 to clarify what it meant by the rate for direct care costs, reads:

> Semiannually, except as provided in division (A)(2) of this section,[1] 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.

By using the identical words, "rate for direct care costs," these interlocking statutory directives demonstrate that the rate to be used for each facility under section 5165.26(E)(1)(a) is the

[1] Division (A)(2), which deals with case-mix score, is not relevant to this issue.

product of its peer group cost per case-mix unit (price) and its semiannual case-mix score, not the price alone.

In sum, ODM's calculation of the value per quality point is not in accordance with statute because *the statute requires ODM to use the direct care rate, not the price*.

E. The General Assembly intended to divide the additional funding generated by rebasing SNF rates with 40% going to the base rate and 60% to the quality incentive

The clear instruction of section 5165.26(E)(1)(a) is further supported by another statutory provision, which also was enacted in HB 33. As was widely discussed while the General Assembly considered HB 33 and even before the bill was introduced,[2] the legislature intended to divide the additional funding generated by rebasing SNF rates between the base rate and the quality incentive. At all relevant times, the legislature intended that 40% was to go to the base rate and 60% was to go to the quality incentive. This funding allocation also reflected Governor DeWine's policy goals for HB 33 relative to SNFs, as confirmed by his post-budget comments and his decision not to veto any portion of the SNF language in the bill.

While section 5165.26(E)(1)(a) addressed the 60% going to quality, another provision of HB 33 addressed the 40% for the base rates:

> SECTION 333.300. NURSING FACILITY BASE RATES
> For fiscal years 2024 and 2025, the Department of Medicaid shall include in each nursing facility's base rate only forty per cent of the increase in its **rate for direct care costs** due to the rebasing conducted pursuant to section 5165.36 of the Revised Code.

This language is virtually identical to the language in 5165.26(E)(1)(a) except it contains the 40% figure instead of the 60%. Both apply the percentage to the "rate for direct care costs," not the price (cost per case-mix unit):

> Section 5165.26(E)(1)(a): "sixty per cent of the per diem amount by which the nursing facility's **rate for direct care costs** … changed as a result of the rebasing conducted under section 5165.36 of the Revised Code."
>
> Section 333.300: "forty per cent of the increase in its **rate for direct care costs** due to the rebasing conducted pursuant to section 5165.36 of the Revised Code."

[2] See House Bill 45 (134th General Assembly), section 280.28, in which the same 60/40 split was used for a different pot of money. Our associations originally proposed applying this split to rebasing in the legislative Nursing Facility Payment Commission in the summer of 2022.

Taken together, these two statutory provisions make the legislative intent crystal clear. The starting point is the amount by which each SNF's *direct care rate* increased by virtue of the rebasing. This amount was on average approximately $56 per day – the average price increase times the average case-mix score. Each individual facility's dollar amount would be different, depending on its peer group price and case-mix score, but $56 is the statewide average. Then the statutory provisions require ODM to divide that roughly $56 amount between quality (60% or approximately $33.60) and the base rate (40% or approximately $22.40). There is no other way to read the identical language in the two sections of statute and the consonant legislative intent than as referring the total amount of additional funding generated by rebasing.

Unfortunately, ODM did not apply the statutory language in a manner that correctly implements the legislative intent. Instead of calculating the whole pie (total price increase times case-mix score and then dividing it 60/40), ODM attempted to determine each slice separately and inconsistently with the statutory language, with the result that the two slices do not add up to the whole pie. ODM first divided the price increase into 60% and 40% portions, then multiplied the 40% portion by case-mix score, *but failed to do the same for the 60% portion despite the statutory language directing them to do so*. While the base rate portion is correct – an average of around $22.40 per day – the portion that went to quality is not, averaging only about $11.22. The two slices obviously do not add up to the whole pie: $33.62 instead of $56. Contrary to the intent of the legislature and the Governor, it is quality that is shortchanged by this erroneous application of statute.

The impact of ODM's mistake is borne out in the total funding equation, which is similarly out-of-whack with the intended result. According to ODM's figures, the total increased funding for the quality incentive is approximately $169 million, while the added funding for the base rate is approximately $415 million. *Instead of 60% of the funding increase going to quality as the legislature and Governor intended, under ODM's interpretation it is only 29%.*

F. ODM's arguments in support of its calculation are flawed

ODM has advanced two arguments to support its calculation: 1) it interpreted the new language in section 5165.26(E)(1)(a) to mean that the amount added to the quality incentive is 60% of the rebasing (the change in price) under 5165.36; and 2) its approach would keep the total increase in spending on SNFs under HB 33 below the amount appropriated for that purpose.

The first argument ignores most of the language that the legislature added to section 5165.26(E)(1)(a). The plain language of the statute applies the 60% allocation to the amount by which the *rate for direct care costs changed as a result of the rebasing* – the funding generated by rebasing – not to the rebasing itself (the change in the price). Giving meaning to all words in a statute is a fundamental tenet of statutory construction.

The second argument is inapposite because the statute does not specify a cap on the increase in SNF spending generated by the statutory formula as adjusted by HB 33.[3] The funding amount cited by ODM is an (erroneous) estimate of how much it would cost to implement the statute as amended by the legislature. It is not a cap on spending. Actual spending always will be different – higher or lower – than any estimate used for budgeting purposes unless the legislature mandates that the estimate really is a cap. The legislature did not do so in this instance.

It is true that the SNF estimate became one component of a multi-faceted appropriation for a broad range of Medicaid services that amounts to more than $17 billion for state fiscal year 2024. That fact, however, does not change the requirement that ODM must follow the statute in calculating SNF rates even if its updated estimate of the cost does not comport with an earlier, mistaken estimate used in building the state budget.

While there is no provision of law prohibiting ODM from spending more on SNFs than the incorrect estimate, it is true that ODM cannot spend more than the $17 billion total Medicaid appropriation in HB 33. If, at some time later in the fiscal year, ODM identifies that it is on target to spend more than the total appropriation because of expenditures for SNFs or other parts of the Medicaid program, there are mechanisms to remedy the funding shortfall. These mechanisms include tapping the Health and Human Services Fund, requesting the Controlling Board to increase appropriations, and asking the legislature for a supplemental appropriation. However, these remedies only come into play when actual expenditures appear likely to exceed the total Medicaid appropriation, which would be much later in the fiscal year. The permissible remedies do not include calculating SNF rates in a manner contrary to statute at the beginning of the fiscal year, when there is no way to know whether total Medicaid expenditures actually will end up exceeding the total appropriation.

G. ODM must recalculate its initial rates in accordance with the law

As required by section 5165.38 of the Revised Code, we request that ODM correct the rates of the affected SNFs, which are all SNFs that qualify for the quality incentive. As further required by section 5165.38, if any claims are paid using the inaccurate rates before they are corrected, we request that ODM pay these SNFs the difference between the amount each SNF was paid and the amount it should have been paid.

[3] Compare section 333.240(C) of the previous budget bill, HB 110 (134th General Assembly): "Of the foregoing appropriation item 651525, Medicaid Health Care Services, $125,000,000 in each fiscal year shall be used by the Department of Medicaid to pay for rebasing determinations of nursing facilities' Medicaid rates under this section." This provision demonstrates that the legislature knew how to cap the amount spent for rebasing, but chose not to do so in HB 33.

The value per quality point that ODM erroneously determined is $1.88. Using data supplied by ODM (peer group direct care prices of $61.80, $60.16, and $53.10; 18.47 average quality points; and 15,055,888 Medicaid days), we estimate the value per point required by the statute to be $3.04, a difference of $1.16. The rates for all SNFs that qualified for the quality incentive should be recalculated to include the additional amount per quality point.

Sincerely,

Pete Van Runkle, Executive Director, OHCA
Chris Murray, CEO, ASHS
Susan Wallace, President & CEO, LAO

Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

October 4, 2023

Pete VanRunkle, Executive Director
Ohio Health Care Association
9200 Worthington Road
Suite 110
Westerville, Ohio 43082

Chris Murray, CEO
Academy of Senior Health Services, Inc.
17 South High Street
Suite 770
Columbus, Ohio 43215

Susan Wallace, President & CEO
LeadingAge Ohio
2233 North Bank Drive
Columbus, Ohio 43220

RE: Request for Reconsideration of Nursing Facility Rates effective July 1, 2023

Dear Mr. VanRunkle, Mr. Murray, and Ms. Wallace:

This letter is in response to your August 9, 2023 request to reconsider the Medicaid rates for skilled nursing facilities for the state fiscal year beginning July 1, 2023. You indicated in your letter that the reason for the reconsideration request is that the rates were not calculated in accordance with Chapter 5165. of the Ohio Revised Code. Specifically, you allege that the rates fail to comport with statute and legislative intent.

The department's rate calculations properly apply the language of the newly-revised quality incentive payment statute

Ohio Revised Code, 5165.26(E), as amended by HB 33 of the 135th Ohio General Assembly, provides the total amount to be spent by the department on quality incentive payments for a fiscal year. Specifically, it provides:

> (E) The total amount to be spent on quality incentive payments under division (B) of this section for a fiscal year shall be determined as follows:
>
> (1) Determine the following amount for each nursing facility:

> (a) The amount that is five and two-tenths per cent of the nursing facility's base rate for nursing facility services provided on the first day of the state fiscal year plus one dollar and seventy-nine cents; **plus sixty per cent of the per diem amount by which the nursing facility's rate for direct care costs determined for the fiscal year under section 5165.19 of the Revised Code changed as a result of the rebasing conducted under section 5165.36 of the Revised Code**.
>
> (b) Multiply the amount determined under division (E)(1)(a) of this section by the number of the nursing facility's medicaid days for the calendar year preceding the fiscal year for which the rate is determined.
>
> (2) Determine the sum of the products determined under division (E)(1)(b) of this section for all nursing facilities for which the product was determined for the state fiscal year.
>
> (3) To the sum determined under division (E)(2) of this section, add one hundred twenty-five million dollars.

(Emphasis added)

Pursuant to Ohio Revised Code, 5165.01(SS), rebasing for direct care costs is a redetermination of the peer group cost per case mix unit, also known as the price. Rebasing is not a redetermination of the rate for an individual facility. Therefore, the change to the rate as a result of rebasing is a change to the price and 60% of the change in price is to be added to the quality pool of funds.

Your reconsideration request focuses on the term, "rate," without consideration of the remainder of the sentence that focuses on the change as a result of rebasing. The plain language of the statute does not require the addition of 60% of the **funding generated by rebasing** to the quality pool of funds. Rather, as noted in division (E)(1)(a) above, the quality pool of funds includes sixty percent of the amount by which the nursing facility's rate for direct care costs changed **as a result of rebasing**. Had the General Assembly wanted 60% to apply to the funding generated by rebasing, it would have included that language in the statute. It did not. Instead, it required that 60% of the change in price be applied to the quality pool of funds.

The department applied 60% of the change as a result of rebasing to quality incentive payments

The amendment to Ohio Revised Code, 5165.26(E), in HB 33 requires the addition of 60% of the amount by which the nursing facility's rate for direct care costs changed **as a result of rebasing** to the quality pool of funds. As noted above, the change to the rate as a result of rebasing is a change to the price. Sixty percent was properly applied to the change in price.

The department's calculation is consistent with the intent of the General Assembly

The funds appropriated from the General Assembly to the department align with the department's calculation. Specifically, the Legislative Budget Office (LBO) estimated the nursing home provisions would increase costs for Medicaid services by $627,600,000 in FY 2024 and $747,600,000 in FY 2025. The statutory language, when applied as the department did, produced this monetary result. The fiscal assessment by the LBO of the cost of the full nursing facility HB 33 budget package matches the result of a change in price. It does not match a change in the rate. The total expenditures estimated by the LBO were known to all parties during the budget process. No concerns were raised.

Applying terms in the manner you have suggested would result in an expenditure of $285.6 million more per year than was authorized by the General Assembly.

It is noteworthy that the funds appropriated from the General Assembly represent one of the largest investments in nursing home quality that any state has made. The policy provisions to incentivize better care outcomes for residents look to ensure higher levels of staffing, decrease bed sores, decrease instances of urinary tract infections, and decrease the amount of antipsychotics, among other things. The overall investment in new funding toward nursing home care by the General Assembly also will have a substantial impact in support of direct care professionals across the state through the historic investment of an estimated additional $1.3 billion over the biennium, representing a 17% rate increase over the previous fiscal year. In addition, new investments were made to increase the ability of the Department of Health and Department of Aging to support high quality nursing home care and those residents they serve.

In conclusion, the department's calculation of the FY2024 nursing facility rates comports with statute and legislative intent and no change will be made.

Sincerely,

Joan Schlagheck

Joan Schlagheck, Deputy Director
Ratesetting

Baldwin's Ohio Revised Code Annotated
Title LI. Public Welfare
Chapter 5165. Nursing Facility Services
Payments; Rates

R.C. § 5165.26

5165.26 Quality incentive payments

Effective: October 24, 2024
Currentness

(A) As used in this section:

(1) “Base rate” means the portion of a nursing facility's total per medicaid day payment rate determined under divisions (A) and (B) of section 5165.15 of the Revised Code.

(2) “CMS” means the United States centers for medicare and medicaid services.

(3) “Long-stay resident” means an individual who has resided in a nursing facility for at least one hundred one days.

(4) “Nursing facilities for which a quality score was determined” includes nursing facilities that are determined to have a quality score of zero.

(5) “SFF list” means the list of nursing facilities that the United States department of health and human services creates under the special focus facility program.

(6) “Special focus facility program” means the program conducted by the United States secretary of health and human services pursuant to section 1919(f)(10) of the “Social Security Act,” 42 U.S.C. 1396r(f)(10).

(B) Subject to divisions (D) and (E) and except as provided in division (F) of this section, the department of medicaid shall determine each nursing facility's per medicaid day quality incentive payment rate as follows:

(1) Determine the sum of the quality scores determined under division (C) of this section for all nursing facilities.

(2) Determine the average quality score by dividing the sum determined under division (B)(1) of this section by the number of nursing facilities for which a quality score was determined.

(3) Determine the sum of the total number of medicaid days for all of the calendar year preceding the fiscal year for which the rate is determined for all nursing facilities for which a quality score was determined.

(4) Multiply the average quality score determined under division (B)(2) of this section by the sum determined under division (B)(3) of this section.

(5) Determine the value per quality point by determining the quotient of the following:

(a) The sum determined under division (E)(2) of this section.

(b) The product determined under division (B)(4) of this section.

(6) Multiply the value per quality point determined under division (B)(5) of this section by the nursing facility's quality score determined under division (C) of this section.

(C)(1) Except as provided in divisions (C)(2) and (3) of this section, a nursing facility's quality score for a state fiscal year shall be the sum of the following:

(a) The total number of points that CMS assigned to the nursing facility under CMS's nursing facility five-star quality rating system for the following quality metrics, or CMS's successor metrics as described below, based on the most recent four-quarter average data, or the average data for fewer quarters in the case of successor metrics, available in the database maintained by CMS and known as nursing home compare in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins:

(i) The percentage of the nursing facility's long-stay residents at high risk for pressure ulcers who had pressure ulcers;

(ii) The percentage of the nursing facility's long-stay residents who had a urinary tract infection;

(iii) The percentage of the nursing facility's long-stay residents whose ability to move independently worsened;

(iv) The percentage of the nursing facility's long-stay residents who had a catheter inserted and left in their bladder.

If CMS ceases to publish any of the metrics specified in division (C)(1)(a) of this section, the department shall use the nursing facility quality metrics on the same topics that CMS subsequently publishes.

(b) Seven and five-tenths points for fiscal year 2024 and three points for fiscal year 2025 and subsequent fiscal years if the nursing facility's occupancy rate is greater than seventy-five per cent. For purposes of this division, the department shall utilize the facility's occupancy rate for licensed beds reported on its cost report for the calendar year preceding the fiscal year for which the rate is determined or, if the facility is not required to be licensed, the facility's occupancy rate for certified beds. If the facility surrenders licensed or certified beds before the first day of July of the calendar year in which the fiscal year begins, the department shall calculate a nursing facility's occupancy rate by dividing the inpatient days reported on the facility's cost report for the calendar year preceding the fiscal year for which the rate is determined by the product of the number of days in

the calendar year and the facility's number of licensed, or if applicable, certified beds on the first day of July of the calendar year in which the fiscal year begins.

(c) Beginning with state fiscal year 2025, the total number of points that CMS assigned to the nursing facility under CMS's nursing facility five-star quality rating system for the following quality metrics, or successor metrics designated by CMS, based on the most recent four-quarter average data available in the database maintained by CMS and known as nursing home compare in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins:

(i) The percentage of the nursing facility's long-stay residents whose need for help with daily activities has increased;

(ii) The percentage of the nursing facility's long-stay residents experiencing one or more falls with major injury;

(iii) The percentage of the nursing facility's long-stay residents who were administered an antipsychotic medication;

(iv) Adjusted total nurse staffing hours per resident per day using quintiles instead of deciles by using the points assigned to the higher of the two deciles that constitute the quintile.

If CMS ceases to publish any of the metrics specified in division (C)(1)(c) of this section, the department shall use the nursing facility quality metrics on the same topics CMS subsequently publishes.

(2) In determining a nursing facility's quality score for a state fiscal year, the department shall make the following adjustment to the number of points that CMS assigned to the nursing facility for each of the quality metrics specified in divisions (C)(1)(a) and (c) of this section:

(a) Unless division (C)(2)(b) or (c) of this section applies, divide the number of the nursing facility's points for the quality metric by twenty.

(b) If CMS assigned the nursing facility to the lowest percentile for the quality metric, reduce the number of the nursing facility's points for the quality metric to zero.

(c) If the nursing facility’s total number of points calculated for or during a state fiscal year for all of the quality metrics specified in divisions [1] (C)(1)(a), and if applicable, division (C)(1)(c) of this section is less than a number of points that is equal to the twenty-fifth percentile of all nursing facilities, calculated using the points for the July 1 rate setting of that fiscal year reduce the nursing facility’s points to zero until the next point calculation. If a facility's recalculated points under division (C)(3) of this section are below the number of points determined to be the twenty-fifth percentile for that fiscal year, the facility shall receive zero points for the remainder of that fiscal year.

(3) A nursing facility's quality score shall be recalculated for the second half of the state fiscal year based on the most recent four quarter average data, or the average data for fewer quarters in the case of successor metrics, available in the database maintained by CMS and known as the care compare, in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins. The metrics specified by division (C)(1)(b) of this section shall not be recalculated.

In redetermining the quality payment for each facility based on the recalculated points, the department shall use the same per point value determined for the quality payment at the start of the fiscal year.

(D) A nursing facility shall not receive a quality incentive payment if the Department of Health assigned the nursing facility to the SFF list under the special focus facility program and the nursing facility is listed in table A, on the first day of May of the calendar year for which the rate is being determined.

(E) The total amount to be spent on quality incentive payments under division (B) of this section for a fiscal year shall be determined as follows:

(1) Determine the following amount for each nursing facility:

(a) The amount that is five and two-tenths per cent of the nursing facility's base rate for nursing facility services provided on the first day of the state fiscal year plus one dollar and seventy-nine cents plus sixty per cent of the per diem amount by which the nursing facility's rate for direct care costs determined for the fiscal year under section 5165.19 of the Revised Code changed as a result of the rebasing conducted under section 5165.36 of the Revised Code.

(b) Multiply the amount determined under division (E)(1)(a) of this section by the number of the nursing facility's medicaid days for the calendar year preceding the fiscal year for which the rate is determined.

(2) Determine the sum of the products determined under division (E)(1)(b) of this section for all nursing facilities for which the product was determined for the state fiscal year.

(3) To the sum determined under division (E)(2) of this section, add one hundred twenty-five million dollars.

(F)(1) Beginning July 1, 2023, a new nursing facility shall receive a quality incentive payment for the fiscal year in which the new facility obtains an initial provider agreement and the immediately following fiscal year equal to the median quality incentive payment determined for nursing facilities for the fiscal year. For the state fiscal year after the immediately following fiscal year and subsequent fiscal years, the quality incentive payment shall be determined under division (C) of this section.

(2) A nursing facility that undergoes a change of operator with an effective date of July 1, 2023, or later shall not receive a quality incentive payment until the earlier of the first day of January or the first day of July that is at least six months after the effective date of the change of operator. Thereafter quality incentive payment shall be determined under division (C) of this section.

(3) A nursing facility that undergoes a change of owner with an effective date of July 1, 2023, or later shall not receive a quality incentive payment until the earlier of the first day of January or the first day of July that is at least six months after the effective date of the change of owner if, within one year after the change of owner, there is an increase in the lease payments or other financial obligations of the operator to the owner above the payments or obligations specified by the agreement between the previous owner and the operator. Thereafter, any quality incentive payments for the facility shall be determined under division (C) of this section.

CREDIT(S)

(2024 S 144, eff. 10-24-24; 2023 H 33, eff. 7-4-23; 2021 H 110, eff. 6-30-21; 2020 H 481, § 29, eff. 6-19-20; 2019 H 166, eff. 10-17-19)

Footnotes

1 So in original.

R.C. § 5165.26, OH ST § 5165.26
Current through Files 1 to 56 of the 135th General Assembly (2023-2024) and 2023 Statewide Issues 1 and 2 (November Election).

End of Document

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 22nd day of November, 2024, a true and accurate copy of the foregoing was electronically filed with the Court and served on parties of record listed below via electronic mail:

Frank J. Reed
Frost Brown Todd LLP
One Columbus, Suite 2300
10 West Broad Street
Columbus, OH 43215
freed@fbtlaw.com

Ryan W. Goellner
Nathaniel L. Truitt
Frost Brown Todd LLP
3300 Great American Tower
301 East Fourth Street, Suite 3300
Cincinnati, OH 45202
rgoellner@fbtlaw.com
ntruitt@fbtlaw.com

Counsel for Respondents Ohio Department Of Medicaid and Maureen M. Corcoran, Director

/s David Paragas

David Paragas