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Sub. H. B. No. 461

A BILL

To amend sections 5165.01 and 5165.15 and to enact section 5165.27 of the Revised Code regarding nursing facility Medicaid payments for private rooms.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 5165.01 and 5165.15 be amended and section 5165.27 of the Revised Code be enacted to read as follows:

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 calendar year that precedes 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" means an entering operator becoming 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 transfer of all the exiting operator's ownership interest in the operation of the nursing facility to the entering operator, 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 the exiting operator's termination of the exiting operator's lease;

(d) If the exiting operator is a partnership, dissolution of the partnership;

(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply:

(i) The change in composition does not cause the

partnership's dissolution under state law.

(ii) The partners agree that the change in composition does not constitute a change in operator.

(f) If the operator is a corporation, dissolution of the corporation, a merger of the corporation into another corporation that is the survivor of the merger, or a consolidation of one or more other corporations to form a new corporation.

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

(a) A contract for an entity to manage a nursing facility as the operator's agent, subject to the operator's approval of daily operating and management decisions;

(b) A change of ownership, lease, or termination of a lease of real property or personal property associated with a nursing facility if an entering operator does not become the operator in place of an exiting operator;

(c) If the operator is a corporation, 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.

(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 resource utilization 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 resource utilization groups, excluding any resource utilization 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) "Medicaid-certified capacity" means the number of a nursing facility's beds that are certified for participation in medicaid as nursing facility beds.

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

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

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

(HH) "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) "Operator" means the person or government entity responsible for the daily operating and management decisions for a nursing facility.

(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.

(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.

(LL) <u>"Private room" means a room with permanent walls that</u>

contains one licensed or certified bed that is occupied by one individual, with direct unshared access to a hallway, and direct unshared access to a toilet and sink shared by not more than one other private room, and that meets all applicable licensure or other standards pertaining to furniture, fixtures, and temperature control.

(MM) "Private room capacity" means the total number of private rooms in a nursing facility, as calculated and adjusted according to section 5165.27 of the Revised Code.

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

~~(MM)~~ (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.

~~(NN)~~ (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.

~~(OO)~~ (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.

~~(PP)~~ (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.

~~(QQ)~~ (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.

~~(RR)~~ (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.

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

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

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

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

~~(WW)~~ (YY) "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.

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

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

~~(ZZ)~~ (BBB) "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 5165.157 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 per medicaid day payment rate for direct care costs determined for the nursing facility under section 5165.19 of the Revised Code;

(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;

(6) If the nursing facility is providing services to a medicaid recipient in a private room, the private room per day rate determined under section 5165.27 of the Revised Code.

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

(C) From the sum determined under division (B) of this section, subtract one dollar and seventy-nine cents.

(D) To the sum determined under division (C) of this

section, add, for state fiscal year 2022 and for state fiscal year 2023, the per medicaid day quality incentive payment rate determined for the nursing facility under section 5165.26 of the Revised Code.

Sec. 5165.27. (A) In accordance with this section and section 5165.15 of the Revised Code, the department of medicaid shall pay a private room per day rate to each nursing facility provider that provides, or has provided, services to a medicaid recipient in a private room on or after July 1, 2022.

(B) A nursing facility's private room per day rate for state fiscal year 2023 is twenty-five dollars. The department shall determine the private room per day rate for subsequent fiscal years.

(C) For purposes of this section, a nursing facility's private room capacity means the total number of private rooms in the facility, calculated pursuant to this division. After the initial calculation, a facility's private room capacity may change only if the facility removes licensed beds from their licensed capacity or, if the facility does not hold a license, the facility surrenders beds that have been certified by the U.S. centers for medicare and medicaid services. A nursing facility's private room capacity for a fiscal year shall be calculated as follows:

(1) Determine the number of resident rooms in the nursing facility that are occupied or that are available to be occupied by a resident during the fiscal year;

(2) Determine the number of licensed beds for that nursing facility during the fiscal year, or, if the facility is not licensed, the number of certified beds;

(3) Subtract the sum determined under division (C)(1) of this section from the sum determined under division (C)(2) of this section;

(4) Subtract the sum determined under division (C)(3) of this section from the sum determined under division (C)(1) of this section.

(D) A nursing facility provider shall not bill the department for more private rooms in one day than the facility's private room capacity. The department may recoup the excess amount paid to a nursing facility provider for any private room days billed that exceed the facility's private room capacity and may use vendor offsets to recoup the payments.

(E) Not later than sixty days after the effective date of this section, the department shall calculate the initial private room capacity for each nursing facility in this state. In the case of a new nursing facility, the department shall calculate the facility's initial private room capacity not later than sixty days after the date the facility is certified as a nursing facility by the U.S. centers for medicare and medicaid services. Each nursing facility provider shall submit, and the department shall collect, the number of rooms occupied and available for occupancy, in the manner prescribed by the department.

(1) If a nursing facility provider removes medicaid beds licensed by the department of health or surrenders beds that were certified by the U.S. centers for medicare and medicaid services, the provider shall notify the department of medicaid of the number of beds removed or surrendered and the effective date of the change. Upon receiving such a notice, the department of medicaid shall do all of the following:

(a) Verify the number of beds removed and the effective date of the removal with the department of health, if applicable;

(b) Not later than sixty days after receipt of the notification, adjust the facility's private room capacity in accordance with division (C) of this section;

(c) Amend the facility's provider agreement.

(2) The department of medicaid shall include in a facility's private room per day rate the adjusted private room capacity for the facility calculated pursuant to division (E)(1) of this section beginning on the later of the following:

(a) The date the beds were removed or surrendered;

(b) The date the department received the notice of the removal or surrender under division (E)(1) of this section.

Section 2. That existing sections 5165.01 and 5165.15 of the Revised Code are hereby repealed.