

H. B. No. 96
As Introduced

_____ moved to amend as follows:

In line 301 of the title, after "5163.05," insert "5165.152," 1

After line 88031, insert: 2

"Sec. 5165.01. As used in this chapter: 3

(A) "Affiliated operator" means an operator affiliated 4
with either of the following: 5

(1) The exiting operator for whom the affiliated operator 6
is to assume liability for the entire amount of the exiting 7
operator's debt under the medicaid program or the portion of the 8
debt that represents the franchise permit fee the exiting 9
operator owes; 10

(2) The entering operator involved in the change of 11
operator with the exiting operator specified in division (A) (1) 12
of this section. 13

(B) "Allowable costs" are a nursing facility's costs that 14
the department of medicaid determines are reasonable. Fines paid 15
under sections 5165.60 to 5165.89 and section 5165.99 of the 16
Revised Code are not allowable costs. 17

(C) "Ancillary and support costs" means all reasonable 18

costs incurred by a nursing facility other than direct care 19
costs, tax costs, or capital costs. "Ancillary and support 20
costs" includes, but is not limited to, costs of activities, 21
social services, pharmacy consultants, habilitation supervisors, 22
qualified intellectual disability professionals, program 23
directors, medical and habilitation records, program supplies, 24
incontinence supplies, food, enterals, dietary supplies and 25
personnel, laundry, housekeeping, security, administration, 26
medical equipment, utilities, liability insurance, bookkeeping, 27
purchasing department, human resources, communications, travel, 28
dues, license fees, subscriptions, home office costs not 29
otherwise allocated, legal services, accounting services, minor 30
equipment, maintenance and repairs, help-wanted advertising, 31
informational advertising, start-up costs, organizational 32
expenses, other interest, property insurance, employee training 33
and staff development, employee benefits, payroll taxes, and 34
workers' compensation premiums or costs for self-insurance 35
claims and related costs as specified in rules adopted under 36
section 5165.02 of the Revised Code, for personnel listed in 37
this division. "Ancillary and support costs" also means the cost 38
of equipment, including vehicles, acquired by operating lease 39
executed before December 1, 1992, if the costs are reported as 40
administrative and general costs on the nursing facility's cost 41
report for the cost reporting period ending December 31, 1992. 42

(D) "Applicable calendar year" means the calendar year 43
immediately preceding the first of the state fiscal years for 44
which a rebasing is conducted. 45

(E) For purposes of calculating a critical access nursing 46
facility's occupancy rate and utilization rate under this 47
chapter, "as of the last day of the calendar year" refers to the 48

occupancy and utilization rates during the calendar year 49
identified in the cost report filed under section 5165.10 of the 50
Revised Code. 51

(F) (1) "Capital costs" means the actual expense incurred 52
by a nursing facility for all of the following: 53

(a) Depreciation and interest on any capital assets that 54
cost five hundred dollars or more per item, including the 55
following: 56

(i) Buildings; 57

(ii) Building improvements; 58

(iii) Except as provided in division (D) of this section, 59
equipment; 60

(iv) Transportation equipment. 61

(b) Amortization and interest on land improvements and 62
leasehold improvements; 63

(c) Amortization of financing costs; 64

(d) Lease and rent of land, buildings, and equipment. 65

(2) The costs of capital assets of less than five hundred 66
dollars per item may be considered capital costs in accordance 67
with a provider's practice. 68

(G) "Capital lease" and "operating lease" shall be 69
construed in accordance with generally accepted accounting 70
principles. 71

(H) "Case-mix score" means a measure determined under 72
section 5165.192 of the Revised Code of the relative direct-care 73
resources needed to provide care and habilitation to a nursing 74

facility resident.	75
(I) "Change of operator" includes circumstances in which	76
an entering operator becomes the operator of a nursing facility	77
in the place of the exiting operator.	78
(1) Actions that constitute a change of operator include	79
the following:	80
(a) A change in an exiting operator's form of legal	81
organization, including the formation of a partnership or	82
corporation from a sole proprietorship;	83
(b) A change in operational control of the nursing	84
facility, regardless of whether ownership of any or all of the	85
real property or personal property associated with the nursing	86
facility is also transferred;	87
(c) A lease of the nursing facility to the entering	88
operator or termination of the exiting operator's lease;	89
(d) If the exiting operator is a partnership, dissolution	90
of the partnership, a merger of the partnership into another	91
person that is the survivor of the merger, or a consolidation of	92
the partnership and at least one other person to form a new	93
person;	94
(e) If the exiting operator is a limited liability	95
company, dissolution of the limited liability company, a merger	96
of the limited liability company into another person that is the	97
survivor of the merger, or a consolidation of the limited	98
liability company and at least one other person to form a new	99
person.	100
(f) If the operator is a corporation, dissolution of the	101
corporation, a merger of the corporation into another person	102

that is the survivor of the merger, or a consolidation of the 103
corporation and at least one other person to form a new person; 104

(g) A contract for a person to assume operational control 105
of a nursing facility; 106

(h) A change of fifty per cent or more in the ownership of 107
the licensed operator that results in a change of operational 108
control; 109

(i) Any pledge, assignment, or hypothecation of or lien or 110
other encumbrance on any of the legal or beneficial equity 111
interests in the operator or a person with operational control. 112

(2) The following do not constitute a change of operator: 113

(a) Actions necessary to create an employee stock 114
ownership plan under section 401(a) of the "Internal Revenue 115
Code," 26 U.S.C. 401(a); 116

(b) A change of ownership of real property or personal 117
property associated with a nursing facility; 118

(c) If the operator is a corporation that has securities 119
publicly traded in a marketplace, a change of one or more 120
members of the corporation's governing body or transfer of 121
ownership of one or more shares of the corporation's stock, if 122
the same corporation continues to be the operator; 123

(d) An initial public offering for which the securities 124
and exchange commission has declared the registration statement 125
effective, and the newly created public company remains the 126
operator. 127

(J) "Cost center" means the following: 128

(1) Ancillary and support costs; 129

(2) Capital costs;	130
(3) Direct care costs;	131
(4) Tax costs.	132
(K) "Custom wheelchair" means a wheelchair to which both of the following apply:	133 134
(1) It has been measured, fitted, or adapted in consideration of either of the following:	135 136
(a) The body size or disability of the individual who is to use the wheelchair;	137 138
(b) The individual's period of need for, or intended use of, the wheelchair.	139 140
(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.	141 142 143 144 145 146
(L) (1) "Date of licensure" means the following:	147
(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;	148 149 150 151 152
(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	153 154 155 156

date the nursing facility was first licensed as a nursing home. 157

(2) If, after a nursing facility's original date of 158
licensure, more nursing home beds are added to the nursing 159
facility, the nursing facility has a different date of licensure 160
for the additional beds. This does not apply, however, to 161
additional beds when both of the following apply: 162

(a) The additional beds are located in a part of the 163
nursing facility that was constructed at the same time as the 164
continuing beds already located in that part of the nursing 165
facility; 166

(b) The part of the nursing facility in which the 167
additional beds are located was constructed as part of the 168
nursing facility at a time when the nursing facility was not 169
required by law to be licensed as a nursing home. 170

(3) The definition of "date of licensure" in this section 171
applies in determinations of nursing facilities' medicaid 172
payment rates but does not apply in determinations of nursing 173
facilities' franchise permit fees. 174

(M) "Desk-reviewed" means that a nursing facility's costs 175
as reported on a cost report submitted under section 5165.10 of 176
the Revised Code have been subjected to a desk review under 177
section 5165.108 of the Revised Code and preliminarily 178
determined to be allowable costs. 179

(N) "Direct care costs" means all of the following costs 180
incurred by a nursing facility: 181

(1) Costs for registered nurses, licensed practical 182
nurses, and nurse aides employed by the nursing facility; 183

(2) Costs for direct care staff, administrative nursing 184

staff, medical directors, respiratory therapists, and except as	185
provided in division (N) (8) of this section, other persons	186
holding degrees qualifying them to provide therapy;	187
(3) Costs of purchased nursing services;	188
(4) Costs of quality assurance;	189
(5) Costs of training and staff development, employee	190
benefits, payroll taxes, and workers' compensation premiums or	191
costs for self-insurance claims and related costs as specified	192
in rules adopted under section 5165.02 of the Revised Code, for	193
personnel listed in divisions (N) (1), (2), (4), and (8) of this	194
section;	195
(6) Costs of consulting and management fees related to	196
direct care;	197
(7) Allocated direct care home office costs;	198
(8) Costs of habilitation staff (other than habilitation	199
supervisors), medical supplies, emergency oxygen, over-the-	200
counter pharmacy products, physical therapists, physical therapy	201
assistants, occupational therapists, occupational therapy	202
assistants, speech therapists, audiologists, habilitation	203
supplies, and universal precautions supplies;	204
(9) Costs of wheelchairs other than the following:	205
(a) Custom wheelchairs;	206
(b) Repairs to and replacements of custom wheelchairs and	207
parts that are made in accordance with the instructions of the	208
physician of the individual who uses the custom wheelchair.	209
(10) Costs of other direct-care resources that are	210
specified as direct care costs in rules adopted under section	211

5165.02 of the Revised Code.	212
(O) "Dual eligible individual" has the same meaning as in	213
section 5160.01 of the Revised Code.	214
(P) "Effective date of a change of operator" means the day	215
the entering operator becomes the operator of the nursing	216
facility.	217
(Q) "Effective date of a facility closure" means the last	218
day that the last of the residents of the nursing facility	219
resides in the nursing facility.	220
(R) "Effective date of an involuntary termination" means	221
the date the department of medicaid terminates the operator's	222
provider agreement for the nursing facility.	223
(S) "Effective date of a voluntary withdrawal of	224
participation" means the day the nursing facility ceases to	225
accept new medicaid residents other than the individuals who	226
reside in the nursing facility on the day before the effective	227
date of the voluntary withdrawal of participation.	228
(T) "Entering operator" means the person or government	229
entity that will become the operator of a nursing facility when	230
a change of operator occurs or following an involuntary	231
termination.	232
(U) "Exiting operator" means any of the following:	233
(1) An operator that will cease to be the operator of a	234
nursing facility on the effective date of a change of operator;	235
(2) An operator that will cease to be the operator of a	236
nursing facility on the effective date of a facility closure;	237
(3) An operator of a nursing facility that is undergoing	238

or has undergone a voluntary withdrawal of participation; 239

(4) An operator of a nursing facility that is undergoing 240
or has undergone an involuntary termination. 241

(V) (1) Subject to divisions (V) (2) and (3) of this 242
section, "facility closure" means either of the following: 243

(a) Discontinuance of the use of the building, or part of 244
the building, that houses the facility as a nursing facility 245
that results in the relocation of all of the nursing facility's 246
residents; 247

(b) Conversion of the building, or part of the building, 248
that houses a nursing facility to a different use with any 249
necessary license or other approval needed for that use being 250
obtained and one or more of the nursing facility's residents 251
remaining in the building, or part of the building, to receive 252
services under the new use. 253

(2) A facility closure occurs regardless of any of the 254
following: 255

(a) The operator completely or partially replacing the 256
nursing facility by constructing a new nursing facility or 257
transferring the nursing facility's license to another nursing 258
facility; 259

(b) The nursing facility's residents relocating to another 260
of the operator's nursing facilities; 261

(c) Any action the department of health takes regarding 262
the nursing facility's medicaid certification that may result in 263
the transfer of part of the nursing facility's survey findings 264
to another of the operator's nursing facilities; 265

(d) Any action the department of health takes regarding 266

the nursing facility's license under Chapter 3721. of the 267
Revised Code. 268

(3) A facility closure does not occur if all of the 269
nursing facility's residents are relocated due to an emergency 270
evacuation and one or more of the residents return to a 271
medicaid-certified bed in the nursing facility not later than 272
thirty days after the evacuation occurs. 273

(W) "Franchise permit fee" means the fee imposed by 274
sections 5168.40 to 5168.56 of the Revised Code. 275

(X) "Inpatient days" means both of the following: 276

(1) All days during which a resident, regardless of 277
payment source, occupies a licensed bed in a nursing facility; 278

(2) Fifty per cent of the days for which payment is made 279
under section 5165.34 of the Revised Code. 280

(Y) "Involuntary termination" means the department of 281
medicaid's termination of the operator's provider agreement for 282
the nursing facility when the termination is not taken at the 283
operator's request. 284

~~(Z) "Low case-mix resident" means a medicaid recipient 285
residing in a nursing facility who, for purposes of calculating 286
the nursing facility's medicaid payment rate for direct care 287
costs, is placed in either of the two lowest case-mix groups, 288
excluding any case-mix group that is a default group used for 289
residents with incomplete assessment data. 290~~

~~(AA)~~ "Maintenance and repair expenses" means a nursing 291
facility's expenditures that are necessary and proper to 292
maintain an asset in a normally efficient working condition and 293
that do not extend the useful life of the asset two years or 294

more. "Maintenance and repair expenses" includes but is not 295
limited to the costs of ordinary repairs such as painting and 296
wallpapering. 297

~~(BB)~~ (AA) "Medicaid-certified capacity" means the number of 298
a nursing facility's beds that are certified for participation 299
in medicaid as nursing facility beds. 300

~~(CC)~~ (BB) "Medicaid days" means both of the following: 301

(1) All days during which a resident who is a medicaid 302
recipient eligible for nursing facility services occupies a bed 303
in a nursing facility that is included in the nursing facility's 304
medicaid-certified capacity; 305

(2) Fifty per cent of the days for which payment is made 306
under section 5165.34 of the Revised Code. 307

~~(DD)~~ ~~(1)~~ (CC) (1) "New nursing facility" means a nursing 308
facility for which the provider obtains an initial provider 309
agreement following medicaid certification of the nursing 310
facility by the director of health, including such a nursing 311
facility that replaces one or more nursing facilities for which 312
a provider previously held a provider agreement. 313

(2) "New nursing facility" does not mean a nursing 314
facility for which the entering operator seeks a provider 315
agreement pursuant to section 5165.511 or 5165.512 or (pursuant 316
to section 5165.515) section 5165.07 of the Revised Code. 317

~~(EE)~~ (DD) "Nursing facility" has the same meaning as in the 318
"Social Security Act," section 1919(a), 42 U.S.C. 1396r(a). 319

~~(FF)~~ (EE) "Nursing facility services" has the same meaning 320
as in the "Social Security Act," section 1905(f), 42 U.S.C. 321
1396d(f). 322

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

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

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

(2) Actually being used.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) It contains one licensed or certified bed that is 377
occupied by one individual. 378

(3) It has access to a hallway without traversing another 379
bedroom. 380

(4) It has access to a toilet and sink shared by not more 381
than one other resident without traversing another bedroom. 382

(5) It meets all applicable licensure or other standards 383
pertaining to furniture, fixtures, and temperature control. 384

~~(OO)~~(NN) "Provider" means an operator with a provider 385
agreement. 386

~~(PP)~~(OO) "Provider agreement" means a provider agreement, 387
as defined in section 5164.01 of the Revised Code, that is 388
between the department of medicaid and the operator of a nursing 389
facility for the provision of nursing facility services under 390
the medicaid program. 391

~~(QQ)~~(PP) "Purchased nursing services" means services that 392
are provided in a nursing facility by registered nurses, 393
licensed practical nurses, or nurse aides who are not employees 394
of the nursing facility. 395

~~(RR)~~(QQ) "Reasonable" means that a cost is an actual cost 396
that is appropriate and helpful to develop and maintain the 397
operation of patient care facilities and activities, including 398
normal standby costs, and that does not exceed what a prudent 399
buyer pays for a given item or services. Reasonable costs may 400
vary from provider to provider and from time to time for the 401
same provider. 402

~~(SS)~~(RR) "Rebasing" means a redetermination of each of the 403
following using information from cost reports for an applicable 404

calendar year that is later than the applicable calendar year 405
used for the previous rebasing: 406

(1) Each peer group's rate for ancillary and support costs 407
as determined pursuant to division (C) of section 5165.16 of the 408
Revised Code; 409

(2) Each peer group's rate for capital costs as determined 410
pursuant to division (C) of section 5165.17 of the Revised Code; 411

(3) Each peer group's cost per case-mix unit as determined 412
pursuant to division (C) of section 5165.19 of the Revised Code; 413

(4) Each nursing facility's rate for tax costs as 414
determined pursuant to section 5165.21 of the Revised Code. 415

~~(TT)~~(SS) "Related party" means an individual or 416
organization that, to a significant extent, has common ownership 417
with, is associated or affiliated with, has control of, or is 418
controlled by, the provider. 419

(1) An individual who is a relative of an owner is a 420
related party. 421

(2) Common ownership exists when an individual or 422
individuals possess significant ownership or equity in both the 423
provider and the other organization. Significant ownership or 424
equity exists when an individual or individuals possess five per 425
cent ownership or equity in both the provider and a supplier. 426
Significant ownership or equity is presumed to exist when an 427
individual or individuals possess ten per cent ownership or 428
equity in both the provider and another organization from which 429
the provider purchases or leases real property. 430

(3) Control exists when an individual or organization has 431
the power, directly or indirectly, to significantly influence or 432

direct the actions or policies of an organization. 433

(4) An individual or organization that supplies goods or 434
services to a provider shall not be considered a related party 435
if all of the following conditions are met: 436

(a) The supplier is a separate bona fide organization. 437

(b) A substantial part of the supplier's business activity 438
of the type carried on with the provider is transacted with 439
others than the provider and there is an open, competitive 440
market for the types of goods or services the supplier 441
furnishes. 442

(c) The types of goods or services are commonly obtained 443
by other nursing facilities from outside organizations and are 444
not a basic element of patient care ordinarily furnished 445
directly to patients by nursing facilities. 446

(d) The charge to the provider is in line with the charge 447
for the goods or services in the open market and no more than 448
the charge made under comparable circumstances to others by the 449
supplier. 450

~~(UU)~~(TT) "Relative of owner" means an individual who is 451
related to an owner of a nursing facility by one of the 452
following relationships: 453

(1) Spouse; 454

(2) Natural parent, child, or sibling; 455

(3) Adopted parent, child, or sibling; 456

(4) Stepparent, stepchild, stepbrother, or stepsister; 457

(5) Father-in-law, mother-in-law, son-in-law, daughter-in- 458
law, brother-in-law, or sister-in-law; 459

(6) Grandparent or grandchild; 460

(7) Foster caregiver, foster child, foster brother, or 461
foster sister. 462

~~(VV)~~ (UU) "Residents' rights advocate" has the same meaning 463
as in section 3721.10 of the Revised Code. 464

~~(WW)~~ (VV) "Skilled nursing facility" has the same meaning 465
as in the "Social Security Act," section 1819(a), 42 U.S.C. 466
1395i-3(a). 467

~~(XX)~~ (WW) "State fiscal year" means the fiscal year of this 468
state, as specified in section 9.34 of the Revised Code. 469

~~(YY)~~ (XX) "Sponsor" has the same meaning as in section 470
3721.10 of the Revised Code. 471

~~(ZZ)~~ (YY) "Surrender" has the same meaning as in section 472
5168.40 of the Revised Code. 473

~~(AAA)~~ (ZZ) "Tax costs" means the costs of taxes imposed 474
under Chapter 5751. of the Revised Code, real estate taxes, 475
personal property taxes, and corporate franchise taxes. 476

~~(BBB)~~ (AAA) "Title XIX" means Title XIX of the "Social 477
Security Act," 42 U.S.C. 1396 et seq. 478

~~(CCC)~~ (BBB) "Title XVIII" means Title XVIII of the "Social 479
Security Act," 42 U.S.C. 1395 et seq. 480

~~(DDD)~~ (CCC) "Voluntary withdrawal of participation" means 481
an operator's voluntary election to terminate the participation 482
of a nursing facility in the medicaid program but to continue to 483
provide service of the type provided by a nursing facility. 484

Sec. 5165.15. Except as otherwise provided by sections 485
5165.151 to 5165.158 and 5165.34 of the Revised Code, the total 486

per medicaid day payment rate that the department of medicaid 487
shall pay a nursing facility provider for nursing facility 488
services the provider's nursing facility provides during a state 489
fiscal year shall be determined as follows: 490

(A) Determine the sum of all of the following: 491

(1) The per medicaid day payment rate for ancillary and 492
support costs determined for the nursing facility under section 493
5165.16 of the Revised Code; 494

(2) ~~The~~ Until June 30, 2027, the per medicaid day payment 495
rate for capital costs determined for the nursing facility under 496
section 5165.17 of the Revised Code~~;~~. Beginning July 1, 2027, a 497
per medicaid day payment rate for capital costs that equals 498
zero. 499

(3) ~~The~~ Except as otherwise provided in this division, the 500
per medicaid day payment rate for direct care costs determined 501
for the nursing facility under section 5165.19 of the Revised 502
Code~~;~~. For the period beginning January 1, 2026, and ending 503
December 31, 2026, the per medicaid day payment rate for direct 504
care costs for each nursing facility shall instead be the 505
greater of the following: 506

(a) The nursing facility's rate for direct care costs on 507
December 31, 2025; 508

(b) The lesser of the following: 509

(i) The rate determined for the nursing facility under 510
section 5165.19 of the Revised Code; 511

(ii) The sum of the nursing facility's rate for direct 512
care costs on December 31, 2025, and five dollars. 513

(4) The per medicaid day payment rate for tax costs 514

determined for the nursing facility under section 5165.21 of the Revised Code;

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

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

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

(D) ~~If~~ Beginning July 1, 2027, to the sum determined under division (C) of this section, add the per medicaid day environmental quality incentive payment rate determined for the nursing facility under section 5165.27 of the Revised Code.

(E) (1) Until June 30, 2027, if the nursing facility
qualifies as a low occupancy nursing facility, subtract from the sum determined under division (C) of this section the nursing facility's low occupancy deduction determined under section 5165.23 of the Revised Code.

(2) Beginning July 1, 2027, if the nursing facility
qualifies as a low occupancy nursing facility, subtract from the
sum determined under division (D) of this section the nursing
facility's low occupancy deduction determined under section
5165.23 of the Revised Code.

Sec. 5165.151. (A) The total per medicaid day payment rate determined under section 5165.15 of the Revised Code shall not

be the initial rate for nursing facility services provided by a 543
new nursing facility. Instead, the initial total per medicaid 544
day payment rate for nursing facility services provided by a new 545
nursing facility shall be determined in the following manner: 546

(1) The initial rate for ancillary and support costs shall 547
be the rate for the new nursing facility's peer group determined 548
under division (C) of section 5165.16 of the Revised Code. 549

(2) ~~The~~ Until June 30, 2027, the initial rate for capital 550
costs shall be the rate for the new nursing facility's peer 551
group determined under division (C) of section 5165.17 of the 552
Revised Code~~;~~. Beginning July 1, 2027, a nursing facility's 553
initial rate for capital costs shall be zero. 554

(3) The initial rate for direct care costs shall be the 555
product of the cost per case-mix unit determined under division 556
(C) of section 5165.19 of the Revised Code for the new nursing 557
facility's peer group and the new nursing facility's case-mix 558
score determined under division (B) of this section. 559

(4) The initial rate for tax costs shall be the following: 560

(a) If the provider of the new nursing facility submits to 561
the department of medicaid the nursing facility's projected tax 562
costs for the calendar year in which the provider obtains an 563
initial provider agreement for the new nursing facility, an 564
amount determined by dividing those projected tax costs by the 565
number of inpatient days the nursing facility would have for 566
that calendar year if its occupancy rate were one hundred per 567
cent; 568

(b) If division (A) (4) (a) of this section does not apply, 569
the median rate for tax costs for the new nursing facility's 570
peer group in which the nursing facility is placed under 571

division (B) of section 5165.16 of the Revised Code.

(5) The initial quality incentive payment rate for the new nursing facility shall be the amount determined under section 5165.26 of the Revised Code.

(6) Beginning July 1, 2027, the initial per medicaid day environmental quality incentive payment rate for the new nursing facility for the fiscal year in which the nursing facility opens shall be the environmental quality incentive payment rate determined under section 5165.27 of the Revised Code for a nursing facility that is at the ninetieth percentile of environmental quality rates.

(7) Sixteen dollars and forty-four cents shall be added to the sum of the rates and payment specified in divisions (A) (1) to ~~(5)~~ (6) of this section.

(B) For the purpose of division (A) (3) of this section, a new nursing facility's case-mix score shall be the following:

(1) Unless the new nursing facility replaces an existing nursing facility that participated in the medicaid program immediately before the new nursing facility begins participating in the medicaid program, the median annual average case-mix score for the new nursing facility's peer group.

(2) If the nursing facility replaces an existing nursing facility that participated in the medicaid program immediately before the new nursing facility begins participating in the medicaid program, the semiannual case-mix score most recently determined under section 5165.192 of the Revised Code for the replaced nursing facility as adjusted, if necessary, to reflect any difference in the number of beds in the replaced and new nursing facilities.

(C) Subject to division (D) of this section, the
department of medicaid shall adjust the rates established under
division (A) of this section effective the first day of July, to
reflect new rate calculations for all nursing facilities under
this chapter.

(D) If a rate for direct care costs is determined under
this section for a new nursing facility using the median annual
average case-mix score for the new nursing facility's peer
group, the rate shall be redetermined to reflect the new nursing
facility's actual semiannual average case-mix score determined
under section 5165.192 of the Revised Code after the new nursing
facility submits its first two quarterly assessment data that
qualify for use in calculating a case-mix score in accordance
with rules authorized by section 5165.192 of the Revised Code.
If the new nursing facility's quarterly submissions do not
qualify for use in calculating a case-mix score, the department
shall continue to use the median annual average case-mix score
for the new nursing facility's peer group in lieu of the new
nursing facility's semiannual case-mix score until the new
nursing facility submits two consecutive quarterly assessment
data that qualify for use in calculating a case-mix score.

Sec. 5165.158. (A) As used in this section:

(1) "Category one private room" means a private room that
has unshared access to a toilet and sink.

(2) "Category two private room" means a private room that
has shared access to a toilet and sink.

(B) ~~Beginning six months following approval by the United~~
~~States centers for medicare and medicaid services or on the~~
~~effective date of applicable department of medicaid rules,~~

~~whichever is later, but not sooner than April 1, 2024, the~~ The 630
total per medicaid day payment rate for nursing facility 631
services provided ~~on or after that date~~ in private rooms 632
approved by the department of medicaid under division (C) of 633
this section shall be the sum of both of the following: 634

(1) The total per medicaid day payment rate determined for 635
the nursing facility under section 5165.15 of the Revised Code; 636

(2) The private room incentive payment. The private room 637
incentive payment shall be thirty dollars per day for a category 638
one private room and twenty dollars per day for a category two 639
private room, beginning in state fiscal year 2024. The 640
department may increase the payment amount for subsequent fiscal 641
years. 642

(C) (1) The department shall approve rooms in nursing 643
facilities to qualify for the rate described in division (B) of 644
this section. A nursing facility provider shall apply for 645
approval of its private rooms by submitting an application in 646
the form and manner prescribed by the department. ~~The department~~ 647
~~shall begin accepting applications for approval of category one~~ 648
~~private rooms on January 1, 2024, and category two private rooms~~ 649
~~on March 1, 2024.~~ The department may specify evidence that an 650
applicant must supply to demonstrate that a room meets the 651
definition of a private room under section 5165.01 of the 652
Revised Code and may conduct an on-site inspection of the room 653
to verify that it meets the definition. Subject to division (C) 654
(2) of this section, the department shall approve an application 655
if the rooms included in the application meet the definition of 656
a private room under section 5165.01 of the Revised Code. 657

(2) The department shall only consider applications that 658
meet the following criteria: 659

(a) Private rooms that are in existence on July 1, 2023,
in facilities where all of the licensed beds are in service on
the application date;

(b) Private rooms created by surrendering licensed beds
from its licensed capacity, or, if the facility does not hold a
license, surrendering beds that have been certified by CMS. A
nursing facility where the beds are owned by a county and the
facility is operated by a person other than the county may
satisfy this requirement by removing beds from service.

(c) Private rooms created by adding space to the nursing
facility or renovating nonbedroom space, either without
increasing the total licensed bed capacity or by increasing the
total licensed bed capacity through the certificate of need
process described in sections 3702.59 to 3702.594 of the Revised
Code;

(d) A nursing facility licensed after July 1, 2023, in
which all licensed beds are in service on the application date
or in which private rooms were created by surrendering licensed
beds from its licensed capacity.

(3) The department may specify evidence that an applicant
must supply to demonstrate that it meets the conditions
specified in division (C) (2) of this section and may conduct an
on-site inspection to verify that the conditions are met.

(4) The department may deny an application if the
department determines that any of the following circumstances
apply:

(a) The rooms included in the application do not meet the
definition of a private room under section 5165.01 of the
Revised Code;

(b) The rooms included in the application do not meet the 689
criteria specified in division (C)(2) of this section; 690

(c) The applicant created private rooms by reducing the 691
number of available beds without surrendering the beds, and 692
surrender of the beds is required by this section; 693

~~(d) Approval of the room would cause projected 694
expenditures for private room incentive payments under this 695
section for the fiscal year to exceed forty million dollars in 696
fiscal year 2024 or one hundred sixty million dollars in fiscal 697
year 2025 or subsequent fiscal years. In projecting expenditures 698
for private room incentive payments, the department shall use a 699
medicaid utilization percentage of fifty per cent. If the 700
department determines that there are more approvable eligible 701
applications submitted than can be accommodated within the 702
applicable spending limit specified in this division, the 703
department shall prioritize category one private rooms. 704~~

~~(e) On the application date, the nursing facility is 705
listed on table A or table D of the SFF list, as defined in 706
section 5165.01 of the Revised Code or is designated as having a 707
one-star overall rating in the United States centers for 708
medicare and medicaid services nursing facility five-star 709
quality rating system known as care compare. 710~~

(5) Beginning July 1, 2025, to retain eligibility for 711
private room rates, a nursing facility must do both of the 712
following: 713

(a) Have a policy in place to prioritize placement in a 714
private room based on the medical and psychosocial needs of the 715
resident; 716

(b) Participate in the resident or family satisfaction 717

survey performed pursuant to section 173.47 of the Revised Code. 718

~~(6) The department shall hold all applications for a private room incentive payment in a pending status until the United States centers for medicare and medicaid services approves private room incentive payments and the department determines a facility is qualified for the payment. An application in pending status shall be included in the payment cap described in division (C) (4) (d) of this section as if the application were approved.~~ 719
720
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~~(7) An applicant may request reconsideration of a denial under division (C) of this section.~~ 727
728

Sec. 5165.19. (A) (1) Semiannually, except as provided in 729
division (A) (2) of this section, the department of medicaid 730
shall determine each nursing facility's per medicaid day payment 731
rate for direct care costs by multiplying the facility's 732
semiannual case-mix score determined under section 5165.192 of 733
the Revised Code by the cost per case-mix unit determined under 734
division (C) of this section for the facility's peer group. 735

(2) Beginning January 1, 2024, during state fiscal years 736
2024 and 2025, the department shall determine each nursing 737
facility's per medicaid day payment rate for direct care costs 738
by multiplying the cost per case-mix unit determined under 739
division (C) of this section for the facility's peer group by 740
the case-mix score specified in division (A) (2) (a) or (b) of 741
this section, as selected by the nursing facility not later than 742
October 1, 2023. If the nursing facility does not make a 743
selection by October 1, 2023, the case-mix score specified in 744
division (A) (2) (a) of this section shall apply. The case-mix 745
score may be either of the following: 746

(a) The semiannual case-mix score determined for the 747
facility under division (A)(1) of this section; 748

(b) The facility's quarterly case-mix score from March 31, 749
2023, which shall apply to the facility's direct care rate from 750
January 1, 2024, to June 30, 2025. 751

(3) For the period beginning July 1, 2025, and ending 752
December 31, 2025, the department shall determine each nursing 753
facility's per medicaid day payment rate for direct care costs 754
by multiplying the cost per case-mix unit determined under 755
division (C) of this section for the facility's peer group by 756
the following case-mix score: 757

(a) If the facility's case-mix score during state fiscal 758
year 2025 is the case-mix score specified in division (A)(2)(b) 759
of this section, that case-mix score; 760

(b) If the facility's case-mix score during state fiscal 761
year 2025 is the semiannual case-mix score determined for the 762
facility under division (A)(1) of this section, the semiannual 763
case-mix score determined under that division for the semiannual 764
period beginning July 1, 2025. 765

(B) For the purpose of determining nursing facilities' 766
rates for direct care costs, the department shall establish 767
three peer groups. 768

(1) Each nursing facility located in any of the following 769
counties shall be placed in peer group one: Brown, Butler, 770
Clermont, Clinton, Hamilton, and Warren. 771

(2) Each nursing facility located in any of the following 772
counties shall be placed in peer group two: Allen, Ashtabula, 773
Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, 774

Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, 775
Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, 776
Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, 777
Sandusky, Seneca, Stark, Summit, Trumbull, Union, and Wood. 778

(3) Each nursing facility located in any of the following 779
counties shall be placed in peer group three: Adams, Ashland, 780
Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, 781
Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, 782
Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, 783
Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, 784
Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, 785
Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and 786
Wyandot. 787

(C) (1) ~~The~~ Except as provided in division (C) (4) of this 788
section, the department shall determine a cost per case-mix unit 789
for each peer group established under division (B) of this 790
section. The cost per case-mix unit determined under this 791
division for a peer group shall be used for subsequent years 792
until the department conducts a rebasing. To determine a peer 793
group's cost per case-mix unit, the department shall do both of 794
the following: 795

(a) Determine the cost per case-mix unit for each nursing 796
facility in the peer group for the applicable calendar year by 797
dividing each facility's desk-reviewed, actual, allowable, per 798
diem direct care costs for the applicable calendar year by the 799
facility's annual average case-mix score determined under 800
section 5165.192 of the Revised Code for the applicable calendar 801
year; 802

(b) Subject to division (C) (2) of this section, identify 803
which nursing facility in the peer group is at the seventieth 804

percentile of the cost per case-mix units determined under 805
division (C) (1) (a) of this section. 806

(2) In making the identification under division (C) (1) (b) 807
of this section, the department shall exclude both of the 808
following: 809

(a) Nursing facilities that participated in the medicaid 810
program under the same provider for less than twelve months in 811
the applicable calendar year; 812

(b) Nursing facilities whose cost per case-mix unit is 813
more than one standard deviation from the mean cost per case-mix 814
unit for all nursing facilities in the nursing facility's peer 815
group for the applicable calendar year. 816

(3) The department shall not redetermine a peer group's 817
cost per case-mix unit under this division based on additional 818
information that it receives after the peer group's per case-mix 819
unit is determined. The department shall redetermine a peer 820
group's cost per case-mix unit only if it made an error in 821
determining the peer group's cost per case-mix unit based on 822
information available to the department at the time of the 823
original determination. 824

(4) The department shall multiply each cost per case-mix 825
unit determined under division (C) (1) of this section by the 826
statewide average case-mix score in effect on December 31, 2025, 827
divided by the statewide average blended case-mix score 828
determined under section 5165.192 of the Revised Code for the 829
semiannual period beginning January 1, 2026. The product 830
determined under this division shall be the cost per case-mix 831
unit used to determine each nursing facility's per medicaid day 832
payment rate for direct care costs under division (A) (1) of this 833

section for the period beginning January 1, 2026, and ending on 834
the day before the department's next rebasing conducted after 835
that date takes effect." 836

In line 88039, strike through "and is not a low case-mix resident" 837

In line 88057, strike through "in rules authorized"; after "by" 838
insert "division (A) (2) (d) of" 839

In line 88059, delete "nursing index" 840

In line 88062, after "program" insert ";" 841

(d) In applying the grouper methodology specified by division (A) (2) 842
(c) of this section, the department shall utilize the following blend of 843
case-mix indexes from the methodology: 844

(i) Seventy per cent of the nursing case-mix index; 845

(ii) Twenty per cent of the speech-language pathology case-mix 846
index; 847

(iii) Ten per cent of the non-therapy ancillaries case-mix index" 848

In line 88119, strike through "Modify the grouper methodology" 849
specified in division" 850

Strike through line 88120 851

In line 88121, strike through "(i)" 852

In line 88125, reinsert "changes to" 853

In line 88126, delete "nursing index used by" 854

In line 88127, reinsert "makes" 855

In line 88128, reinsert "after"; delete "on" 856

In line 88130, delete "(ii)"; strike through the balance of the line 857

Strike through line 88131 858

After line 88152, insert: 859

"Sec. 5165.23. (A) Each state fiscal year, the department 860
of medicaid shall determine the critical access incentive 861
payment for each nursing facility that qualifies as a critical 862
access nursing facility. To qualify as a critical access nursing 863
facility for a state fiscal year, a nursing facility must meet 864
all of the following requirements: 865

(1) The nursing facility must be located in an area that, 866
on December 31, 2011, was designated an empowerment zone under 867
the "Internal Revenue Code of 1986," section 1391, 26 U.S.C. 868
1391. 869

(2) The nursing facility must have an occupancy rate of at 870
least eighty-five per cent as of the last day of the calendar 871
year immediately preceding the state fiscal year. 872

(3) The nursing facility must have a medicaid utilization 873
rate of at least sixty-five per cent as of the last day of the 874
calendar year immediately preceding the state fiscal year. 875

(B) A critical access nursing facility's critical access 876
incentive payment for a state fiscal year shall equal five per 877
cent of the portion of the nursing facility's total per medicaid 878
day payment rate for the state fiscal year that is the sum of 879
the rates identified in divisions (A) (1) to (4) of section 880
5165.15 of the Revised Code. 881

(C) Each state fiscal year, the department shall determine 882
the low occupancy deduction for each nursing facility that 883
qualifies as a low occupancy nursing facility. To qualify as a 884
low occupancy nursing facility for a state fiscal year, a 885

nursing facility must have an occupancy rate lower than sixty- 886
five per cent. For purposes of this division, the department 887
shall utilize a nursing facility's occupancy rate for the 888
licensed beds reported on the facility's cost report for the 889
calendar year preceding the fiscal year for which the rate is 890
determined, or if the facility is not required to be licensed, 891
the facility's occupancy rate for its certified beds. If the 892
facility surrenders licensed or certified beds before the first 893
day of July of the calendar year in which the fiscal year 894
begins, the department shall calculate a nursing facility's 895
occupancy rate by dividing the inpatient days reported on the 896
facility's cost report for the calendar year preceding the 897
fiscal year for which the rate is determined by the product of 898
the number of days in the calendar year and the facility's 899
number of licensed, or if applicable, certified beds on the 900
first day of July of the calendar year in which the fiscal year 901
begins. 902

A low occupancy nursing facility's low occupancy deduction 903
for a state fiscal year shall equal five per cent of the nursing 904
facility's total per medicaid day payment rate ~~for the state~~ 905
~~fiscal year identified in division (D) of~~ calculated under 906
section 5165.15 of the Revised Code, ~~for the state fiscal year.~~ 907

This division does not apply to any of the following: 908

(1) A nursing facility where the beds are owned by a 909
county and the facility is operated by a person other than the 910
county; 911

(2) A nursing facility that opened during the calendar 912
year preceding the fiscal year for which the rate is determined 913
or the preceding fiscal year; 914

(3) A nursing facility that underwent a renovation during the calendar year preceding the fiscal year for which the rate is determined if both of the following apply:

(a) The renovation involved a capital expenditure of one hundred fifty thousand dollars or more, excluding expenditures for equipment;

(b) The renovation included one or more rooms housing beds that are part of the nursing facility's licensed capacity and that were taken out of service for at least thirty days while the rooms were being renovated."

After line 88353, insert:

"Sec. 5165.27. (A) Beginning July 1, 2027, each nursing facility's per medicaid day environmental quality incentive payment rate shall be the sum of the adjusted per bed value amount determined under division (B) of this section and the environmental quality features amount determined under division (C) of this section.

(B) (1) The department of medicaid shall determine the adjusted per bed value component of each nursing facility's per medicaid day environmental quality incentive payment rate as follows:

(a) Determine the nursing facility's per bed value under division (B) (2) of this section;

(b) Apply a rental rate of ten per cent;

(c) Divide by three hundred sixty-five.

(2) (a) Subject to the limitation established by division (B) (2) (b) of this section, the department of medicaid shall determine each nursing facility's per bed value by utilizing the

per bed value assigned by the most recent appraisal conducted 943
under division (B) (3) of this section. 944

(b) The per bed value determined under division (B) (2) (a) 945
of this section shall not exceed one hundred thousand dollars. 946

(3) Every three years, each nursing facility shall secure 947
a depreciated replacement cost appraisal conducted by a 948
certified appraiser approved by the department of medicaid and 949
submit the appraisal report to the department. The nursing 950
facility shall pay the cost of the appraisal. The initial 951
appraisal for a nursing facility in operation on May 1, 2027, 952
shall be submitted not later than that date. Subsequent 953
appraisals and initial appraisals for new facilities that open 954
after the previous appraisal period shall be submitted not later 955
than the first day of May of the calendar year that is three 956
years after the calendar year in which the previous appraisal 957
was required to be submitted. If a nursing facility does not 958
submit an appraisal by the date specified in this division, its 959
per bed value shall be zero until the first day of January or 960
July that occurs after the nursing facility submits an 961
appraisal. 962

(C) The department of medicaid shall determine an 963
environmental quality features component of each nursing 964
facility's per medicaid day environmental quality incentive 965
payment rate as follows: 966

(1) Identify whether the nursing facility has one or more 967
environmental quality features, as specified in rules adopted by 968
the department of medicaid under division (D) (1) of this 969
section, based on review of the documentation the facility must 970
submit to the department, as required by rules under division 971
(D) (3) of this section; 972

(2) Determine the sum of the per diem amounts assigned for 973
each environmental quality feature identified under division (C) 974
(1) of this section. 975

(D) Not later than December 31, 2026, the department of 976
medicaid shall adopt rules authorized by section 5165.02 of the 977
Revised Code that do all of the following: 978

(1) Specify additional environmental features that enhance 979
the quality of life for nursing facility residents but are not 980
considered in appraisals conducted under division (B) (3) of this 981
section; 982

(2) Assign a per diem amount for each such feature to be 983
used in calculating a portion of the per medicaid day 984
environmental quality incentive payment rate under division (C) 985
of this section; 986

(3) Prescribe documentation that a nursing facility must 987
submit to the department to verify that the facility has such a 988
feature." 989

In line 102589, after "5163.05," insert "5165.152," 990

In the table on line 107303, in row D, delete "\$20,232,492,970 991
 \$21,770,643,885" and insert "\$20,248,492,970 \$21,786,643,885" 992

In the table on line 107303, in row E, delete "\$5,624,594,001 993
 \$6,005,647,524" and insert "\$5,630,194,001 \$6,011,247,524" 994

In the table on line 107303, in row F, delete "\$14,607,898,969 995
 \$15,764,996,361" and insert "\$14,618,298,969 \$15,775,396,361" 996

In the table on line 107303, in rows H and AE, add \$16,000,000 to 997
 each fiscal year 998

Delete lines 107675 through 107693 (remove Section 333.280) and 999

insert:	1000
"Section 333.280. NURSING FACILITY ENVIRONMENTAL QUALITY	1001
WORKGROUP	1002
(A) The Department of Medicaid shall convene a nursing	1003
facility environmental quality workgroup consisting of two	1004
representatives from each of the following:	1005
(1) The Department of Medicaid;	1006
(2) The Department of Health;	1007
(3) The Department of Aging;	1008
(4) The Academy of Senior Health Sciences;	1009
(5) LeadingAge Ohio;	1010
(6) The Ohio Health Care Association.	1011
(B) Not later than September 30, 2026, the workgroup shall	1012
make recommendations for rules to be adopted by the Department	1013
of Medicaid under division (D) of section 5165.27 of the Revised	1014
Code. The Department shall consider those recommendations in	1015
adopting the rules. The recommendations shall include all of the	1016
following:	1017
(1) Additional environmental features that enhance the	1018
quality of life for nursing facility residents but are not	1019
considered in appraisals conducted under division (B) (3) of	1020
section 5165.27 of the Revised Code;	1021
(2) A per diem amount for each such feature to be used in	1022
calculating a portion of the per medicaid day environmental	1023
quality incentive payment rate under division (C) of section	1024
5165.27 of the Revised Code;	1025

(3) Documentation that a nursing facility must submit to 1026
the department to verify that the facility has such a feature." 1027
Update the title, amend, enact, or repeal clauses accordingly 1028

The motion was _____ agreed to.

SYNOPSIS

1029

Nursing facility Medicaid funding 1030

R.C. 5165.01, 5165.15, and 5165.151; conforming change in 1031
R.C. 5165.23; R.C. 5165.152 (repealed) 1032

Modifies the Medicaid nursing facility funding formula as 1033
follows: 1034

--Beginning July 1, 2027, reduces the capital costs rate 1035
to zero. 1036

--For calendar year 2026, specifies that instead of the 1037
regular direct care costs formula, a facility's direct care 1038
costs rate is the greater of (1) the facility's direct care 1039
costs rate on December 31, 2025, or (2) the lesser of the 1040
facility's current direct care costs rate, or \$5 plus its direct 1041
care costs rate as of December 31, 2025. 1042

--Beginning July 1, 2027, adds an environmental quality 1043
incentive payment rate component to the formula. 1044

--Eliminates reference to low case-mix residents - 1045
specifically, the set per Medicaid day payment rate of \$115 per 1046
day for low case-mix residents (resulting in those resident 1047
rates being subject to the regular rate calculation). 1048

--Makes similar provisions for the initial rate for new nursing facilities. 1049
1050

Direct care costs and case-mix scores 1051

R.C. 5165.19 and 5165.192 1052

For purposes of calculating a nursing facility's direct care costs: prescribes the case-mix score to use in calculations 1053
1054
from July 1 through December 31, 2025; specifies the cost per case-mix unit calculation for the semiannual period from January 1, 2026, through the next rebasing. 1055
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1057

Regarding the case-mix score used as a multiplier to calculate a nursing facility's direct care costs: 1058
1059

--Removes the exclusion of Medicaid recipients who are low case-mix residents from a component of the case-mix score calculation (i.e. all Medicaid residents will be counted for purposes of calculating a facility's case-mix score); 1060
1061
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--Prescribes how ODM must blend case-mix indexes when using the grouper methodology to determine case-mix scores, and removes ODM's authority to adopt different procedures by rule; 1064
1065
1066

--As such, requires ODM to incorporate in rules changes to the CMS grouper methodology, rather than incorporating the full methodology by rule. 1067
1068
1069

Private room incentive payments 1070

R.C. 5165.158 1071

Regarding the private room incentive rate paid to nursing facilities for private occupancy rooms, removes (1) outdated terms related to the initial CMS approval and ODM initial application process, and (2) a provision permitting ODM to deny 1072
1073
1074
1075

an application if expenditures on the private room payments are 1076
projected to exceed \$160 million in a fiscal year. 1077

Environmental quality incentive payment 1078

R.C. 5165.27 and Section 333.280 1079

Beginning July 1, 2027, adds an environmental quality 1080
incentive payment rate component to a nursing facility's per 1081
Medicaid day payment rate, comprised of an adjusted per bed 1082
value amount and an environmental quality features amount. 1083

Requires ODM to adopt rules by December 31, 2026, to (1) 1084
specify additional environmental features to be considered, (2) 1085
assign a per diem amount for each, and (3) prescribe 1086
documentation nursing facilities must submit to verify such a 1087
feature. 1088

Establishes a workgroup of state agencies and industry 1089
stakeholders to make recommendations to ODM by September 30, 1090
2026, regarding the three items described above that must be 1091
included in ODM rules. 1092

Department of Medicaid 1093

Sections 333.10 and 333.280 1094

Increases GRF appropriation item 651525, Medicaid Health 1095
Care Services, by \$16,000,000 in each fiscal year (\$5,600,000 1096
state share). 1097

Removes Executive provisions that establish a gradual 1098
implementation of using the patient driven payment model to 1099
calculate case-mix scores for nursing facility's direct care 1100
rates (replaces it with the environmental quality incentive 1101
payment workgroup described above). 1102