

Am. S. B. No. 310
As Passed by the Senate

_____ moved to amend as follows:

In line 1 of the title, after "To" insert "amend sections 5165.01, 1
5165.15, 5165.16, 5165.17, 5165.19, 5165.26, and 5166.01 and to repeal 2
section 5165.361 of the Revised Code; to amend Section 333.10 of H.B. 166 3
of the 133rd General Assembly; and to repeal Section 333.270 of H.B. 166 4
of the 133rd General Assembly to" 5

In line 3 of the title, after "subdivisions," insert "to revise the 6
formula used to determine Medicaid rates for nursing facility services," 7

After line 4, insert: 8

"Section 1. That sections 5165.01, 5165.15, 5165.16, 9
5165.17, 5165.19, 5165.26, and 5166.01 of the Revised Code be 10
amended to read as follows: 11

Sec. 5165.01. As used in this chapter: 12

(A) "Affiliated operator" means an operator affiliated 13
with either of the following: 14

(1) The exiting operator for whom the affiliated operator 15
is to assume liability for the entire amount of the exiting 16
operator's debt under the medicaid program or the portion of the 17



debt that represents the franchise permit fee the exiting operator owes; 18
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(2) The entering operator involved in the change of operator with the exiting operator specified in division (A) (1) of this section. 20
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(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. 23
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(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 27
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of equipment, including vehicles, acquired by operating lease 48
executed before December 1, 1992, if the costs are reported as 49
administrative and general costs on the nursing facility's cost 50
report for the cost reporting period ending December 31, 1992. 51

(D) "Applicable calendar year" means the calendar year 52
immediately preceding the calendar year that precedes the first 53
of the state fiscal years for which a rebasing is conducted. 54

~~(E) "Budget reduction adjustment factor" means the factor 55
specified pursuant to or in section 5165.361 of the Revised Code 56
for a state fiscal year. 57~~

~~(F)~~(1) "Capital costs" means the actual expense incurred 58
by a nursing facility for all of the following: 59

(a) Depreciation and interest on any capital assets that 60
cost five hundred dollars or more per item, including the 61
following: 62

(i) Buildings; 63

(ii) Building improvements; 64

(iii) Except as provided in division (C) of this section, 65
equipment; 66

(iv) Transportation equipment. 67

(b) Amortization and interest on land improvements and 68
leasehold improvements; 69

(c) Amortization of financing costs; 70

(d) Lease and rent of land, buildings, and equipment. 71

(2) The costs of capital assets of less than five hundred 72
dollars per item may be considered capital costs in accordance 73

with a provider's practice.	74
(G) <u>(F)</u> "Capital lease" and "operating lease" shall be	75
construed in accordance with generally accepted accounting	76
principles.	77
(H) <u>(G)</u> "Case-mix score" means a measure determined under	78
section 5165.192 of the Revised Code of the relative direct-care	79
resources needed to provide care and habilitation to a nursing	80
facility resident.	81
(I) <u>(H)</u> "Change of operator" means an entering operator	82
becoming the operator of a nursing facility in the place of the	83
exiting operator.	84
(1) Actions that constitute a change of operator include	85
the following:	86
(a) A change in an exiting operator's form of legal	87
organization, including the formation of a partnership or	88
corporation from a sole proprietorship;	89
(b) A transfer of all the exiting operator's ownership	90
interest in the operation of the nursing facility to the	91
entering operator, regardless of whether ownership of any or all	92
of the real property or personal property associated with the	93
nursing facility is also transferred;	94
(c) A lease of the nursing facility to the entering	95
operator or the exiting operator's termination of the exiting	96
operator's lease;	97
(d) If the exiting operator is a partnership, dissolution	98
of the partnership;	99
(e) If the exiting operator is a partnership, a change in	100
composition of the partnership unless both of the following	101

apply:	102
(i) The change in composition does not cause the partnership's dissolution under state law.	103 104
(ii) The partners agree that the change in composition does not constitute a change in operator.	105 106
(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.	107 108 109 110 111
(2) The following, alone, do not constitute a change of operator:	112 113
(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;	114 115 116
(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;	117 118 119 120
(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.	121 122 123 124
(J) <u>(I)</u> "Cost center" means the following:	125
(1) Ancillary and support costs;	126
(2) Capital costs;	127
(3) Direct care costs;	128

(4) Tax costs.	129
(K) <u>(J)</u> "Custom wheelchair" means a wheelchair to which	130
both of the following apply:	131
(1) It has been measured, fitted, or adapted in	132
consideration of either of the following:	133
(a) The body size or disability of the individual who is	134
to use the wheelchair;	135
(b) The individual's period of need for, or intended use	136
of, the wheelchair.	137
(2) It has customized features, modifications, or	138
components, such as adaptive seating and positioning systems,	139
that the supplier who assembled the wheelchair, or the	140
manufacturer from which the wheelchair was ordered, added or	141
made in accordance with the instructions of the physician of the	142
individual who is to use the wheelchair.	143
(I) (1) <u>(K) (1)</u> "Date of licensure" means the following:	144
(a) In the case of a nursing facility that was required by	145
law to be licensed as a nursing home under Chapter 3721. of the	146
Revised Code when it originally began to be operated as a	147
nursing home, the date the nursing facility was originally so	148
licensed;	149
(b) In the case of a nursing facility that was not	150
required by law to be licensed as a nursing home when it	151
originally began to be operated as a nursing home, the date it	152
first began to be operated as a nursing home, regardless of the	153
date the nursing facility was first licensed as a nursing home.	154
(2) If, after a nursing facility's original date of	155
licensure, more nursing home beds are added to the nursing	156

facility, the nursing facility has a different date of licensure 157
for the additional beds. This does not apply, however, to 158
additional beds when both of the following apply: 159

(a) The additional beds are located in a part of the 160
nursing facility that was constructed at the same time as the 161
continuing beds already located in that part of the nursing 162
facility; 163

(b) The part of the nursing facility in which the 164
additional beds are located was constructed as part of the 165
nursing facility at a time when the nursing facility was not 166
required by law to be licensed as a nursing home. 167

(3) The definition of "date of licensure" in this section 168
applies in determinations of nursing facilities' medicaid 169
payment rates but does not apply in determinations of nursing 170
facilities' franchise permit fees. 171

~~(M)~~ (L) "Desk-reviewed" means that a nursing facility's 172
costs as reported on a cost report submitted under section 173
5165.10 of the Revised Code have been subjected to a desk review 174
under section 5165.108 of the Revised Code and preliminarily 175
determined to be allowable costs. 176

~~(N)~~ (M) "Direct care costs" means all of the following 177
costs incurred by a nursing facility: 178

(1) Costs for registered nurses, licensed practical 179
nurses, and nurse aides employed by the nursing facility; 180

(2) Costs for direct care staff, administrative nursing 181
staff, medical directors, respiratory therapists, and except as 182
provided in division ~~(N) (8)~~ (M) (8) of this section, other 183
persons holding degrees qualifying them to provide therapy; 184

(3) Costs of purchased nursing services;	185
(4) Costs of quality assurance;	186
(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) <u>(M) (1)</u> , (2), (4), and (8) of this section;	187 188 189 190 191 192
(6) Costs of consulting and management fees related to direct care;	193 194
(7) Allocated direct care home office costs;	195
(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;	196 197 198 199 200 201
(9) Costs of wheelchairs other than the following:	202
(a) Custom wheelchairs;	203
(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.	204 205 206
(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.	207 208 209
(O) <u>(N)</u> "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.	210 211

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

(V) (1) <u>(U) (1)</u> Subject to divisions (V) (2) <u>(U) (2)</u> and (3)	239
of this section, "facility closure" means either of the	240
following:	241
(a) Discontinuance of the use of the building, or part of	242
the building, that houses the facility as a nursing facility	243
that results in the relocation of all of the nursing facility's	244
residents;	245
(b) Conversion of the building, or part of the building,	246
that houses a nursing facility to a different use with any	247
necessary license or other approval needed for that use being	248
obtained and one or more of the nursing facility's residents	249
remaining in the building, or part of the building, to receive	250
services under the new use.	251
(2) A facility closure occurs regardless of any of the	252
following:	253
(a) The operator completely or partially replacing the	254
nursing facility by constructing a new nursing facility or	255
transferring the nursing facility's license to another nursing	256
facility;	257
(b) The nursing facility's residents relocating to another	258
of the operator's nursing facilities;	259
(c) Any action the department of health takes regarding	260
the nursing facility's medicaid certification that may result in	261
the transfer of part of the nursing facility's survey findings	262
to another of the operator's nursing facilities;	263
(d) Any action the department of health takes regarding	264
the nursing facility's license under Chapter 3721. of the	265
Revised Code.	266

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

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

(1) All days during which a resident, regardless of
payment source, 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.

~~(Y)~~ (X) "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)~~ (Y) "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)~~ (Z) "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 295
limited to the costs of ordinary repairs such as painting and 296
wallpapering. 297

~~(BB)~~ (AA) "Medicaid-certified capacity" means the number 298
of a nursing facility's beds that are certified for 299
participation 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) "Medicare skilled nursing facility market basket 308
index" means the index established by the United States 309
secretary of health and human services under section 1888(e)(5) 310
of the "Social Security Act," 42 U.S.C. 1395yy(e)(5). 311~~

~~(EE)~~ (1) ~~(CC)~~ (1) "New nursing facility" means a nursing 312
facility for which the provider obtains an initial provider 313
agreement following medicaid certification of the nursing 314
facility by the director of health, including such a nursing 315
facility that replaces one or more nursing facilities for which 316
a provider previously held a provider agreement. 317

(2) "New nursing facility" does not mean a nursing 318
facility for which the entering operator seeks a provider 319
agreement pursuant to section 5165.511 or 5165.512 or (pursuant 320
to section 5165.515) section 5165.07 of the Revised Code. 321

~~(FF)~~ (DD) "Nursing facility" has the same meaning as in 322

the "Social Security Act," section 1919(a), 42 U.S.C. 1396r(a). 323

~~(GG)~~(EE) "Nursing facility services" has the same meaning 324
as in the "Social Security Act," section 1905(f), 42 U.S.C. 325
1396d(f). 326

~~(HH)~~(FF) "Nursing home" has the same meaning as in 327
section 3721.01 of the Revised Code. 328

~~(II)~~(GG) "Operator" means the person or government entity 329
responsible for the daily operating and management decisions for 330
a nursing facility. 331

~~(JJ)~~(1)~~(HH)~~(1) "Owner" means any person or government 332
entity that has at least five per cent ownership or interest, 333
either directly, indirectly, or in any combination, in any of 334
the following regarding a nursing facility: 335

(a) The land on which the nursing facility is located; 336

(b) The structure in which the nursing facility is 337
located; 338

(c) Any mortgage, contract for deed, or other obligation 339
secured in whole or in part by the land or structure on or in 340
which the nursing facility is located; 341

(d) Any lease or sublease of the land or structure on or 342
in which the nursing facility is located. 343

(2) "Owner" does not mean a holder of a debenture or bond 344
related to the nursing facility and purchased at public issue or 345
a regulated lender that has made a loan related to the nursing 346
facility unless the holder or lender operates the nursing 347
facility directly or through a subsidiary. 348

~~(KK)~~(II) "Per diem" means a nursing facility's actual, 349

allowable costs in a given cost center in a cost reporting 350
period, divided by the nursing facility's inpatient days for 351
that cost reporting period. 352

~~(LL)~~ (JJ) "Provider" means an operator with a provider 353
agreement. 354

~~(MM)~~ (KK) "Provider agreement" means a provider agreement, 355
as defined in section 5164.01 of the Revised Code, that is 356
between the department of medicaid and the operator of a nursing 357
facility for the provision of nursing facility services under 358
the medicaid program. 359

~~(NN)~~ (LL) "Purchased nursing services" means services that 360
are provided in a nursing facility by registered nurses, 361
licensed practical nurses, or nurse aides who are not employees 362
of the nursing facility. 363

~~(OO)~~ (MM) "Reasonable" means that a cost is an actual cost 364
that is appropriate and helpful to develop and maintain the 365
operation of patient care facilities and activities, including 366
normal standby costs, and that does not exceed what a prudent 367
buyer pays for a given item or services. Reasonable costs may 368
vary from provider to provider and from time to time for the 369
same provider. 370

~~(PP)~~ (NN) "Rebasing" means a redetermination of each of 371
the following using information from cost reports for an 372
applicable calendar year that is later than the applicable 373
calendar year used for the previous rebasing: 374

(1) Each peer group's rate for ancillary and support costs 375
as determined pursuant to division (C) of section 5165.16 of the 376
Revised Code; 377

(2) Each peer group's rate for capital costs as determined pursuant to division (C) of section 5165.17 of the Revised Code;	378 379
(3) Each peer group's cost per case-mix unit as determined pursuant to division (C) of section 5165.19 of the Revised Code;	380 381
(4) Each nursing facility's rate for tax costs as determined pursuant to section 5165.21 of the Revised Code.	382 383
(00) <u>(00)</u> "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.	384 385 386 387
(1) An individual who is a relative of an owner is a related party.	388 389
(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.	390 391 392 393 394 395 396 397 398
(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.	399 400 401
(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:	402 403 404
(a) The supplier is a separate bona fide organization.	405

(b) A substantial part of the supplier's business activity 406
of the type carried on with the provider is transacted with 407
others than the provider and there is an open, competitive 408
market for the types of goods or services the supplier 409
furnishes. 410

(c) The types of goods or services are commonly obtained 411
by other nursing facilities from outside organizations and are 412
not a basic element of patient care ordinarily furnished 413
directly to patients by nursing facilities. 414

(d) The charge to the provider is in line with the charge 415
for the goods or services in the open market and no more than 416
the charge made under comparable circumstances to others by the 417
supplier. 418

~~(RR)~~(PP) "Relative of owner" means an individual who is 419
related to an owner of a nursing facility by one of the 420
following relationships: 421

- (1) Spouse; 422
- (2) Natural parent, child, or sibling; 423
- (3) Adopted parent, child, or sibling; 424
- (4) Stepparent, stepchild, stepbrother, or stepsister; 425
- (5) Father-in-law, mother-in-law, son-in-law, daughter-in-
law, brother-in-law, or sister-in-law; 426
427
- (6) Grandparent or grandchild; 428
- (7) Foster caregiver, foster child, foster brother, or
foster sister. 429
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~~(SS)~~(OO) "Residents' rights advocate" has the same 431
meaning as in section 3721.10 of the Revised Code. 432

~~(TT)~~ (RR) "Skilled nursing facility" has the same meaning 433
as in the "Social Security Act," section 1819(a), 42 U.S.C. 434
1395i-3(a). 435

~~(UU)~~ (SS) "State fiscal year" means the fiscal year of 436
this state, as specified in section 9.34 of the Revised Code. 437

~~(VV)~~ (TT) "Sponsor" has the same meaning as in section 438
3721.10 of the Revised Code. 439

~~(WW)~~ (UU) "Tax costs" means the costs of taxes imposed 440
under Chapter 5751. of the Revised Code, real estate taxes, 441
personal property taxes, and corporate franchise taxes. 442

~~(XX)~~ (VV) "Title XIX" means Title XIX of the "Social 443
Security Act," 42 U.S.C. 1396 et seq. 444

~~(YY)~~ (WW) "Title XVIII" means Title XVIII of the "Social 445
Security Act," 42 U.S.C. 1395 et seq. 446

~~(ZZ)~~ (XX) "Voluntary withdrawal of participation" means an 447
operator's voluntary election to terminate the participation of 448
a nursing facility in the medicaid program but to continue to 449
provide service of the type provided by a nursing facility. 450

Sec. 5165.15. Except as otherwise provided by sections 451
5165.151 to 5165.157 and 5165.34 of the Revised Code, the total 452
per medicaid day payment rate that the department of medicaid 453
shall pay a nursing facility provider for nursing facility 454
services the provider's nursing facility provides during a state 455
fiscal year shall be determined as follows: 456

(A) Determine the sum of all of the following: 457

(1) The per medicaid day payment rate for ancillary and 458
support costs determined for the nursing facility under section 459
5165.16 of the Revised Code; 460

(2) The per medicaid day payment rate for capital costs 461
determined for the nursing facility under section 5165.17 of the 462
Revised Code; 463

(3) The per medicaid day payment rate for direct care 464
costs determined for the nursing facility under section 5165.19 465
of the Revised Code; 466

(4) The per medicaid day payment rate for tax costs 467
determined for the nursing facility under section 5165.21 of the 468
Revised Code; 469

(5) If the nursing facility qualifies as a critical access 470
nursing facility, the nursing facility's critical access 471
incentive payment paid under section 5165.23 of the Revised 472
Code. 473

(B) To the sum determined under division (A) of this 474
section, add sixteen dollars and forty-four cents. 475

(C) From the sum determined under division (B) of this 476
section, subtract one dollar and seventy-nine cents. 477

(D) To the difference determined under division (C) of 478
this section, add the per medicaid day quality payment rate 479
determined for the nursing facility under section 5165.25 of the 480
Revised Code. 481

(E) To the sum determined under division (D) of this 482
section, add, for ~~the second half of state fiscal year 2020 and~~ 483
~~all of each state fiscal year thereafter~~2021, the per medicaid 484
day quality incentive payment rate determined for the nursing 485
facility under section 5165.26 of the Revised Code. 486

Sec. 5165.16. (A) The department of medicaid shall 487
determine each nursing facility's per medicaid day payment rate 488

for ancillary and support costs. A nursing facility's rate shall 489
be the rate determined under division (C) of this section for 490
the nursing facility's peer group. 491

(B) For the purpose of determining nursing facilities' 492
rates for ancillary and support costs, the department shall 493
establish six peer groups composed as follows: 494

(1) Each nursing facility located in any of the following 495
counties shall be placed in peer group one or two: Brown, 496
Butler, Clermont, Clinton, Hamilton, and Warren. Each nursing 497
facility located in any of those counties that has fewer than 498
one hundred beds shall be placed in peer group one. Each nursing 499
facility located in any of those counties that has one hundred 500
or more beds shall be placed in peer group two. 501

(2) Each nursing facility located in any of the following 502
counties shall be placed in peer group three or four: Allen, 503
Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, 504
Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, 505
Knox, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, 506
Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, 507
Preble, Ross, Sandusky, Seneca, Stark, Summit, Trumbull, Union, 508
and Wood. Each nursing facility located in any of those counties 509
that has fewer than one hundred beds shall be placed in peer 510
group three. Each nursing facility located in any of those 511
counties that has one hundred or more beds shall be placed in 512
peer group four. 513

(3) Each nursing facility located in any of the following 514
counties shall be placed in peer group five or six: Adams, 515
Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, 516
Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, 517
Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, 518

Jefferson, Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, 519
Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, 520
Scioto, Shelby, Tuscarawas, Van Wert, Vinton, Washington, Wayne, 521
Williams, and Wyandot. Each nursing facility located in any of 522
those counties that has fewer than one hundred beds shall be 523
placed in peer group five. Each nursing facility located in any 524
of those counties that has one hundred or more beds shall be 525
placed in peer group six. 526

(C) (1) The department shall determine the rate for 527
ancillary and support costs for each peer group established 528
under division (B) of this section. The rate for ancillary and 529
support costs determined under this division for a peer group 530
shall be used for subsequent years until the department conducts 531
a rebasing. To determine a peer group's rate for ancillary and 532
support costs, the department shall do all of the following: 533

(a) Subject to division (C) (2) of this section, determine 534
the rate for ancillary and support costs for each nursing 535
facility in the peer group for the applicable calendar year by 536
using the greater of the nursing facility's actual inpatient 537
days for the applicable calendar year or the inpatient days the 538
nursing facility would have had for the applicable calendar year 539
if its occupancy rate had been ninety per cent; 540

(b) Subject to division (C) (3) of this section, identify 541
which nursing facility in the peer group is at the twenty-fifth 542
percentile of the rate for ancillary and support costs for the 543
applicable calendar year determined under division (C) (1) (a) of 544
this section; 545

(c) Multiply the rate for ancillary and support costs 546
determined under division (C) (1) (a) of this section for the 547
nursing facility identified under division (C) (1) (b) of this 548

section by the rate of inflation for the eighteen-month period 549
beginning on the first day of July of the applicable calendar 550
year and ending the last day of December of the calendar year 551
immediately following the applicable calendar year using the 552
following: 553

(i) Except as provided in division (C) (1) (c) (ii) of this 554
section, the consumer price index for all items for all urban 555
consumers for the midwest region, published by the United States 556
bureau of labor statistics; 557

(ii) If the United States bureau of labor statistics 558
ceases to publish the index specified in division (C) (1) (c) (i) 559
of this section, the index the bureau subsequently publishes 560
that covers urban consumers' prices for items for the region 561
that includes this state. 562

~~(d) For state fiscal year 2020 and each state fiscal year~~ 563
~~thereafter (other than the first state fiscal year in a group of~~ 564
~~consecutive state fiscal years for which a rebasing is~~ 565
~~conducted), adjust the amount calculated under division (C) (1)~~ 566
~~(c) of this section using the difference between the following:~~ 567

~~(i) The medicare skilled nursing facility market basket~~ 568
~~index determined for the federal fiscal year that begins during~~ 569
~~the state fiscal year immediately preceding the state fiscal~~ 570
~~year for which the adjustment is being made under division (C)~~ 571
~~(1) (d) of this section;~~ 572

~~(ii) The budget reduction adjustment factor for the state~~ 573
~~fiscal year for which the adjustment is being made under~~ 574
~~division (C) (1) (d) of this section.~~ 575

(2) For the purpose of determining a nursing facility's 576
occupancy rate under division (C) (1) (a) of this section, the 577

department shall include any beds that the nursing facility 578
removes from its medicaid-certified capacity unless the nursing 579
facility also removes the beds from its licensed bed capacity. 580

(3) In making the identification under division (C) (1) (b) 581
of this section, the department shall exclude both of the 582
following: 583

(a) Nursing facilities that participated in the medicaid 584
program under the same provider for less than twelve months in 585
the applicable calendar year; 586

(b) Nursing facilities whose ancillary and support costs 587
are more than one standard deviation from the mean desk- 588
reviewed, actual, allowable, per diem ancillary and support cost 589
for all nursing facilities in the nursing facility's peer group 590
for the applicable calendar year. 591

(4) The department shall not redetermine a peer group's 592
rate for ancillary and support costs under this division based 593
on additional information that it receives after the rate is 594
determined. The department shall redetermine a peer group's rate 595
for ancillary and support costs only if the department made an 596
error in determining the rate based on information available to 597
the department at the time of the original determination. 598

Sec. 5165.17. (A) The department of medicaid shall 599
determine each nursing facility's per medicaid day payment rate 600
for capital costs. A nursing facility's rate shall be the rate 601
determined under division (C) of this section for the nursing 602
facility's peer group. 603

(B) For the purpose of determining nursing facilities' 604
rates for capital costs, the department shall establish six peer 605
groups. 606

(1) Each nursing facility located in any of the following 607
counties shall be placed in peer group one or two: Brown, 608
Butler, Clermont, Clinton, Hamilton, and Warren. Each nursing 609
facility located in any of those counties that has fewer than 610
one hundred beds shall be placed in peer group one. Each nursing 611
facility located in any of those counties that has one hundred 612
or more beds shall be placed in peer group two. 613

(2) Each nursing facility located in any of the following 614
counties shall be placed in peer group three or four: Allen, 615
Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, 616
Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, 617
Knox, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, 618
Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, 619
Preble, Ross, Sandusky, Seneca, Stark, Summit, Trumbull, Union, 620
and Wood. Each nursing facility located in any of those counties 621
that has fewer than one hundred beds shall be placed in peer 622
group three. Each nursing facility located in any of those 623
counties that has one hundred or more beds shall be placed in 624
peer group four. 625

(3) Each nursing facility located in any of the following 626
counties shall be placed in peer group five or six: Adams, 627
Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, 628
Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, 629
Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, 630
Jefferson, Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, 631
Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, 632
Scioto, Shelby, Tuscarawas, Van Wert, Vinton, Washington, Wayne, 633
Williams, and Wyandot. Each nursing facility located in any of 634
those counties that has fewer than one hundred beds shall be 635
placed in peer group five. Each nursing facility located in any 636
of those counties that has one hundred or more beds shall be 637

placed in peer group six. 638

(C) (1) The department shall determine the rate for capital 639
costs for each peer group established under division (B) of this 640
section. The rate for capital costs determined under this 641
division for a peer group shall be used for subsequent years 642
until the department conducts a rebasing. ~~To determine a~~ A peer 643
group's rate for capital costs, ~~the department shall do both of~~
~~the following:~~ 644
645

~~(a) Determine~~ be the rate for capital costs for the 646
nursing facility in the peer group that is at the twenty-fifth 647
percentile of the rate for capital costs for the applicable 648
calendar year. 649

~~(b) For state fiscal year 2020 and each state fiscal year~~ 650
~~thereafter (other than the first state fiscal year in a group of~~ 651
~~consecutive state fiscal years for which a rebasing is~~ 652
~~conducted), adjust the amount calculated under division (C) (1)~~ 653
~~(a) of this section using the difference between the following:~~ 654

~~(i) The medicare skilled nursing facility market basket~~ 655
~~index determined for the federal fiscal year that begins during~~ 656
~~the state fiscal year immediately preceding the state fiscal~~ 657
~~year for which the adjustment is being made under division (C)~~ 658
~~(1) (a) of this section.~~ 659

~~(ii) The budget reduction adjustment factor for the state~~ 660
~~fiscal year for which the adjustment is being made under~~ 661
~~division (C) (1) (a) of this section.~~ 662

(2) To identify the nursing facility in a peer group that 663
is at the twenty-fifth percentile of the rate for capital costs 664
for the applicable calendar year, the department shall do both 665
of the following: 666

(a) Subject to division (C) (3) of this section, use the greater of each nursing facility's actual inpatient days for the applicable calendar year or the inpatient days the nursing facility would have had for the applicable calendar year if its occupancy rate had been one hundred per cent;

(b) Exclude both of the following:

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

(ii) Nursing facilities whose capital costs are more than one standard deviation from the mean desk-reviewed, actual, allowable, per diem capital cost for all nursing facilities in the nursing facility's peer group for the applicable calendar year.

(3) For the purpose of determining a nursing facility's occupancy rate under division (C) (2) (a) of this section, the department shall include any beds that the nursing facility removes from its medicaid-certified capacity after June 30, 2005, unless the nursing facility also removes the beds from its licensed bed capacity.

(4) The department shall not redetermine a peer group's rate for capital costs under this division based on additional information that it receives after the rate is determined. The department shall redetermine a peer group's rate for capital costs only if the department made an error in determining the rate based on information available to the department at the time of the original determination.

(D) Buildings shall be depreciated using the straight line method over forty years or over a different period approved by

the department. Components and equipment shall be depreciated 696
using the straight-line method over a period designated in rules 697
adopted under section 5165.02 of the Revised Code, consistent 698
with the guidelines of the American hospital association, or 699
over a different period approved by the department. Any rules 700
authorized by this division that specify useful lives of 701
buildings, components, or equipment apply only to assets 702
acquired on or after July 1, 1993. Depreciation for costs paid 703
or reimbursed by any government agency shall not be included in 704
capital costs unless that part of the payment under this chapter 705
is used to reimburse the government agency. 706

(E) The capital cost basis of nursing facility assets 707
shall be determined in the following manner: 708

(1) Except as provided in division (E) (3) of this section, 709
for purposes of calculating the rates to be paid for facilities 710
with dates of licensure on or before June 30, 1993, the capital 711
cost basis of each asset shall be equal to the desk-reviewed, 712
actual, allowable, capital cost basis that is listed on the 713
facility's cost report for the calendar year preceding the state 714
fiscal year during which the rate will be paid. 715

(2) For facilities with dates of licensure after June 30, 716
1993, the capital cost basis shall be determined in accordance 717
with the principles of the medicare program, except as otherwise 718
provided in this chapter. 719

(3) Except as provided in division (E) (4) of this section, 720
if a provider transfers an interest in a facility to another 721
provider after June 30, 1993, there shall be no increase in the 722
capital cost basis of the asset if the providers are related 723
parties or the provider to which the interest is transferred 724
authorizes the provider that transferred the interest to 725

continue to operate the facility under a lease, management 726
agreement, or other arrangement. If the previous sentence does 727
not prohibit the adjustment of the capital cost basis under this 728
division, the basis of the asset shall be adjusted by one-half 729
of the change in the consumer price index for all items for all 730
urban consumers, as published by the United States bureau of 731
labor statistics, during the time that the transferor held the 732
asset. 733

(4) If a provider transfers an interest in a facility to 734
another provider who is a related party, the capital cost basis 735
of the asset shall be adjusted as specified in division (E) (3) 736
of this section if all of the following conditions are met: 737

(a) The related party is a relative of owner; 738

(b) Except as provided in division (E) (4) (c) (ii) of this 739
section, the provider making the transfer retains no ownership 740
interest in the facility; 741

(c) The department determines that the transfer is an 742
arm's length transaction pursuant to rules adopted under section 743
5165.02 of the Revised Code. The rules shall provide that a 744
transfer is an arm's length transaction if all of the following 745
apply: 746

(i) Once the transfer goes into effect, the provider that 747
made the transfer has no direct or indirect interest in the 748
provider that acquires the facility or the facility itself, 749
including interest as an owner, officer, director, employee, 750
independent contractor, or consultant, but excluding interest as 751
a creditor. 752

(ii) The provider that made the transfer does not 753
reacquire an interest in the facility except through the 754

exercise of a creditor's rights in the event of a default. If 755
the provider reacquires an interest in the facility in this 756
manner, the department shall treat the facility as if the 757
transfer never occurred when the department calculates its 758
reimbursement rates for capital costs. 759

(iii) The transfer satisfies any other criteria specified 760
in the rules. 761

(d) Except in the case of hardship caused by a 762
catastrophic event, as determined by the department, or in the 763
case of a provider making the transfer who is at least sixty- 764
five years of age, not less than twenty years have elapsed 765
since, for the same facility, the capital cost basis was 766
adjusted most recently under division (E) (4) of this section or 767
actual, allowable capital costs was determined most recently 768
under division (F) (9) of this section. 769

(F) As used in this division: 770

"Imputed interest" means the lesser of the prime rate plus 771
two per cent or ten per cent. 772

"Lease expense" means lease payments in the case of an 773
operating lease and depreciation expense and interest expense in 774
the case of a capital lease. 775

"New lease" means a lease, to a different lessee, of a 776
nursing facility that previously was operated under a lease. 777

(1) Subject to division (A) of this section, for a lease 778
of a facility that was effective on May 27, 1992, the entire 779
lease expense is an actual, allowable capital cost during the 780
term of the existing lease. The entire lease expense also is an 781
actual, allowable capital cost if a lease in existence on May 782

27, 1992, is renewed under either of the following	783
circumstances:	784
(a) The renewal is pursuant to a renewal option that was	785
in existence on May 27, 1992;	786
(b) The renewal is for the same lease payment amount and	787
between the same parties as the lease in existence on May 27,	788
1992.	789
(2) Subject to division (A) of this section, for a lease	790
of a facility that was in existence but not operated under a	791
lease on May 27, 1992, actual, allowable capital costs shall	792
include the lesser of the annual lease expense or the annual	793
depreciation expense and imputed interest expense that would be	794
calculated at the inception of the lease using the lessor's	795
entire historical capital asset cost basis, adjusted by one-half	796
of the change in the consumer price index for all items for all	797
urban consumers, as published by the United States bureau of	798
labor statistics, during the time the lessor held each asset	799
until the beginning of the lease.	800
(3) Subject to division (A) of this section, for a lease	801
of a facility with a date of licensure on or after May 27, 1992,	802
that is initially operated under a lease, actual, allowable	803
capital costs shall include the annual lease expense if there	804
was a substantial commitment of money for construction of the	805
facility after December 22, 1992, and before July 1, 1993. If	806
there was not a substantial commitment of money after December	807
22, 1992, and before July 1, 1993, actual, allowable capital	808
costs shall include the lesser of the annual lease expense or	809
the sum of the following:	810
(a) The annual depreciation expense that would be	811

calculated at the inception of the lease using the lessor's 812
entire historical capital asset cost basis; 813

(b) The greater of the lessor's actual annual amortization 814
of financing costs and interest expense at the inception of the 815
lease or the imputed interest expense calculated at the 816
inception of the lease using seventy per cent of the lessor's 817
historical capital asset cost basis. 818

(4) Subject to division (A) of this section, for a lease 819
of a facility with a date of licensure on or after May 27, 1992, 820
that was not initially operated under a lease and has been in 821
existence for ten years, actual, allowable capital costs shall 822
include the lesser of the annual lease expense or the annual 823
depreciation expense and imputed interest expense that would be 824
calculated at the inception of the lease using the entire 825
historical capital asset cost basis of one-half of the change in 826
the consumer price index for all items for all urban consumers, 827
as published by the United States bureau of labor statistics, 828
during the time the lessor held each asset until the beginning 829
of the lease. 830

(5) Subject to division (A) of this section, for a new 831
lease of a facility that was operated under a lease on May 27, 832
1992, actual, allowable capital costs shall include the lesser 833
of the annual new lease expense or the annual old lease payment. 834
If the old lease was in effect for ten years or longer, the old 835
lease payment from the beginning of the old lease shall be 836
adjusted by one-half of the change in the consumer price index 837
for all items for all urban consumers, as published by the 838
United States bureau of labor statistics, from the beginning of 839
the old lease to the beginning of the new lease. 840

(6) Subject to division (A) of this section, for a new 841

lease of a facility that was not in existence or that was in 842
existence but not operated under a lease on May 27, 1992, 843
actual, allowable capital costs shall include the lesser of 844
annual new lease expense or the annual amount calculated for the 845
old lease under division (F) (2), (3), (4), or (6) of this 846
section, as applicable. If the old lease was in effect for ten 847
years or longer, the lessor's historical capital asset cost 848
basis shall be, for purposes of calculating the annual amount 849
under division (F) (2), (3), (4), or (6) of this section, 850
adjusted by one-half of the change in the consumer price index 851
for all items for all urban consumers, as published by the 852
United States bureau of labor statistics, from the beginning of 853
the old lease to the beginning of the new lease. 854

In the case of a lease under division (F) (3) of this 855
section of a facility for which a substantial commitment of 856
money was made after December 22, 1992, and before July 1, 1993, 857
the old lease payment shall be adjusted for the purpose of 858
determining the annual amount. 859

(7) For any revision of a lease described in division (F) 860
(1), (2), (3), (4), (5), or (6) of this section, or for any 861
subsequent lease of a facility operated under such a lease, 862
other than execution of a new lease, the portion of actual, 863
allowable capital costs attributable to the lease shall be the 864
same as before the revision or subsequent lease. 865

(8) Except as provided in division (F) (9) of this section, 866
if a provider leases an interest in a facility to another 867
provider who is a related party or previously operated the 868
facility, the related party's or previous operator's actual, 869
allowable capital costs shall include the lesser of the annual 870
lease expense or the reasonable cost to the lessor. 871

(9) If a provider leases an interest in a facility to another provider who is a related party, regardless of the date of the lease, the related party's actual, allowable capital costs shall include the annual lease expense, subject to the limitations specified in divisions (F) (1) to (7) of this section, if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) If the lessor retains an ownership interest, it is, except as provided in division (F) (9) (c) (ii) of this section, in only the real property and any improvements on the real property;

(c) The department determines that the lease is an arm's length transaction pursuant to rules adopted under section 5165.02 of the Revised Code. The rules shall provide that a lease is an arm's length transaction if all of the following apply:

(i) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in division (F) (9) (b) of this section, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(ii) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, the department shall treat the facility as if the lease never occurred when the department calculates its reimbursement rates for capital costs.

(iii) The lease satisfies any other criteria specified in

the rules. 901

(d) Except in the case of hardship caused by a 902
catastrophic event, as determined by the department, or in the 903
case of a lessor who is at least sixty-five years of age, not 904
less than twenty years have elapsed since, for the same 905
facility, the capital cost basis was adjusted most recently 906
under division (E) (4) of this section or actual, allowable 907
capital costs were determined most recently under division (F) 908
(9) of this section. 909

(10) This division does not apply to leases of specific 910
items of equipment. 911

Sec. 5165.19. (A) Semiannually, the department of 912
medicaid shall determine each nursing facility's per medicaid 913
day payment rate for direct care costs by multiplying the 914
facility's semiannual case-mix score determined under section 915
5165.192 of the Revised Code by the cost per case-mix unit 916
determined under division (C) of this section for the facility's 917
peer group. 918

(B) For the purpose of determining nursing facilities' 919
rates for direct care costs, the department shall establish 920
three peer groups. 921

(1) Each nursing facility located in any of the following 922
counties shall be placed in peer group one: Brown, Butler, 923
Clermont, Clinton, Hamilton, and Warren. 924

(2) Each nursing facility located in any of the following 925
counties shall be placed in peer group two: Allen, Ashtabula, 926
Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, 927
Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, 928
Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, 929

Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, 930
Sandusky, Seneca, Stark, Summit, Trumbull, Union, and Wood. 931

(3) Each nursing facility located in any of the following 932
counties shall be placed in peer group three: Adams, Ashland, 933
Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, 934
Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, 935
Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, 936
Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, 937
Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, 938
Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and 939
Wyandot. 940

(C) (1) The department shall determine a cost per case-mix 941
unit for each peer group established under division (B) of this 942
section. The cost per case-mix unit determined under this 943
division for a peer group shall be used for subsequent years 944
until the department conducts a rebasing. To determine a peer 945
group's cost per case-mix unit, the department shall do all of 946
the following: 947

(a) Determine the cost per case-mix unit for each nursing 948
facility in the peer group for the applicable calendar year by 949
dividing each facility's desk-reviewed, actual, allowable, per 950
diem direct care costs for the applicable calendar year by the 951
facility's annual average case-mix score determined under 952
section 5165.192 of the Revised Code for the applicable calendar 953
year; 954

(b) Subject to division (C) (2) of this section, identify 955
which nursing facility in the peer group is at the twenty-fifth 956
percentile of the cost per case-mix units determined under 957
division (C) (1) (a) of this section; 958

(c) Calculate the amount that is two per cent above the
cost per case-mix unit determined under division (C) (1) (a) of
this section for the nursing facility identified under division
(C) (1) (b) of this section;

(d) Using the index specified in division (C) (3) of this
section, multiply the rate of inflation for the eighteen-month
period beginning on the first day of July of the applicable
calendar year and ending the last day of December of the
calendar year immediately following the applicable calendar year
by the amount calculated under division (C) (1) (c) of this
section;

~~(e) For state fiscal year 2020 and each state fiscal year
thereafter (other than the first state fiscal year in a group of
consecutive state fiscal years for which a rebasing is
conducted), adjust the amount calculated under division (C) (1)
(d) of this section using the difference between the following:~~

~~(i) The medicare skilled nursing facility market basket
index determined for the federal fiscal year that begins during
the state fiscal year immediately preceding the state fiscal
year for which the adjustment is being made under division (C)
(1) (e) of this section;~~

~~(ii) The budget reduction adjustment factor for the state
fiscal year for which the adjustment is being made under
division (C) (1) (e) of this section.~~

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

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

the applicable calendar year;	988
(b) Nursing facilities whose cost per case-mix unit is more than one standard deviation from the mean cost per case-mix unit for all nursing facilities in the nursing facility's peer group for the applicable calendar year.	989 990 991 992
(3) The following index shall be used for the purpose of the calculation made under division (C)(1)(d) of this section:	993 994
(a) Except as provided in division (C)(3)(b) of this section, the employment cost index for total compensation, nursing and residential care facilities occupational group, published by the United States bureau of labor statistics;	995 996 997 998
(b) If the United States bureau of labor statistics ceases to publish the index specified in division (C)(3)(a) of this section, the index the bureau subsequently publishes that covers nursing facilities' staff costs.	999 1000 1001 1002
(4) The department shall not redetermine a peer group's cost per case-mix unit under this division based on additional information that it receives after the peer group's per case-mix unit is determined. The department shall redetermine a peer group's cost per case-mix unit only if it made an error in determining the peer group's cost per case-mix unit based on information available to the department at the time of the original determination.	1003 1004 1005 1006 1007 1008 1009 1010
Sec. 5165.26. (A) As used in this section:	1011
(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.	1012 1013 1014
(2) "CMS" means the United States centers for medicare and	1015

medicaid services. 1016

(3) "Force majeure event" means an uncontrollable force or 1017
natural disaster not within the power of a nursing facility's 1018
operator. 1019

(4) "Long-stay resident" and "measurement period" have has 1020
the same meanings ~~meaning~~ as in section 5165.25 of the Revised 1021
Code. 1022

(5) "Nursing facilities for which a quality score was 1023
determined" includes nursing facilities that are determined to 1024
have a quality score of zero. 1025

(B) ~~For the second half of state fiscal year 2020 and all~~ 1026
~~of each state fiscal year thereafter~~ 2021, and subject to 1027
divisions (D) ~~and~~, (E), and (F) of this section, the department 1028
of medicaid shall determine each nursing facility's per medicaid 1029
day quality incentive payment rate as follows: 1030

(1) Determine the sum of the quality scores determined 1031
under division (C) of this section for all nursing facilities. 1032

(2) Determine the average quality score by dividing the 1033
sum determined under division (B) (1) of this section by the 1034
number of nursing facilities for which a quality score was 1035
determined. 1036

~~(3) Determine the following:—~~ 1037

~~(a) For the second half of state fiscal year 2020, the sum~~ 1038
~~of the total number of medicaid days for the second half of~~ 1039
~~calendar year 2018 for all nursing facilities for which a~~ 1040
~~quality score was determined;—~~ 1041

~~(b) For all of state fiscal year 2021 and each state~~ 1042
~~fiscal year thereafter, determine~~ the sum of the total number of 1043

medicaid days for ~~the measurement period applicable to the state~~ 1044
~~fiscal year~~ all of calendar year 2019 for all nursing facilities 1045
 for which a quality score was determined. 1046

(4) Multiply the average quality score determined under 1047
 division (B) (2) of this section by the sum determined under 1048
 division (B) (3) of this section. 1049

(5) Determine the value per quality point by determining 1050
 the quotient of the following: 1051

(a) ~~The following:~~ 1052

~~(i) For the second half of state fiscal year 2020, the sum~~ 1053
~~determined under division (E) (1) (b) of this section;~~ 1054

~~(ii) For all of state fiscal year 2021 and each state~~ 1055
~~fiscal year thereafter, the sum determined under division (E) (2)~~ 1056
~~(b) (F) (2) of this section.~~ 1057

(b) The product determined under division (B) (4) of this 1058
 section. 1059

(6) Multiply the value per quality point determined under 1060
 division (B) (5) of this section by the nursing facility's 1061
 quality score determined under division (C) of this section. 1062

(C) (1) Except as provided in divisions (C) (2) and (3) of 1063
 this section, a nursing facility's quality score for a state 1064
 fiscal year 2021 shall be the sum of the total number of points 1065
 that CMS assigned to the nursing facility under CMS's nursing 1066
 facility five-star quality rating system for the following 1067
 quality metrics based on the most recent four-quarter average 1068
data available in the database maintained by the U.S. centers 1069
for medicare and medicaid services and known as nursing home 1070
compare in May of 2020: 1071

(a) The percentage of the nursing facility's long-stay residents at high risk for pressure ulcers who had pressure ulcers ~~during the measurement period;~~

(b) The percentage of the nursing facility's long-stay residents who had a urinary tract infection ~~during the measurement period;~~

(c) The percentage of the nursing facility's long-stay residents whose ability to move independently worsened ~~during the measurement period;~~

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

(2) In determining a nursing facility's quality score for ~~a~~ state fiscal year 2021, 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 division (C) (1) of this section:

(a) Unless division (C) (2) (b) 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.

(3) A nursing facility's quality score shall be zero for a state fiscal year 2021 if it is not to receive a quality incentive payment for that state fiscal year because of division (D) of this section.

(D) (1) Except as provided in division (D) (2) of this

section, a nursing facility shall not receive a quality 1100
incentive payment for ~~a state fiscal year, other than the second~~ 1101
~~half of state fiscal year 2020, 2021~~ if the nursing facility's 1102
licensed occupancy percentage is less than eighty per cent. 1103

(2) Division (D)(1) of this section does not apply to a 1104
nursing facility ~~for a state fiscal year if either any of the~~ 1105
following apply: 1106

(a) The nursing facility has a quality score under 1107
division (C) of this section for ~~the state fiscal year 2021~~ of 1108
at least fifteen points; 1109

(b) The nursing facility was initially certified for 1110
participation in the medicaid program on or after January 1, 1111
2019; 1112

(c) Subject to division (D)(4) of this section, one or 1113
more of the beds that are part of the nursing facility's 1114
licensed capacity could not be used for resident care during 1115
calendar year 2019 due to causes beyond the reasonable control 1116
of the nursing facility's operator, including a force majeure 1117
event; 1118

(d) Subject to division (D)(5) of this section, the 1119
nursing facility underwent a renovation during the period 1120
beginning January 1, 2018, and ending January 1, 2020, to which 1121
both of the following apply: 1122

(i) The renovation involved capital expenditures of at 1123
least fifty thousand dollars, excluding expenditures for 1124
equipment, staffing, or operational costs. 1125

(ii) The renovation directly impacted the area of the 1126
nursing facility in which the beds that are part of the nursing 1127

facility's licensed capacity are located. 1128

(3) A nursing facility's licensed occupancy percentage for 1129
a state fiscal year the purpose of division (D) (1) of this 1130
section shall be determined as follows: 1131

(a) ~~Multiply the~~ Determine the product of the following: 1132

(i) ~~The nursing facility's licensed capacity on the last~~ 1133
~~day of the measurement period applicable to the state fiscal~~ 1134
~~year by the number of days in that measurement period; as of~~ 1135
December 31, 2019, as identified on the nursing facility's cost 1136
report filed with the department pursuant to section 5165.10 of 1137
the Revised Code; 1138

(ii) Three hundred sixty-five. 1139

(b) ~~Divide the~~ Determine the quotient of the following: 1140

(i) The total number of the nursing facility's inpatient 1141
days for the measurement period applicable to the state fiscal 1142
year by the calendar year 2019, as identified on the nursing 1143
facility's cost report filed with the department pursuant to 1144
section 5165.10 of the Revised Code; 1145

(ii) The product determined under division (D) (3) (a) of 1146
this section. 1147

(c) Multiply the quotient determined under division (D) (3) 1148
(b) of this section by one hundred. 1149

(4) For a nursing facility to be exempt from division (D) 1150
(1) of this section on account of division (D) (2) (c) of this 1151
section, the nursing facility's operator must provide to the 1152
department written documentation of the number of days during 1153
calendar year 2019 that one or more of the beds that are part of 1154
the nursing facility's licensed capacity could not be used and 1155

the specific reason why they could not be used. 1156

(5) For a nursing facility to be exempt from division (D) 1157
(1) of this section on account of division (D) (2) (d) of this 1158
section, the nursing facility's operator must provide to the 1159
department written documentation that confirms the renovation 1160
and capital expenditures. 1161

(E) A nursing facility shall not receive a quality 1162
incentive payment for state fiscal year 2021 if either of the 1163
following apply: 1164

(1) The nursing facility's initial total per medicaid day 1165
payment rate for calendar year 2019 or state fiscal year 2021 is 1166
determined pursuant to section 5165.151 of the Revised Code. 1167

(2) The nursing facility undergoes a change of operator 1168
during calendar year 2019 or state fiscal year 2021. 1169

(F) The total amount to be spent on quality incentive 1170
payments for a state fiscal year 2021 shall be the 1171
followingdetermined as follows: 1172

~~(1) For the second half of state fiscal year 2020, the~~ 1173
~~amount determined as follows:—~~ 1174

~~(a) Determine the following amount for each nursing~~ 1175
~~facility, including those that do not receive a quality~~ 1176
~~incentive payment because of division (D) of this section:—~~ 1177

~~(i) The amount that is two and four tenths per cent of the~~ 1178
~~nursing facility's base rate for nursing facility services~~ 1179
~~provided on January 1, 2020;—~~ 1180

~~(ii) Multiply the amount determined under division (E) (1)~~ 1181
~~(a) (i) of this section by the number of the nursing facility's~~ 1182
~~medicaid days for the second half of calendar year 2018.—~~ 1183

~~(b) Determine the sum of the products determined under division (E) (1) (a) (ii) of this section for all nursing facilities for which the product was determined for the second half of state fiscal year 2020.~~ 1184
1185
1186
1187

~~(2) For all of state fiscal year 2021 and each state fiscal year thereafter, the amount determined as follows:~~ 1188
1189

~~(a) (1) Determine the following amount for each nursing facility, including those that do not receive a quality incentive payment because of division (D) of this section:~~ 1190
1191
1192

~~(i) (a) The amount that is two five and four tenths ~~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;~~ 1193
1194
1195
1196

~~(ii) (b) Multiply the amount determined under division ~~(E) (2) (a) (i) (F) (1) (a)~~ of this section by the number of the nursing facility's medicaid days for ~~the measurement period applicable to the state fiscal year~~ calendar year 2019.~~ 1197
1198
1199
1200

~~(b) (2) Determine the sum of the products determined under division ~~(E) (2) (a) (F) (1) (b)~~ of this section for all nursing facilities for which the product was determined for the state fiscal year.~~ 1201
1202
1203
1204

Sec. 5166.01. As used in this chapter: 1205

"209(b) option" means the option described in section 1206
1902(f) of the "Social Security Act," 42 U.S.C. 1396a(f), under 1207
which the medicaid program's eligibility requirements for aged, 1208
blind, and disabled individuals are more restrictive than the 1209
eligibility requirements for the supplemental security income 1210
program. 1211

"Administrative agency" means, with respect to a home and community-based services medicaid waiver component, the department of medicaid or, if a state agency or political subdivision contracts with the department under section 5162.35 of the Revised Code to administer the component, that state agency or political subdivision.	1212 1213 1214 1215 1216 1217
"Care management system" has the same meaning as in section 5167.01 of the Revised Code.	1218 1219
"Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.	1220 1221
"Enrollee" has the same meaning as in section 5167.01 of the Revised Code.	1222 1223
"Expansion eligibility group" has the same meaning as in section 5163.01 of the Revised Code.	1224 1225
"Federal poverty line" has the same meaning as in section 5162.01 of the Revised Code.	1226 1227
"Home and community-based services medicaid waiver component" means a medicaid waiver component under which home and community-based services are provided as an alternative to hospital services, nursing facility services, or ICF/IID services.	1228 1229 1230 1231 1232
"Hospital" has the same meaning as in section 3727.01 of the Revised Code.	1233 1234
"Hospital long-term care unit" has the same meaning as in section 5168.40 of the Revised Code.	1235 1236
"ICDS participant" has the same meaning as in section 5164.01 of the Revised Code.	1237 1238

"ICF/IID" and "ICF/IID services" have the same meanings as in section 5124.01 of the Revised Code.	1239 1240
"Integrated care delivery system" and "ICDS" have the same meanings as in section 5164.01 of the Revised Code.	1241 1242
"Level of care determination" means a determination of whether an individual needs the level of care provided by a hospital, nursing facility, or ICF/IID and whether the individual, if determined to need that level of care, would receive hospital services, nursing facility services, or ICF/IID services if not for a home and community-based services medicaid waiver component.	1243 1244 1245 1246 1247 1248 1249
"Medicaid buy-in for workers with disabilities program" has the same meaning as in section 5163.01 of the Revised Code.	1250 1251
"Medicaid MCO plan" has the same meaning as in section 5167.01 of the Revised Code.	1252 1253
"Medicaid provider" has the same meaning as in section 5164.01 of the Revised Code.	1254 1255
"Medicaid services" has the same meaning as in section 5164.01 of the Revised Code.	1256 1257
"Medicaid waiver component" means a component of the medicaid program authorized by a waiver granted by the United States department of health and human services under the "Social Security Act," section 1115 or 1915, 42 U.S.C. 1315 or 1396n. "Medicaid waiver component" does not include the care management system.	1258 1259 1260 1261 1262 1263
"Medically fragile child" means an individual who is under eighteen years of age, has intensive health care needs, and is considered blind or disabled under section 1614(a)(2) or (3) of	1264 1265 1266

the "Social Security Act," 42 U.S.C. 1382c(a) (2) or (3).	1267
"Medicare skilled nursing facility market basket index"	1268
has the same meaning as in section 5165.01 of the Revised Code.	1269
"Nursing facility" and "nursing facility services" have	1270
the same meanings as in section 5165.01 of the Revised Code.	1271
"Ohio home care waiver program" means the home and	1272
community-based services medicaid waiver component that is known	1273
as Ohio home care and was created pursuant to section 5166.11 of	1274
the Revised Code.	1275
"Provider agreement" has the same meaning as in section	1276
5164.01 of the Revised Code.	1277
"Residential treatment facility" means a residential	1278
facility licensed by the department of mental health and	1279
addiction services under section 5119.34 of the Revised Code, or	1280
an institution certified by the department of job and family	1281
services under section 5103.03 of the Revised Code, that serves	1282
children and either has more than sixteen beds or is part of a	1283
campus of multiple facilities or institutions that, combined,	1284
have a total of more than sixteen beds.	1285
"Skilled nursing facility" has the same meaning as in	1286
section 5165.01 of the Revised Code.	1287
"Unified long-term services and support medicaid waiver	1288
component" means the medicaid waiver component authorized by	1289
section 5166.14 of the Revised Code.	1290
Section 2. That existing sections 5165.01, 5165.15,	1291
5165.16, 5165.17, 5165.19, 5165.26, and 5166.01 of the Revised	1292
Code are hereby repealed.	1293
Section 3. That section 5165.361 of the Revised Code is	1294

hereby repealed. 1295

Section 4. That Section 333.270 of H.B. 166 of the 133rd 1296
General Assembly is hereby repealed. 1297

Section 5. All of the following apply to the Medicaid 1298
payment rates for nursing facility services provided on and 1299
after the effective date of this section and not to the Medicaid 1300
payment rates for those services provided before that date: 1301

(A) The amendments by this act to sections 5165.01, 1302
5165.16, 5165.17, 5165.19, and 5165.26 of the Revised Code; 1303

(B) The repeal by this act of section 5165.361 of the 1304
Revised Code; 1305

(C) The repeal by this act of Section 333.270 of Am. Sub. 1306
H.B. 166 of the 133rd General Assembly. 1307

Section 6. That Section 333.10 of H.B. 166 of the 133rd 1308
General Assembly be amended to read as follows: 1309

Sec. 333.10. 1310

1311

1 2 3 4 5

A MCD DEPARTMENT OF MEDICAID

B General Revenue Fund

C	GRF	651425	Medicaid	\$	164,132,342	\$	170,223,643
			Program				
			Support -				
			State				

D	GRF	651426	Positive Education Program Connections	\$	2,500,000	\$	2,500,000
E	GRF	651525	Medicaid Health Care Services				
F			State	\$	4,153,141,174	\$	4,733,728,704 <u>4,734,928,704</u>
G			Federal	\$	9,959,196,340	\$	11,152,542,781 <u>11,154,542,781</u>
H			Medicaid Health Care Services Total	\$	14,112,337,514	\$	15,886,271,485 <u>15,889,471,485</u>
I	GRF	651526	Medicare Part D	\$	490,402,102	\$	533,290,526
J	GRF	651529	Brigid's Path Pilot	\$	500,000	\$	500,000
K	GRF	651533	Food Farmacy Pilot Project	\$	250,000	\$	250,000
L	TOTAL GRF General Revenue Fund						
M			State	\$	4,810,925,618	\$	5,440,492,873 <u>5,441,692,873</u>
N			Federal	\$	9,959,196,340	\$	11,152,542,781

						<u>11,154,542,781</u>
O		GRF Total	\$	14,770,121,958	\$	16,593,035,654
						<u>16,596,235,654</u>
P	Dedicated Purpose Fund Group					
Q	4E30	651605	Resident Protection Fund	\$	3,910,338	\$ 4,013,000
R	5AN0	651686	Care Innovation and Community Improvement Program	\$	53,435,797	\$ 53,406,291
S	5DL0	651639	Medicaid Services - Recoveries	\$	741,454,299	\$ 781,970,233
T	5DL0	651685	Medicaid Recoveries - Program Support	\$	40,351,245	\$ 44,375,000
U	5DL0	651690	Multi-system Youth Custody Relinquishment	\$	6,000,000	\$ 12,000,000
V	5FX0	651638	Medicaid Services - Payment	\$	12,000,000	\$ 12,000,000

			Withholding				
W	5GF0	651656	Medicaid Services - Hospital Upper Payment Limit	\$	822,016,219	\$	887,150,856
X	5R20	651608	Medicaid Services - Long Term	\$	420,154,000	\$	425,554,000
Y	5SC0	651683	Medicaid Services - Physician UPL	\$	7,520,000	\$	7,645,000
Z	5TN0	651684	Medicaid Services - HIC Fee	\$	834,564,060	\$	806,187,400
AA	6510	651649	Medicaid Services - Hospital Care Assurance Program	\$	249,167,065	\$	168,310,123
AB	TOTAL DPF	Dedicated Purpose	Fund Group	\$	3,205,573,023	\$	3,232,611,903
					<u>3,190,573,023</u>		<u>3,202,611,903</u>
AC	Holding Account		Fund Group				
AD	R055	651644	Refunds and Reconciliation	\$	1,000,000	\$	1,000,000

AE	TOTAL HLD Holding Account	\$	1,000,000	\$	1,000,000
	Fund Group				
AF	Federal Fund Group				
AG	3ER0 651603 Medicaid and Health Transformation Technology	\$	48,031,056	\$	48,340,000
AH	3F00 651623 Medicaid Services - Federal	\$	6,563,381,020	\$	6,596,507,934
AI	3F00 651624 Medicaid Program Support - Federal	\$	516,667,497	\$	527,369,363
AJ	3FA0 \$ Health Care Grants - Federal	\$	11,988,670	\$	12,000,000
AK	3G50 651655 Medicaid Interagency Pass Through	\$	225,701,597	\$	225,701,597
AL	TOTAL FED Federal Fund Group	\$	7,365,769,840	\$	7,409,918,894
AM	TOTAL ALL BUDGET FUND GROUPS	\$	25,342,464,821	\$	27,236,566,451
			<u>25,327,464,821</u>		<u>27,209,766,451</u>

Section 7. That existing Section 333.10 of H.B. 166 of the 133rd General Assembly is hereby repealed." 1312
 In line 5, delete "1" and insert "8" 1314
 In line 130, delete "2" and insert "9" 1315
 In line 154, delete "3" and insert "10" 1316

The motion was _____ agreed to.

SYNOPSIS 1317

Medicaid rates for nursing facility services 1318

R.C. 5165.01, 5165.15, 5165.16, 5165.17, 5165.19; R.C. 5165.361 (repealed); Section 333.270 of H.B. 166 of the 133rd General Assembly (repealed) 1319
 1320
 1321

Repeals provisions of current law that do the following: 1322

(1) Provide for adjustments in nursing facility Medicaid rates in an amount that equals the difference between the Medicare skilled nursing facility market basket index and a budget reduction adjustment factor. 1323
 1324
 1325
 1326

(2) State the General Assembly's intent to enact laws that specify the budget reduction adjustment factor for each state fiscal year. 1327
 1328
 1329

(3) Set the budget reduction adjustment factor at zero for a state fiscal year if the General Assembly fails to enact a law specifying the budget reduction adjustment factor for that year. 1330
 1331
 1332

(4) Provide for the budget reduction adjustment factor to 1333

be, for the second half of FY 2020, 2.4%.	1334
(5) Provide for the budget reduction adjustment factor to	1335
be, for FY 2021, equal to the Medicare skilled nursing facility	1336
market basket index for federal FY 2020.	1337
Nursing facilities' quality incentive payments	1338
R.C. 5165.26	1339
Specifies that FY 2021 is the last year that nursing	1340
facilities will receive a quality incentive payment.	1341
Removes references to calculating the quality insurance	1342
payment for the second half of fiscal year 2020.	1343
Specifies that a nursing facility's quality incentive	1344
payment for state fiscal year 2021 is based in part on the	1345
number of points that the U.S. Centers for Medicare and Medicaid	1346
Services (CMS) assigns to the nursing facility under CMS's five-	1347
star quality rating system for the quality metrics based on the	1348
most recent four-quarter average data available in Nursing Home	1349
Compare in May of 2020.	1350
Revises the method by which a nursing facility's licensed	1351
occupancy percentage is determined for the purpose of	1352
determining whether a nursing facility is eligible for a quality	1353
incentive payment.	1354
Clarifies that, for FY 2021, a nursing facility is not	1355
disqualified from earning a quality incentive payment because	1356
its licensed occupancy percentage is below 80% if the nursing	1357
facility was initially certified for participation in the	1358
Medicaid program on or after January 1, 2019.	1359
Provides generally that a nursing facility is not	1360
disqualified based on occupancy percentage if either of the	1361

following apply:	1362
(1) One or more of the beds that are part of a nursing facility's capacity could not be used for resident care during calendar year 2019 due to causes beyond the reasonable control of the nursing facility's operator.	1363 1364 1365 1366
(2) The nursing facility underwent a renovation between January 1, 2018, and January 1, 2020, to which both of the following apply:	1367 1368 1369
-- The renovation involved capital expenditures of at least \$50,000, excluding expenditures for equipment, staffing, or operational costs.	1370 1371 1372
-- The renovation directly impacted the area where the facility's licensed beds are located.	1373 1374
Prohibits a nursing facility from receiving a quality incentive payment for state fiscal year 2021 if the facility obtains its initial Medicaid provider agreement or undergoes a change of operator during calendar year 2019 or state fiscal year 2021.	1375 1376 1377 1378 1379
For FY 2021, increases the amount to be spent on quality incentive payments by adjusting to 5.2% of nursing facilities' base rate for nursing facility services provided on the first day of the state fiscal year (from 2.4%) one of the factors used to determine the total amount to be spent on quality incentive payments for the state fiscal year.	1380 1381 1382 1383 1384 1385
Department of Medicaid	1386
Sections 6 and 7 (amends Section 333.10 of H.B. 166 of the 133rd General Assembly)	1387 1388
Increases GRF appropriation item 651525, Medicaid Health	1389

Care Services, by \$3.2 million (\$1.2 million state share) in FY	1390
2021. Makes a technical correction in the Dedicated Purpose Fund	1391
group total in both years.	1392