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Before the House Finance Committee
Testimony on House Bill 96 As Introduced

March ~~12~~, 2025

Good morning, Chair Stewart, Vice-Chair Dovilla, Ranking Member Sweeney, and members of the committee. I am Pete Van Runkle, representing the Ohio Health Care Association. We are the largest statewide membership organization for long-term services and supports providers, with more than 1,200 members.

Almost all of our members are Medicaid providers and are significantly affected by legislative and administrative decisions about the program at both the state and federal levels. Medicaid payment rates, in particular, are vitally important for our members to grow business in Ohio, employ Ohio workers, and deliver high-quality services and supports for the steadily-increasing number of Ohio seniors and people with disabilities.

I'm here today to discuss the budget for only one of our member constituencies, skilled nursing facilities (SNFs). Specifically, I will address three policy issues relating to payment rates and also the prohibition in the executive budget on leasing a SNF from a real estate investment trust (REIT).

Medicaid reimbursement for SNFs is a perennial topic in every budget bill. HB 96 is no exception. I would like to start, though, by expressing our sincere gratitude for the outstanding work of the House and Senate in last session's budget, HB 33, to raise Medicaid rates and help offset the extreme cost increases SNFs saw during the early years of this decade, particularly in the cost of labor.

Experience with HB 33, however, shines a light on several areas where reimbursement policy changes are needed. We are proposing an amendment (HC0386, attached) that addresses three of those areas.

First is Ohio's case-mix system, which adjusts each SNF's direct care rate to account for the acuity of its residents – their cognitive and health conditions and their service needs relative to other residents. The system or "grouper" historically used in Ohio and many other states is called Resource Utilization Groups or RUGs. It takes data elements from a nationally-standardized resident assessment required by CMS, the Minimum Data Set (MDS), to determine acuity scores for each resident. Ohio uses the RUG-IV-57 model of RUGs.

More recently, CMS began to phase out RUGs and the version of MDS that supports RUGs and replace it with a new case-mix system, Patient-Driven Payment Model (PDPM). CMS started using PDPM for Medicare rates beginning in October 2019, based on a new MDS assessment, and instructed states that were using RUGs for Medicaid to move to PDPM.

CMS delayed the phase-out of RUGs and the related MDS version during the pandemic, but afterward set a hard date of September 30, 2025, for states to transition. After that date, both RUGs and the MDS version currently used to populate RUGs, the Optional State Assessment (OSA), will no longer be available.

In HB 33, with the end date still two years away, the General Assembly put in place an interim case-mix system that gave providers the choice to freeze their case-mix scores (commonly called "case-mix index" or "CMI") where they were on March 31, 2023, or continue completing OSAs and having a new RUGs CMI calculated every 6 months per previous practice. Over 60% of SNFs chose to freeze their scores, but more than 200 buildings still are doing OSAs to capture changes in resident acuity.

The interim solution ends on June 30, 2025. Ohio must decide what system to use beginning July 1. In the as-introduced version of HB 96, the DeWine Administration offers an idea. We support some aspects of the proposal but request several adjustments.

The administration proposes to use only one of the 5 case-mix-adjusted components of PDPM, the nursing component, and leave out the other 4. They would begin to phase in the nursing component throughout calendar year 2026, after a 6-month CMI freeze that ends December 31, 2025. Starting January 1, 2027, the nursing component would make up 100% of each facility's CMI.

Two things are important to know about the transition to PDPM. One is that PDPM was designed for short-stay Medicare residents who are in a SNF for post-acute rehabilitation and typically have a very different medical and cognitive profile than longer-stay Medicaid residents. The other is that because it is a different methodology, switching to PDPM from RUGs results in "winners and losers," just like any other change in a payment formula. In other words, when PDPM is implemented, approximately half of the state's SNFs will see rate increases and the other half will see rate cuts, even though everyone is still serving the same residents and delivering the same care as before.

Based on our modeling of the impact of moving to PDPM, many of the increases and cuts would be quite large, up to $50-60 per day. We are particularly concerned about the cuts. Sudden rate reductions of that magnitude would jeopardize the ability of affected SNFs to continue operating and could lead to closures and unfortunately moving residents to other facilities. In some areas of the state, those facilities could be far away. On the other hand, some providers could be perceived to be receiving a windfall if their rates go up by a large amount just because of a change in methodology.

The problem of winners and losers is why the administration is proposing a phase-in. We agree that a phase-in is needed, but the administration's approach doesn't solve the problem. We also disagree with their proposal to use only one PDPM component to measure the acuity of Medicaid residents.

Instead of using only the nursing component and ignoring the other pieces of PDPM, HC0386 would blend three PDPM components to create an acuity measure that better reflects the Medicaid population in SNFs. Under this approach, 70% of overall CMI would be from the nursing component, with the remainder coming from the speech-language pathology component (20%) and the non-therapy ancillaries component (10%).

These additions would recognize common conditions among Medicaid residents that are not captured by the nursing component alone. Examples of conditions that are more frequent in Medicaid residents compared to Medicare residents are cognitive impairment (dementia) and diabetes, among others. While we agree that the bulk of CMI should come from the nursing component, we were advised by a group of national and Ohio PDPM experts that it is important to add in a bit of the other two components to make PDPM better-suited for Medicaid residents.

In addition, using the nursing component alone maximizes the winners and losers in terms of impact on their payment rates. Nursing-only generates bigger cuts and bigger increases than the blended model we are proposing.

The phase-in is intended to mitigate wins and losses for a period of time while providers adjust to the new system, which requires different assessments and emphasizes different data elements within the assessment. Individual nurses coding MDSs in the 924 Medicaid-certified SNFs across the state will need to be trained on the new process and have time to assimilate and implement the training.

We agree with the administration's proposed timeline of a 6-month CMI freeze and gradual implementation of PDPM over the following 12 months. HC0386 would make a technical correction to the language in HB 96 on the 6-month freeze, which cannot be implemented as currently written.

For the 12-month phase-in, HC0386 includes two changes. One would require ODM to adjust the prices used for setting direct care rates to account for the different scales used in RUGs and PDPM. A facility's direct care rate is the product of the per case-mix unit price for its peer group (there are 3 peer groups in Ohio) multiplied by its CMI. RUGs CMIs average around 3.0 while PDPM CMIs average around 1.4. If the same price is multiplied by a much lower nominal CMI, it would result in a gigantic rate cut. Our amendment would adjust the three prices by the percentage difference between the average CMI under RUGs and PDPM, which means multiplying each peer group's price by about 2.13. This approach would even things out globally, although not for each facility.

To address the impact on individual SNFs, HC0386 would use a different phase-in methodology than the administration proposed, while leaving the timetable intact. In HB 96 as introduced, the phase-in would be a blend of each SNF's previous direct care rate under RUGs and its rate under PDPM. For the first 6 months of 2026, the blend would be 2/3 RUGs and 1/3 PDPM. For the second 6 months of the year, it would be 1/3 RUGs and 2/3 PDPM. After that, it would be all PDPM.

We agree with moving to all PDPM as of January 1, 2027, but do not agree with the blending approach for the phase-in because it would result in rate cuts starting January 1, 2026. For instance, if full PDPM would cut a facility's rate by $60 per day, the administration's phase-in would impose a $20 cut on January 1 and a $40 cut on July 1. CMI is calculated from MDS assessments that were done in the past. The PDPM CMI for January 1, 2026, would be based in part on assessments done before HB 96 passes and before providers knew what the new system would look like.

HC0386 would prevent any rate cuts during the phase-in period. The first cuts would occur January 1, 2027, based on assessments done starting April 1, 2026. That means the nurses who prepare MDSs would have 9 months to learn and adjust to the new case-mix system. It is not much time, but we believe it would be sufficient. We are strongly opposed to penalizing providers and their residents during this learning period just because the system changed.

The amendment also would limit rate increases for "winners" to $5 per day. Once the phase-in period is over, SNFs would feel the full impact of moving to PDPM, positive or negative, but hopefully providers who would be negatively impacted will adjust sufficiently either to eliminate or significantly mitigate the cuts. This phase-in policy would have some incidental cost, which we estimate to be $16 million all funds ($5.6 million state share) in each of fiscal years 2026 and 2027, because it allows a small amount of "gain" during the phase-in.

The last change HC0386 would make to the administration's PDPM plan would eliminate the antiquated $115 total rate for residents on the two lowest rungs of the acuity scale. This rate is now far below the base rate for assisted living, let alone the average SNF daily rate of around $270. These residents currently are excluded from the CMI calculation because they are paid at the low rate. Under our amendment, they would be included in CMI, which would have the effect of lowering rates slightly for SNFs serving low-acuity residents.

The second policy issue addressed in HC0386 is availability of private rooms in SNFs. The private room incentive payment was an important innovation in HB 33. No one disputes that having a private room is better for residents' quality of life, privacy, and dignity. It is also better for quality of care by reducing exposure to respiratory infections and other communicable diseases and offering a less distracting environment for providing care.

The private room program proved to be very popular once it finally kicked off last December. As of late January, the Department of Medicaid (ODM) had approved nearly 28,000 private rooms for incentive payments, which amounts to more than a third of the 80,911 beds in certified SNFs

in Ohio. Thousands of beds were taken out of the system to convert semiprivate rooms into private rooms. Residents all across the state are benefiting from this program, which to our knowledge is unique in the country.

But there is an impediment to further expansion of private rooms to serve even more SNF residents. HB 33 capped the number of private rooms that can be approved by limiting the total dollar amount of the incentive payments in a fiscal year. ODM is only allowed to approve the number of private rooms that would fit under the cap, assuming 50% utilization of approved private rooms by Medicaid residents.

Director Corcoran testified in Medicaid Committee that there is still space under the cap for more private rooms. She also noted, though, that the space depends on the percentage of actual Medicaid utilization – whether it is above or below the assumed 50%. There is a risk that during fiscal year 2026, ODM's ability to approve more private rooms could evaporate because actual utilization turns out to be greater than 50%. Moreover, ODM issued a memo late last year stating that they will cut off incentive payments to all *approved* private rooms if the cap is breached sometime in FY 2026.

To remove these risks and support Ohio's policy of expanding private room availability, our amendment would eliminate the cap and also fix a glitch in the statutory wording that prevents some providers from adding private rooms. We feel this issue needs to be addressed in HB 96 so we don't find ourselves in place where private room approvals and payments are cut off, but the opportunity to address the issue has already passed.

There may or may not be a cost to this change because actual Medicaid utilization and the number of private rooms that would be added over the next two years are both unknown. If utilization is 50% or less, more private rooms can be added below the cost cap. If it is greater than 50%, there would be some additional cost, although we believe it would be minimal. Only a comparative trickle of private rooms have been added in the 5 months since the original mass approvals. The vast majority of the approvable private rooms already have been approved. A reasonable guess of the maximum cost exposure over the biennium might be $22.5 million all funds ($7.9 million in state share). But that number is totally speculative, and there may be no cost impact at all.

The third policy issue that HC0386 would address is the portion of the SNF payment rate that in theory reimburses providers for the capital costs of their buildings (that is, construction, renovation, and capital equipment). The current rates for capital don't serve that function because they are frozen at 2014 cost levels. HB 33 continued the freeze, but the problems with capital rates were supposed to be addressed shortly after the bill passed.

In late 2022, the General Assembly passed HB 45, which included a requirement for ODM to present a proposal for a new capital methodology based on fair rental value to the legislature by October 1, 2023. Unfortunately, though, ODM did not comply with the legislative directive, leaving the capital rate unaddressed for another budget cycle.

In the executive version of HB 96, the administration again fails to take the broken capital rate methodology. In addition to being based on 2014 costs, the current formula pays every provider in each peer group the same amount regardless of whether their building is spacious or cramped, old or new, well-maintained and upgraded or allowed to deteriorate, or meets any other objective factors measuring the quality of the environment where residents live. The system is simply inequitable. Just as direct care rates are adjusted for acuity, capital rates should be adjusted for the value of the building.

HB0386 would scrap the current capital rate methodology after leaving the freeze in place for another two years while a new system is ramped up. Starting July 1, 2027, the old capital rates would be replaced by a new environmental quality incentive payment. Following the legislative intent from HB 45, the incentive payment would be based on a fair rental value methodology. In simple terms, this methodology, which has been the state of the art for capital reimbursement across the country for 30 years, takes the value assigned to each facility based on a standardized appraisal and converts it to a per diem "rental" payment.

The amendment also includes language authorizing ODM to adopt rules specifying additional environmental quality factors that are not captured by an appraisal but would have a significant positive impact on residents' quality of life. A stakeholder workgroup would advise ODM on those factors and the dollar value that should be attached to them.

During the FY 2026-2027 biennium, the department would put in place the structure for the new methodology, including the rules, and secure CMS approval of the necessary state plan amendment. Providers across the state would obtain (and pay for) appraisals and submit them to ODM in time to calculate rates under the new system for July 1, 2027. No change to the Medicaid appropriation in HB 96 would be needed because the old, frozen capital rates would continue to apply during the biennium.

This timing also would allow the legislature, in the next budget, to review progress on implementing the environmental quality incentive payment and whether any revisions are needed.

Another serious concern we have about HB 96 is the DeWine Administration's proposal to prohibit a SNF operator from leasing the real estate from a REIT. The language is specific to REITs, not any other type of business entity that owns the building where a SNF operates. It applies to any new lease of a SNF from a REIT after the bill's effective date. We are proposing another amendment (HC0632, also attached) to remove this language.

We strongly oppose the REIT prohibition. In a state that supposedly is "open for business," the administration's proposal would slam the door in the face of one specific type of business that is commonplace in Ohio and elsewhere around the country. So far in the budget process, the administration has offered no rational basis for singling out REITs in this manner.

A REIT is a specific type of business entity, defined in the Internal Revenue Code, that invests in real estate. REITS own all types of buildings, although typically a given REIT concentrates on property used in one or more specific business sectors such as offices, warehouses, data centers, retail, or residential. Health care is one of those sectors. Some REITs are publicly traded while others are privately held. Around 1,100 REITs exist in the United States, of which 225 are publicly traded. Institutional and individual investors frequently hold positions in REITs as an alternative to equities and fixed income.

For the thousands of businesses, including SNF operators, that lease buildings or space from REITs, the REIT is a financing mechanism. It is no different than other methods of commercial financing such as banks, private equity firms, or other businesses or individuals who own or have a financial interest in real estate and receive periodic payments from the business that uses the building. The administration's proposed prohibition on leasing from REITs would cut off a financing option used by many SNF operators at a time when commercial banks are tightening down because of uncertainty about Medicaid rates.

Reportedly, the REIT prohibition in HB 96 is modeled on one piece of a larger health care bill the Massachusetts legislature passed in December, following the collapse of the Steward *hospital system*. Steward was based in Massachusetts and happened to lease its hospital buildings from a REIT. One of them was in Ohio. Steward did not operate SNFs.

The only clue as to why the administration is seeking to expand this radical prohibition to SNFs came during ODH Director Vanderhoff's testimony in the Health Committee last month. He mentioned a few SNFs that the department closed in the relatively recent past. He said there was a "high probability" that the same problems would occur anytime a SNF operator leases from an "out-of-state owner," e.g., a REIT. (As a side note, one of the main health care REITs is based in Toledo, so not out of state.) Dr. Vanderhoff offered no evidence to support a wholesale ban on leasing from REITs while continuing to allow leasing from any other type of business entity and loan financing through banks or other lenders.

The proposed ban would create multiple market dislocations. The language in HB 96 prohibits ODH from licensing a SNF operator if they enter into a new lease with a REIT. While existing leases would be grandfathered, a REIT could not replace a poorly-performing operator with a better one. They – and the facility's residents - would be stuck with the bad operator. An operator who wants to build a new SNF or acquire an existing SNF would be denied an important source of financing that is available and widely used today. A SNF owner who wishes to sell a building would be denied access to a pool of potential purchasers, as would an owner/operator who wants to get out of the ownership business but continue to operate the buildings.

All of these dislocations would happen because the administration apparently thinks leasing from a REIT – any and all leases from any and all REITs – somehow automatically results in extremely poor quality, so poor that it results in the SNFs being closed down.

This theory is false.

After HB 96 was introduced and we discovered the REIT language, we began to research REIT ownership of SNFs in Ohio. There is no publicly-available list, but through intensive searching, we identified 103 REIT-owned SNFs. We believe this group encompasses most if not all Ohio facilities with REIT involvement. Using the most recent available data, we compared the performance of REIT-owned buildings against the entire Ohio SNF population on key quality metrics.

The following table shows that on all but one of these widely-used metrics, the REIT-owned facilities outperformed the statewide average.

Measure	REIT-Owned SNFs	All Ohio SNFs
5-star status	21%	18%
1-star status	11%	16%
Ohio quality points	32.3	30.9
CMS long-stay quality measures	4.62	4.45
CMS short-stay quality measures	3.25	3.02
Adjusted total nurse staffing	3.36	3.55

Clearly, leasing from a REIT is not a recipe for poor care, as the administration seems to be suggesting.

Building owners are not responsible for the quality of care, operators are. The operator provides care and services to the facility's residents on a daily basis. The building owner, whether it is a REIT or someone else, is simply a landlord. It is no different than the myriad businesses that operate in leased space. The success of the business is driven by the business owner (the operator), not the landlord. It is true that unfavorable lease terms can create difficulties for a business and even lead to closure or relocation. But that is true of only a small minority of businesses operating under leases and also applies to businesses that "can't pay the mortgage."

Governor DeWine has been very clear, over the past two years, about his interest in the quality of services provided in Ohio's SNFs. He is right to take interest. But the focus should be on how facilities are operating, not how they are financed.

The answer is already in place.

Over the last two years, the General Assembly acted in HB 33 and again in SB 144 to require much greater scrutiny of the qualifications of operators who take over Ohio facilities (so-called "CHOPs"). The legislation applies even-handedly to potential operators based in Ohio and those based in other states. The applicant for a CHOP license must provide full transparency about ownership of both the operating entity and the real estate. The new operator must be able to demonstrate operational experience and cannot have a track record of problems like facility closures, license revocations, or bankruptcies.

In addition to regulating which new or expanding operators, the recently-enacted CHOP law addresses the real estate owner. The legislature included language imposing a penalty if a new owner acquires a building and raises the rent or other financial obligations of the operator within 12 months after the acquisition. This language deals with concerns about owners potentially stripping resources from operators. In addition, if a CHOP involves a building that will be leased, a 5-year surety bond of $10,000 per bed is required for the operator to receive a license.

This legislation is operational and enforced vigorously by the Department of Health. The "bad operator" in the case we believe Dr. Vanderhoff is referring to took over before the legislature enacted the CHOP reforms. The REIT in that case was not the problem. It is a major, publicly-traded company that continues to finance numerous, high-quality SNFs in Ohio and elsewhere. In the case at issue, the REIT replaced the problem operator and advanced significant funding to fix the issues with the facilities, but ODH closed them anyway.

During proceedings in the Health Committee, committee members asked if we could work on a compromise with the administration. While we believe the legislature already has put the necessary statutory changes in place, we are certainly willing to talk with the administration about an alternative solution. We had a preliminary discussion last week.

In the meantime, though, we feel the existing provisions in HB 96 are inappropriate and harmful to SNF residents and operators and should be stripped out of the bill. Accordingly, we respectfully request your support of HC0632. If an alternative solution is developed through our discussions with the administration, it can be added to the bill in the Senate.

Thank you for your attention to these important topics for Ohio's SNFs. I would be happy to answer any questions you may have at this time. I also am available to meet in person or communicate via email (pvanrunkle@ohca.org) or phone (614-361-5169) regarding these issues.

HC0386

H. B. No. 96
As Introduced

_____ moved to amend as follows:

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

After line 88031, insert:

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

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

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

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

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

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

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

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

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

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

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

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

(i) Buildings;

(ii) Building improvements;

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

(iv) Transportation equipment.

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

(c) Amortization of financing costs;

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

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

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

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

facility resident.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(J) "Cost center" means the following:

(1) Ancillary and support costs;

(2) Capital costs;

(3) Direct care costs;

(4) Tax costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Costs for direct care staff, administrative nursing

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

(3) Costs of purchased nursing services;

(4) Costs of quality assurance;

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

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

(7) Allocated direct care home office costs;

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

(9) Costs of wheelchairs other than the following:

(a) Custom wheelchairs;

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

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

5165.02 of the Revised Code.

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

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

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

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

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

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

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

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

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

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

or has undergone a voluntary withdrawal of participation;

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

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

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

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

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

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

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

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

(d) Any action the department of health takes regarding

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Actually being used.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

direct the actions or policies of an organization.

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

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

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

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

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

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

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted parent, child, or sibling;

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

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

(6) Grandparent or grandchild;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The lesser of the following:

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

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

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

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

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

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

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

(D) ~~If~~ 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 new nursing facility. Instead, the initial total per medicaid day payment rate for nursing facility services provided by a new nursing facility shall be determined in the following manner:

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

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

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

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

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

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

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 total per medicaid day payment rate for nursing facility services provided ~~on or after that date~~ in private rooms approved by the department of medicaid under division (C) of this section shall be the sum of both of the following:

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

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

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

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

(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 criteria specified in division (C)(2) of this section;

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

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

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

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

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

(b) Participate in the resident or family satisfaction

survey performed pursuant to section 173.47 of the Revised Code.

(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.~~

~~(7)~~ An applicant may request reconsideration of a denial under division (C) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In line 88059, delete "nursing index"

In line 88062, after "program" insert ";

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

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

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

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

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

Strike through line 88120

In line 88121, strike through "(i)"

In line 88125, reinsert "changes to"

In line 88126, delete "nursing index used by"

In line 88127, reinsert "makes"

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

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

Strike through line 88131

After line 88152, insert:

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

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

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

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

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

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

nursing facility must have an occupancy rate lower than sixty-five per cent. For purposes of this division, the department shall utilize a nursing facility's occupancy rate for the licensed beds reported on the facility's cost report for the calendar year preceding the fiscal year for which the rate is determined, or if the facility is not required to be licensed, the facility's occupancy rate for its certified beds. If the facility surrenders licensed or certified beds before the first day of July of the calendar year in which the fiscal year begins, the department shall calculate a nursing facility's occupancy rate by dividing the inpatient days reported on the facility's cost report for the calendar year preceding the fiscal year for which the rate is determined by the product of the number of days in the calendar year and the facility's number of licensed, or if applicable, certified beds on the first day of July of the calendar year in which the fiscal year begins.

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

This division does not apply to any of the following:

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

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

(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 under division (B)(3) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Delete lines 107675 through 107693 (remove Section 333.280) and

insert:

"Section 333.280. NURSING FACILITY ENVIRONMENTAL QUALITY WORKGROUP

(A) The Department of Medicaid shall convene a nursing facility environmental quality workgroup consisting of two representatives from each of the following:

(1) The Department of Medicaid;

(2) The Department of Health;

(3) The Department of Aging;

(4) The Academy of Senior Health Sciences;

(5) LeadingAge Ohio;

(6) The Ohio Health Care Association.

(B) Not later than September 30, 2026, the workgroup shall make recommendations for rules to be adopted by the Department of Medicaid under division (D) of section 5165.27 of the Revised Code. The Department shall consider those recommendations in adopting the rules. The recommendations shall include all of the following:

(1) Additional environmental features that enhance the quality of life for nursing facility residents but are not considered in appraisals conducted under division (B)(3) of section 5165.27 of the Revised Code;

(2) A per diem amount for each such feature to be used in calculating a portion of the per medicaid day environmental quality incentive payment rate under division (C) of section 5165.27 of the Revised Code;

(3) Documentation that a nursing facility must submit to the department to verify that the facility has such a feature."

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

The motion was _____ agreed to.

SYNOPSIS

Nursing facility Medicaid funding

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

Modifies the Medicaid nursing facility funding formula as follows:

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

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

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

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

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

Direct care costs and case-mix scores

R.C. 5165.19 and 5165.192

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

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

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

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

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

Private room incentive payments

R.C. 5165.158

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

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

Environmental quality incentive payment

R.C. 5165.27 and Section 333.280

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

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

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

Department of Medicaid

Sections 333.10 and 333.280

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

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

HC0632

H. B. No. 96
As Introduced
DOHCD28, DOHCD29

_____ moved to amend as follows:

Delete lines 49410 through 50085 (remove R.C. 3721.01, 3721.026, 3721.07, and 3721.073)

Delete lines 50207 through 50687 (remove R.C. 3722.01, 3722.03, 3722.031, 3722.04, 3722.06, and 3722.13)

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

The motion was _____ agreed to.

SYNOPSIS

Hospitals and nursing homes - health care real estate investment trusts

R.C. 3721.01, 3721.026, 3721.07, 3721.073, 3722.01, 3722.03, 3722.031, and 3722.04

Removes Executive provisions that would have prohibited the following from leasing from a health care real estate investment trust the building or buildings in which a hospital

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is located or nursing home is housed: (1) an applicant seeking an initial license to operate a hospital or nursing home, (2) the holder of a license to operate a hospital or nursing home, or (3) an applicant seeking a license to operate a hospital or nursing home as its entering owner.

Change of owner - hospitals

R.C. 3722.01, 3722.04, 3722.06, and 3722.13

Removes Executive provisions that would have eliminated current law requiring a hospital's new owner to apply to the ODH Director for a license transfer and would have instead established in statute (1) a process for an entering owner to apply for a license and (2) conditions to be met before the new license was issued, including those requiring the disclosure of certain interests in the hospital, such as leases with health care real estate investment trusts.