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Before the Senate Finance Committee
Testimony on House Bill 96 As Passed by the House

May 28, 2025

Good morning, Chair Cirino, Vice-Chair Chavez, Ranking Member Hicks-Hudson, and members of the Finance 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 that 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.

Today I would like to discuss the House-passed version of HB 96 as it affects our skilled nursing facility (SNF) members relative to three specific policy issues.

Ensuring viability of Ohio's private room program (SC1025)

Our first policy concern with the bill as passed by the House relates to the Medicaid incentive payment for private rooms in SNFs, which only started in December 2024. The House budget caps the number of private rooms that the Department of Medicaid (ODM) can approve or pay for at 15,000. This cap is unworkable because it reverses the General Assembly's policy direction in the last budget, HB 33, to allow Medicaid beneficiaries in SNFs broad access to private rooms up to an annual funding limit of $160 million.

ODM implemented this policy direction in accordance with the statutory language and has approved 28,000 private rooms, far more than the House's cap would allow. These private rooms are currently operational. Residents are in them, and providers are billing for the incentive payment. According to Director Corcoran when she testified in House committee, there is still space to approve additional private rooms under the current-law funding cap.

The House cap would prevent further growth of private rooms, which both the General Assembly and Governor DeWine encouraged just two years ago. Even more challenging is that to implement the House language, ODM would have to rescind approval of nearly half of the existing private rooms. Many SNF operators gave up licensed beds and spent money renovating

their buildings to create private rooms. Canceling private rooms that already are operational would lead to mass room changes for Medicaid residents.

As the legislature and administration agreed in the last budget, HB 33, private rooms are good public policy. The 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.

It is not clear to us why the House sought to roll back private rooms only a few months after the program became operational. There may have been confusion about how the private room program works. Fifteen thousand private rooms, where the House set the cap, is approximately half of the estimated 30,662 private rooms that could be approved under the current $160 million cap. The dollar cap assumes that approved rooms are used 50% of the time by Medicaid residents and 50% of the time by residents with other pay sources.

Perhaps the House thought only 15,000 private rooms were needed to serve the assumed number of Medicaid residents under the dollar cap. That would be true only if the rooms were 100% occupied by Medicaid beneficiaries, which is not the case. Current law assumes 50% Medicaid utilization, so if only 15,000 private rooms were available, only 7,500 Medicaid residents would be in them.

The existing statute reflects reality in Ohio SNFs. Residents with a variety of pay sources currently use private rooms in SNFs. Medicare and Medicare Advantage patients who are in the facility for short-term, post-acute rehabilitation stays typically have private rooms. The same is true of private-pay residents. SNFs also serve residents with VA benefits, private insurance coverage, and hospice elections, all of whom may be in private rooms. The legislature structured and CMS approved Ohio's program with this reality in mind: that residents with various pay sources will utilize private rooms.

We suspect the House may have been motivated, at least in part, by a desire to place a firm limit on for private room incentive payments. Given this year's tight budget environment, making sure spending on private rooms doesn't exceed the $160 million appropriation is a legitimate goal, but the cap in the House budget is not the right way to meet that goal. Instead of being budget-neutral, it would be a cut. The right way to ensure spending stays within the limit is to eliminate the 15,000-room cap and restore the spending cap in current law. Amendment SC1025, attached to my testimony, would accomplish this result.

Facilitating transition to a new acuity model for SNF residents (SC1009 or SC1024)

The second policy issue that we feel needs to be addressed in HB 96 is updating Ohio's case-mix system for direct care payment rates to reflect federally-mandated changes. The executive budget proposal on this topic raises several concerns that were not resolved in the House-passed bill.

The case-mix system adjusts each SNF's direct care rate to account for the acuity of its residents, that is 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 to adjust for acuity is called Resource Utilization Groups (RUGs). It takes data elements from a resident assessment required nationally by CMS, the Minimum Data Set (MDS), to determine acuity scores for each resident.

Over the past few years, CMS phased out RUGs and the version of MDS that supports RUGs and replaced it with a new case-mix system, Patient-Driven Payment Model (PDPM). CMS started using PDPM for Medicare payment rates beginning in October 2019, based on a new MDS assessment. PDPM is a methodology designed for Medicare, not Medicaid. Medicaid residents are very different from Medicare residents (long-term care vs. short-term rehabilitation). Nonetheless, CMS instructed states using RUGs for Medicaid to move to PDPM by September 30, 2025. After that date, CMS is canceling both RUGs and the assessment instrument currently used to populate RUGs, the Optional State Assessment (OSA).

In HB 33, with the end date still two years away, the General Assembly set up an interim case-mix system that gave providers the choice to freeze their case-mix scores (commonly called "case-mix index" or "CMI") at the March 31, 2023, level or continue completing OSAs and having a new RUGs CMI calculated every 6 months. 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 case-mix system to use beginning July 1. The DeWine Administration included their ideas in HB 96. They proposed to convert to PDPM, but use only one of 5 components of the federal model. They also proposed to phase in the new methodology over 18 months by freezing all SNFs' CMIs for six months, through December 31, 2025. Then during 2026, the phase-in would be partly the SNF's previous direct care rate under RUGs and partly its rate under PDPM. For the first 6 months of 2026, the proportion 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 support some aspects of the administration's proposal but request several adjustments and corrections.

First, there are two technical problems with the language currently in HB 96. One relates to 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 direct care 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 gigantic, unintentional rate cut for all Ohio SNFs. We suggest solving this technical problem by adding language to HB 96 that would adjust the three peer group prices by the ratio of the average CMI under RUGs and the average under PDPM, which means multiplying each peer group's price by about 2.13. This approach would maintain budget neutrality in the transition.

Second, HB 96's language on the 6-month freeze is erroneous and can't be implemented as written. It calls for freezing each facility's quarterly RUGs CMI for June 30, 2025. The problem is

that the majority of SNFs will not have a June 30 quarterly score because they froze their CMIs over a year ago and have not had quarterly scores since then. The non-frozen buildings also will not have quarterly scores at the time of the July 1, 2025, rate-setting because the quarterly scores will not be finalized until after a 45-day data correction period. We suggest amending this language to use the provider's already-frozen CMI or, for the non-frozen facilities, the normal CMI for the July 2025 rate-setting, which will be the average of the scores from the fourth quarter of 2024 and the first quarter of 2025.

Beyond these technical issues, we agree with the administration's proposed timeline of a 6-month CMI freeze and gradual implementation of PDPM over the following 12 months (January-December 2026). We also agree with moving to 100% PDPM as of January 1, 2027. However, we do not agree with the administration's 1/3-2/3 methodology for the phase-in because it could result in deep direct care rate cuts starting in just 6 months. For example, if moving to full PDPM would reduce a facility's rate by $45 per day, the administration's phase-in would impose a $15 cut on January 1, 2026, and a $30 cut on July 1, 2026. These cuts would be purely because the formula has changed, not because of any difference in residents' care needs.

Just like any other change in a payment formula, switching to PDPM from RUGs results in winners and losers. 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.

We are particularly concerned about the cuts. A sudden, large direct care rate reduction would jeopardize patient care and could even threaten a SNF's ability to continue operating, leading to closures and residents having to move to other facilities. In some areas of the state, those facilities could be far away. On the other hand, the "winners" could be perceived as receiving a windfall if their rates go up by a large amount just because of a change in methodology.

If large rate cuts begin January 1, 2026, as they would under HB 96 as currently written, individual nurses coding MDSs in the 924 Medicaid-certified SNFs across the state would have no time to learn the new system and make necessary adjustments so their assessments accurately reflect residents' conditions under PDPM. Moreover, the January 1, 2026, rates will be based on assessments beginning April 1, 2025, well before finalization of the new system by passage of HB 96.

The purpose of the phase-in is 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. MDS nurses will need to be trained on the new process and have time to assimilate and implement the training.

We believe the transition to PDPM should be a glide path, not a cliff. We suggest limiting both the upside and downside risk – the winners and losers - during the transition to a very manageable $5 per day. Because the stop loss and stop gain would be the same, this approach would be budget-neutral. Larger cuts and increases would not occur until January 1, 2027, based on assessments done starting April 1, 2026. By then, the nurses who prepare MDSs will have 9 months to learn and adjust to the new case-mix system. We are strongly opposed to penalizing

providers and their residents during this learning period just because the system changed. Once the phase-in period is over, SNFs would feel the full impact of moving to PDPM, positive or negative, but they would know what's coming and have the opportunity to adjust as best they can.

In addition to the administration's phase-in approach, we also disagree with their proposal to use only one PDPM component to measure Medicaid residents' acuity. Instead of taking only the nursing component and ignoring the other pieces of PDPM, we recommend blending three PDPM components to create an acuity measure that better reflects the Medicaid population in SNFs. Moving to a blend is the latest trend in other states that are dealing with this same issue. Under our proposal, 70% of the overall CMI still 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 these conditions are cognitive impairment (dementia) and diabetes. While we agree that the bulk of CMI should come from the nursing component, adding in smaller amounts of the other two components will make PDPM better-suited for Medicaid residents.

In addition, using the nursing component alone results in a larger spread between winners and losers. Using nursing only generates bigger cuts and bigger increases than the blended model we are proposing. While winner and losers are inevitable, we feel it is important to minimize the amount of the wins and losses.

As part of moving to PDPM, we also propose eliminating 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 ($130 plus around $30 for room and board), let alone the average SNF daily rate of about $275. The low-acuity residents currently are excluded from the CMI calculation, but would be added back if the $115 rate is eliminated, keeping the change budget-neutral.

We request your consideration of two alternative amendments on the PDPM transition. The first option is SC1024, which only includes the two technical items I mentioned previously. The second option, SC 1009, includes both the technical corrections and the policy changes discussed above. Both alternatives are budget-neutral.

Reforming a broken capital reimbursement system (SC 1019)

The third policy issue, which is not addressed in the executive budget or House version, is the capital component of the SNF payment rate. This rate component is intended to reimburse SNF providers for the capital costs of their buildings (that is, construction, renovation, and capital equipment). The capital reimbursement methodology is broken because the rates are frozen at 2014 cost levels and the current formula pays every provider in a 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. Just as direct care rates are adjusted for acuity, capital rates should be adjusted for the value of the building.

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 (FRV) to the legislature by October 1, 2023. Unfortunately, ODM did not comply with this legislative mandate.

To reform the antiquated capital rate methodology and effectuate legislative intent to move to a FRV system, we suggest adding FRV to HB 96 via SC1019. It takes time to put the new system in place, so we recommend maintaining the current freeze 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 based on a FRV 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, depreciated replacement cost appraisal and converts it to a per diem "rental" payment.

We also suggest 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 develop the structure for the new methodology, including adopting rules and obtaining CMS approval of a Medicaid 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.

This proposal is budget-neutral for the FY 2026-2027 biennium because ODM would continue to pay the frozen capital rates. There would be some amount of added cost in the following biennium, but the July 1, 2027, start date would allow the administration and legislature to take another look at the new methodology in the next budget. The legislature could review the implementation and cost of the environmental quality incentive payment and determine whether any revisions are needed. We feel strongly that movement toward FRV implementation should get underway now. By July 1, 2027, the capital rates will be based on data that are 13 years old.

Thank you for your attention to these important topics for Ohio's SNFs. If you have questions about them, I would be happy to answer them. Please reach out via email (pvanrunkle@ohca.org) or phone (614-361-5169).

SC1009

Am. Sub. H. B. No. 96
As Passed by the House

_____ moved to amend as follows:

In line 351 of the title, after "5163.05," insert "5165.152,"

After line 111909, 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 per medicaid day payment rate for capital costs determined for the nursing facility under section 5165.17 of the Revised Code;

(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 following:

(a) If the nursing facility's rate for direct care costs on December 31, 2025, is greater than the rate determined for the nursing facility under section 5165.19 of the Revised Code, the greater of the following;

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

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

(b) If the nursing facility's rate for direct care costs on December 31, 2025, is less than the rate determined for the

nursing facility under section 5165.19 of the Revised Code, 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 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. "

After line 112019, insert:

"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 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 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 peer group average case-mix score in effect on December 31, 2025, divided by the peer group 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 for each nursing facility's peer group 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 112027, strike through "and is not a low case-mix resident"

In line 112042, strike through "in rules authorized"; after "by" insert "division (A)(2)(d) of"

In line 112047, delete "nursing index"

In line 112050, 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 112107, strike through "Modify the grouper methodology specified in division"

Strike through line 112108

In line 112109, strike through "(i)"

In line 112113, reinsert "changes to"

In line 112114, delete "nursing index used by"

In line 112115, reinsert "makes"

In line 112116, reinsert "after"; delete "on"

In line 112118, delete "(ii)"; strike through the balance of the line

Strike through line 112119

In line 128845, after "5163.05," insert "5165.152,"

Delete lines 134656 through 134674 (Remove Section 333.280)

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

The motion was _____ agreed to.

SYNOPSIS

Nursing facility direct care costs and case-mix scores

R.C. 5165.01 and 5165.15; R.C. 5165.152 (repealed)

Modifies the Medicaid nursing facility funding direct care costs formula as follows:

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

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 June 30, 2026; 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;

--Removes Executive provisions providing for a gradual implementation of the CMS patient-driven payment model for direct care cost case-mix scores.

SC1019

Am. Sub. H. B. No. 96
As Passed by the House

_____ moved to amend as follows:

After line 111909, insert:

"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 per medicaid day payment rate for direct care costs determined for the nursing facility under section 5165.19 of the Revised Code;

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

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

(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. "

After line 112140, 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 112341, 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) 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 appraisals 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 the nursing facility must submit to the department to verify that the facility has such a feature."

After line 141219, insert:

"Section 751.00.01. 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 (C) of section 5165.27 of the Revised Code. The Department shall consider those recommendations in adopting the rules. The recommendations shall include additional environmental features that enhance the quality of life for nursing facility residents, a per diem amount for those features to be used in calculating the per medicaid environmental quality payment rate under section 5165.27 of the Revised Code, and the method or methods necessary to verify that the facility has such

features."

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

The motion was _____ agreed to.

SYNOPSIS

Nursing facility environmental quality incentive payment

R.C. 5165.27, 5165.15, 5165.151, with a conforming change in R.C. 5165.23; Section 751.00.01

Beginning July 1, 2027, modifies the nursing facility per Medicaid day payment formula to reduce the capital costs component to zero, and adds an environmental quality incentive 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 environmental features to be considered, (2) prescribe documentation nursing facilities must submit to verify such a feature, and (3) assign a per diem amount for each.

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.

SC1024

Am. Sub. H. B. No. 96
As Passed by the House
MCDCD36

_____ moved to amend as follows:

After line 112019, insert:

"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:

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(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.

(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 peer group average case-mix score in effect on December 31, 2025, divided by the peer group 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 for each nursing facility's peer group shall be the cost per case-mix unit used to determine the 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."

Delete lines 134658 through 134660

In line 134661, delete "31" and insert "For the period beginning July 1, 2025, and ending December 31, 2025, the Department of Medicaid 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 section 5165.19 of the Revised Code for the facility's peer group by the following case-mix score:

(A) If the facility's case-mix score during fiscal year 2025 is the case-mix score specified in division (A)(2)(b) of section 5165.19 of the Revised Code, that case-mix score;

(B) If the facility's case-mix score during fiscal year 2025 is the semiannual case-mix score determined for the facility under division (A)(1) of section 5165.19 of the Revised Code, the semiannual case-mix score determined under that division for the semiannual period beginning July 1"

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

The motion was _____ agreed to.

SYNOPSIS

Nursing facility direct care costs and case-mix scores

R.C. 5165.19; Section 333.280

Modifies Executive-added provisions that provide for a gradual implementation of PDPM to calculate nursing facility direct care cost rates:

- Provides for calculating a nursing facility's rate for direct care costs for the first half of FY 2026 (July 1, 2025, until December 31, 2025).

- Provides an adjustment including blended case-mix scores to be used to calculate a nursing facility's per medicaid day payment rate for direct care costs from January 1, 2026, until ODM's next rebasing takes effect.

SC1025

Am. Sub. H. B. No. 96
As Passed by the House
MCDCD65

_____ moved to amend as follows:

In line 111959, after the comma insert "either"

In line 111960, after "capacity" insert "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"

In line 111980, reinsert "projected"

In line 111981, reinsert "expenditures for"; delete "the total number of"; reinsert "room incentive"

In line 111982, reinsert "payments"; delete "rooms created"; reinsert "for the fiscal year to"

In line 111983, reinsert "exceed" and "one hundred"

In line 111984, reinsert "sixty million dollars in fiscal year"; after "~~year~~" insert "2026"; reinsert "or subsequent fiscal"

Reinsert lines 111985 and 111986

In line 111987, reinsert "percentage of fifty per cent."

In line 111991, delete "to exceed fifteen thousand private"

In line 111992, delete "rooms across the state" and strike through

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the period

In line 111999, delete everything after "(D)"

Delete lines 111200 and 111201

In line 111202, delete "(E)"

In line 112018, delete "(F)" and insert "(E)"

The motion was _____ agreed to.

SYNOPSIS

Nursing facility private room incentive payment rate

R.C. 5165.158

Removes House-added provisions that capped the number of private rooms eligible for the nursing facility private room incentive payment at 15,000 and prohibited ODM from paying a private room incentive payment for more than 15,000 rooms.

Reverts to the current law cap permitting ODM to deny applications for private room incentive payments if the total payments are projected to exceed $160 million in a fiscal year.