As Introduced

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S. B. No. 390

Senators Cutrona, Patton
Cosponsor: Senator Lang

To amend sections 5165.06, 5165.151, 5165.158, 5165.19, 5165.26, and 5165.36 and to enact section 5165.061 of the Revised Code to make various changes to the law governing nursing facilities in the Medicaid program.

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

Section 1. That sections 5165.06, 5165.151, 5165.158, 5165.19, 5165.26, and 5165.36 be amended and section 5165.061 of the Revised Code be enacted to read as follows:

Sec. 5165.06. Subject to ~~section~~ sections 5165.061 and 5165.072 of the Revised Code, an operator is eligible to enter into and retain a provider agreement for a nursing facility if all of the following apply:

(A) The nursing facility is certified by the director of health for participation in medicaid;

(B) The nursing facility is licensed by the director of health as a nursing home if so required by law and the operator is the licensed operator of the nursing home;

(C) The operator and nursing facility comply with all applicable state and federal laws and rules.

Sec. 5165.061. (A) An operator is not eligible to enter into a provider agreement for a nursing facility under section 5165.06 of the Revised Code for a period of five years after the last effective date of a change of operator for the nursing facility if the effective date of the change of operator occurs after the effective date of this section.

(B) Notwithstanding division (A) of this section, the department of medicaid may permit an operator to enter into a provider agreement for a nursing facility if the department determines, in accordance with rules authorized under section 5165.02 of the Revised Code, that there is an emergency that is not a fiscal emergency that necessitates an operator entering into a provider agreement.

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 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;

(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) Sixteen dollars and forty-four cents shall be added to the sum of the rates and payment specified in divisions (A)(1) to (5) 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 <u>that includes each resident who is a medicaid recipient and is not a low case-mix resident</u> 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~~under division (B)(1) of this section, the rate shall be redetermined to reflect the new nursing facility's actual ~~semiannual average~~ quarterly 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~~ qualifies 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~~ submission does 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 under division (B)(1) of this section in lieu of the new nursing facility's ~~semiannual~~ quarterly case-mix score until the new nursing facility submits ~~two consecutive~~ quarterly assessment data that ~~qualify~~ qualifies 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~~ divisions (C)(2) and (3) 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, without increasing the total licensed bed capacity;

(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) Notwithstanding division (C)(2) of this section, the department shall approve an application for private rooms

submitted by a newly constructed nursing facility that was initially licensed on or after July 1, 2023, in which all licensed beds in the facility are located in category one private rooms.

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

~~(4)~~(5) The department ~~may~~ shall 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~~ Except for applications that are approved under division (C)(3) of this section, 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~~ (6) To retain eligibility for private room rates, a nursing facility must do ~~both~~ all 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;

(c) Except for a new nursing facility that has not yet received its first star rating, maintain a two-star or greater overall rating in the United States centers for medicare and medicaid services nursing facility five-star quality rating system known as compare care;

(d) Not be listed on table A or table D of the SFF list, as defined in section 5165.26 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) If a nursing facility approved for private rooms under this section becomes ineligible to receive private room incentive payments under division (C)(6) of this section, the nursing facility's approval for private rooms under this section shall be deemed withdrawn as of the date the ineligibility occurs. A nursing facility that becomes ineligible to receive private room incentive payments shall not seek payment from the department for such payments on or after the date on which the nursing facility becomes ineligible. A nursing facility that becomes ineligible to receive private room incentive payments shall notify the department in writing not later than thirty days after the date on which ineligibility occurs.

(a) A nursing facility that has its approval for private rooms withdrawn under division (C)(7) of this section may reapply for approval under this section when the nursing facility again meets the eligibility requirements described in this section.

(b) The department or its designee shall recoup any private room incentive payments made for services provided on or after the date on which a nursing facility becomes ineligible to receive private room incentive payments. The department may impose a penalty not to exceed five per cent of the amount recouped.

(8) 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.

(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) 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~~ all 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;

(c) For state fiscal year 2027, reduce the total cost per case-mix unit in effect on June 30, 2026, by a percentage that reduces the total expenditures on nursing facility per medicaid day payment rates by seventy-one million dollars for that fiscal year;

(d) For state fiscal year 2028, reduce the total cost per case-mix unit in effect on June 30, 2027, by a percentage that reduces expenditures on nursing facility per medicaid day payment rates by seventy-one million dollars for that fiscal year;

(e) For subsequent rebasings after state fiscal year 2028, reduce the cost per case-mix units by the percentage determined under division (C) of section 5165.36 of the Revised Code.

(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 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.

Sec. 5165.26. (A) As used in this section:

(1) "Base rate" means the portion of a nursing facility's total per medicaid day payment rate determined under divisions (A) and (B) of section 5165.15 of the Revised Code.

(2) "CMS" means the United States centers for medicare and medicaid services.

(3) "Long-stay resident" means an individual who has resided in a nursing facility for at least one hundred one days.

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

(5) "SFF list" means the list of nursing facilities that the United States department of health and human services creates under the special focus facility program.

(6) "Special focus facility program" means the program conducted by the United States secretary of health and human services pursuant to section 1919(f)(10) of the "Social Security Act," 42 U.S.C. 1396r(f)(10).

(B) Subject to divisions (D) and (E) and except as provided in division (F) of this section, the department of medicaid shall determine each nursing facility's per medicaid day quality incentive payment rate as follows:

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

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

(3) Determine the sum of the total number of medicaid days for all of the calendar year preceding the fiscal year for which the rate is determined for all nursing facilities for which a quality score was determined.

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

(5) Determine the value per quality point by determining

the quotient of the following:

(a) The sum determined under division (E)(2) of this section.

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

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

(C)(1) Except as provided in divisions (C)(2) and (3) of this section, a nursing facility's quality score for a state fiscal year shall be the sum of the following:

(a) The total number of points that CMS assigned to the nursing facility under CMS's nursing facility five-star quality rating system for the following quality metrics, or CMS's successor metrics as described below, based on the most recent four-quarter average data, or the average data for fewer quarters in the case of successor metrics, available in the database maintained by CMS and known as nursing home compare in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins:

(i) The percentage of the nursing facility's long-stay residents at high risk for pressure ulcers who had pressure ulcers;

(ii) The percentage of the nursing facility's long-stay residents who had a urinary tract infection;

(iii) The percentage of the nursing facility's long-stay residents whose ability to move independently worsened;

(iv) The percentage of the nursing facility's long-stay

residents who had a catheter inserted and left in their bladder.

If CMS ceases to publish any of the metrics specified in division (C)(1)(a) of this section, the department shall use the nursing facility quality metrics on the same topics that CMS subsequently publishes.

(b) Seven and five-tenths points for fiscal year 2024 and three points for fiscal year 2025 and subsequent fiscal years if the nursing facility's occupancy rate is greater than seventy-five per cent. For purposes of this division, the department shall utilize the facility's occupancy rate for licensed beds reported on its 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 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.

(c) Beginning with state fiscal year 2025, the total number of points that CMS assigned to the nursing facility under CMS's nursing facility five-star quality rating system for the following quality metrics, or successor metrics designated by CMS, based on the most recent four-quarter average data available in the database maintained by CMS and known as nursing home compare in the most recent month of the calendar year

during which the fiscal year for which the rate is determined begins:

(i) The percentage of the nursing facility's long-stay residents whose need for help with daily activities has increased;

(ii) The percentage of the nursing facility's long-stay residents experiencing one or more falls with major injury;

(iii) The percentage of the nursing facility's long-stay residents who were administered an antipsychotic medication;

(iv) Adjusted total nurse staffing hours per resident per day using quintiles instead of deciles by using the points assigned to the higher of the two deciles that constitute the quintile.

If CMS ceases to publish any of the metrics specified in division (C)(1)(c) of this section, the department shall use the nursing facility quality metrics on the same topics CMS subsequently publishes.

(2) In determining a nursing facility's quality score for a state fiscal year, the department shall make the following adjustment to the number of points that CMS assigned to the nursing facility for each of the quality metrics specified in divisions (C)(1)(a) and (c) of this section:

(a) Unless division (C)(2)(b) or (c) of this section applies, divide the number of the nursing facility's points for the quality metric by twenty.

(b) If CMS assigned the nursing facility to the lowest percentile for the quality metric, reduce the number of the nursing facility's points for the quality metric to zero.

(c) If the nursing facility's total number of points calculated for or during a state fiscal year for all of the quality metrics specified in divisions (C)(1)(a), and if applicable, division (C)(1)(c) of this section is less than ~~a number of points that is equal to the twenty-fifth percentile of all nursing facilities, calculated using the points for the July 1 rate setting of that fiscal year~~ thirty-two, reduce the nursing facility's points to zero until the next point calculation. If a facility's recalculated points under division (C)(3) of this section are below ~~the number of points determined to be the twenty-fifth percentile for that fiscal year~~thirty-two, the facility shall receive zero points for the remainder of that fiscal year.

(3) A nursing facility's quality score shall be recalculated for the second half of the state fiscal year based on the most recent four quarter average data, or the average data for fewer quarters in the case of successor metrics, available in the database maintained by CMS and known as the care compare, in the most recent month of the calendar year during which the fiscal year for which the rate is determined begins. The metrics specified by division (C)(1)(b) of this section shall not be recalculated. In redetermining the quality payment for each facility based on the recalculated points, the department shall use the same per point value determined for the quality payment at the start of the fiscal year.

(D) A nursing facility shall not receive a quality incentive payment if the Department of Health assigned the nursing facility to the SFF list under the special focus facility program and the nursing facility is listed in table A, on the first day of May of the calendar year for which the rate is being determined.

(E) The total amount to be spent on quality incentive payments under division (B) of this section for a fiscal year shall be determined as follows:

(1) Determine the following amount for each nursing facility:

(a) The amount that is five and two-tenths per cent of the nursing facility's base rate for nursing facility services provided on the first day of the state fiscal year plus one dollar and seventy-nine cents ~~plus sixty per cent of the per diem amount by which the nursing facility's cost per case-mix unit changed as a result of the rebasing conducted under section 5165.36 of the Revised Code. The nursing facility's cost per case-mix unit is determined under division (C) of section 5165.19 of the Revised Code and for purposes of this division shall not be multiplied by the facility's semiannual case-mix score determined under section 5165.192 of the Revised Code~~.

(b) Multiply the amount determined under division (E)(1)(a) of this section by the number of the nursing facility's medicaid days for the calendar year preceding the fiscal year for which the rate is determined.

(2) Determine the sum of the products determined under division (E)(1)(b) of this section for all nursing facilities for which the product was determined for the state fiscal year.

(3) To the sum determined under division (E)(2) of this section, add ~~one~~ three hundred ~~twenty-five~~ sixty-six million dollars.

(4) Unless there is a rebasing conducted under section 5165.36 of the Revised Code for state fiscal year 2028, beginning in state fiscal year 2028, add seventy-one million

dollars to the sum determined under division (E)(3) of this section.

(5) To the sum determined under division (E)(4) of this section, for the next rebasing conducted under section 5165.36 of the Revised Code and any subsequent rebasing, add the sum of the amounts determined under division (B) of section 5165.36 of the Revised Code for each rebasing.

(F)(1) Beginning July 1, 2023, a new nursing facility shall receive a quality incentive payment for the fiscal year in which the new facility obtains an initial provider agreement and the immediately following fiscal year equal to the median quality incentive payment determined for nursing facilities for the fiscal year. For the state fiscal year after the immediately following fiscal year and subsequent fiscal years, the quality incentive payment shall be determined under division (C) of this section.

(2) A nursing facility that undergoes a change of operator with an effective date of July 1, 2025, or later shall not receive a quality incentive payment until the earlier of the first day of January or the first day of July that is at least six months after the effective date of the change of operator. Thereafter any quality incentive payment shall be determined under division (C) of this section.

~~(G) The intent of the general assembly, in amending this section, is to clarify statutory language in response to the decision of the Ohio Supreme Court in the case *State ex rel. LeadingAge Ohio v. Ohio Dept. of Medicaid*, Slip Opinion No. 2025-Ohio-3066 and to require the department to continue calculating and paying the quality incentive payments in the manner they were actually paid in state fiscal years 2024 and~~

~~2025. The general assembly acknowledges that the department calculated the quality incentive pool in the way the general assembly originally intended.~~

Sec. 5165.36. (A) Beginning with state fiscal year 2024, the department of medicaid shall conduct a rebasing at least once every five state fiscal years. When the department conducts the rebasing for a state fiscal year, it shall conduct the rebasing for only the direct care and tax cost centers.

(B) For each rebasing of the direct care cost center conducted on or after the effective date of this amendment, the department shall increase the amount of the quality incentive payment under section 5165.26 of the Revised Code by sixty per cent of the total increase in estimated expenditures from the rebasing of the direct care cost center, using the cost per case-mix unit determined under division (C)(1)(b) of section 5165.19 of the Revised Code. The department shall use the most recent calendar year cost report medicaid days when estimating the total expenditures.

(C) For each rebasing of the direct care cost center conducted on or after the effective date of this amendment, the department shall determine a percentage for each peer group's cost per case-mix unit determined under section 5165.19 of the Revised Code that results in a reduction in total estimated expenditures equal to the amount determined under division (B) of this section.

Section 2. That existing sections 5165.06, 5165.151, 5165.158, 5165.19, 5165.26, and 5165.36 of the Revised Code are hereby repealed.