

As Introduced

**136th General Assembly
Regular Session
2025-2026**

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.

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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:

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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:

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

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(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;

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

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Sec. 5165.061. (A) An operator is not eligible to enter 20
into a provider agreement for a nursing facility under section 21
5165.06 of the Revised Code for a period of five years after the 22
last effective date of a change of operator for the nursing 23
facility if the effective date of the change of operator occurs 24
after the effective date of this section. 25

(B) Notwithstanding division (A) of this section, the 26
department of medicaid may permit an operator to enter into a 27
provider agreement for a nursing facility if the department 28
determines, in accordance with rules authorized under section 29
5165.02 of the Revised Code, that there is an emergency that is 30
not a fiscal emergency that necessitates an operator entering 31
into a provider agreement. 32

Sec. 5165.151. (A) The total per medicaid day payment rate 33
determined under section 5165.15 of the Revised Code shall not 34
be the initial rate for nursing facility services provided by a 35
new nursing facility. Instead, the initial total per medicaid 36
day payment rate for nursing facility services provided by a new 37
nursing facility shall be determined in the following manner: 38

(1) The initial rate for ancillary and support costs shall 39
be the rate for the new nursing facility's peer group determined 40
under division (C) of section 5165.16 of the Revised Code. 41

(2) The initial rate for capital costs shall be the rate 42
for the new nursing facility's peer group determined under 43
division (C) of section 5165.17 of the Revised Code; 44

(3) The initial rate for direct care costs shall be the 45
product of the cost per case-mix unit determined under division 46
(C) of section 5165.19 of the Revised Code for the new nursing 47
facility's peer group and the new nursing facility's case-mix 48

score determined under division (B) of this section. 49

(4) The initial rate for tax costs shall be the following: 50

(a) If the provider of the new nursing facility submits to 51
the department of medicaid the nursing facility's projected tax 52
costs for the calendar year in which the provider obtains an 53
initial provider agreement for the new nursing facility, an 54
amount determined by dividing those projected tax costs by the 55
number of inpatient days the nursing facility would have for 56
that calendar year if its occupancy rate were one hundred per 57
cent; 58

(b) If division (A) (4) (a) of this section does not apply, 59
the median rate for tax costs for the new nursing facility's 60
peer group in which the nursing facility is placed under 61
division (B) of section 5165.16 of the Revised Code. 62

(5) The initial quality incentive payment rate for the new 63
nursing facility shall be the amount determined under section 64
5165.26 of the Revised Code. 65

(6) Sixteen dollars and forty-four cents shall be added to 66
the sum of the rates and payment specified in divisions (A) (1) 67
to (5) of this section. 68

(B) For the purpose of division (A) (3) of this section, a 69
new nursing facility's case-mix score shall be the following: 70

(1) Unless the new nursing facility replaces an existing 71
nursing facility that participated in the medicaid program 72
immediately before the new nursing facility begins participating 73
in the medicaid program, the median annual average case-mix 74
score that includes each resident who is a medicaid recipient 75
and is not a low case-mix resident for the new nursing 76
facility's peer group. 77

(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. 109

Sec. 5165.158. (A) As used in this section: 110

(1) "Category one private room" means a private room that 111
has unshared access to a toilet and sink. 112

(2) "Category two private room" means a private room that 113
has shared access to a toilet and sink. 114

(B) ~~Beginning six months following approval by the United~~ 115
~~States centers for medicare and medicaid services or on the~~ 116
~~effective date of applicable department of medicaid rules,~~ 117
~~whichever is later, but not sooner than April 1, 2024, the~~ The 118
total per medicaid day payment rate for nursing facility 119
services provided ~~on or after that date~~ in private rooms 120
approved by the department of medicaid under division (C) of 121
this section shall be the sum of both of the following: 122

(1) The total per medicaid day payment rate determined for 123
the nursing facility under section 5165.15 of the Revised Code; 124

(2) The private room incentive payment. The private room 125
incentive payment shall be thirty dollars per day for a category 126
one private room and twenty dollars per day for a category two 127
private room, beginning in state fiscal year 2024. The 128
department may increase the payment amount for subsequent fiscal 129
years. 130

(C) (1) The department shall approve rooms in nursing 131
facilities to qualify for the rate described in division (B) of 132
this section. A nursing facility provider shall apply for 133
approval of its private rooms by submitting an application in 134
the form and manner prescribed by the department. ~~The department~~ 135
~~shall begin accepting applications for approval of category one~~ 136
~~private rooms on January 1, 2024, and category two private rooms~~ 137

~~on March 1, 2024.~~ The department may specify evidence that an 138
applicant must supply to demonstrate that a room meets the 139
definition of a private room under section 5165.01 of the 140
Revised Code and may conduct an on-site inspection of the room 141
to verify that it meets the definition. Subject to ~~division~~ 142
divisions (C) (2) and (3) of this section, the department shall 143
approve an application if the rooms included in the application 144
meet the definition of a private room under section 5165.01 of 145
the Revised Code. 146

(2) The department shall only consider applications that 147
meet the following criteria: 148

(a) Private rooms that are in existence on July 1, 2023, 149
in facilities where all of the licensed beds are in service on 150
the application date; 151

(b) Private rooms created by surrendering licensed beds 152
from its licensed capacity, or, if the facility does not hold a 153
license, surrendering beds that have been certified by CMS. A 154
nursing facility where the beds are owned by a county and the 155
facility is operated by a person other than the county may 156
satisfy this requirement by removing beds from service. 157

(c) Private rooms created by adding space to the nursing 158
facility or renovating nonbedroom space, without increasing the 159
total licensed bed capacity; 160

(d) A nursing facility licensed after July 1, 2023, in 161
which all licensed beds are in service on the application date 162
or in which private rooms were created by surrendering licensed 163
beds from its licensed capacity. 164

(3) Notwithstanding division (C) (2) of this section, the 165
department shall approve an application for private rooms 166

submitted by a newly constructed nursing facility that was 167
initially licensed on or after July 1, 2023, in which all 168
licensed beds in the facility are located in category one 169
private rooms. 170

(4) The department may specify evidence that an applicant 171
must supply to demonstrate that it meets the conditions 172
specified in division (C) (2) or (3) of this section and may 173
conduct an on-site inspection to verify that the conditions are 174
met. 175

~~(4)~~ (5) The department ~~may~~ shall deny an application if the 176
department determines that any of the following circumstances 177
apply: 178

(a) The rooms included in the application do not meet the 179
definition of a private room under section 5165.01 of the 180
Revised Code; 181

(b) The rooms included in the application do not meet the 182
criteria specified in division (C) (2) of this section; 183

(c) The applicant created private rooms by reducing the 184
number of available beds without surrendering the beds, and 185
surrender of the beds is required by this section; 186

(d) ~~Approval~~ Except for applications that are approved 187
under division (C) (3) of this section, approval of the room 188
would cause projected expenditures for private room incentive 189
payments under this section for the fiscal year to exceed ~~forty-~~ 190
~~million dollars in fiscal year 2024 or one hundred sixty million~~ 191
~~dollars in fiscal year 2025 or subsequent fiscal years.~~ In 192
projecting expenditures for private room incentive payments, the 193
department shall use a medicaid utilization percentage of fifty 194
per cent. If the department determines that there are more 195

approvable eligible applications submitted than can be 196
accommodated within the applicable spending limit specified in 197
this division, the department shall prioritize category one 198
private rooms. 199

(e) On the application date, the nursing facility is 200
listed on table A or table D of the SFF list, as defined in 201
section 5165.01 of the Revised Code or is designated as having a 202
one-star overall rating in the United States centers for 203
medicare and medicaid services nursing facility five-star 204
quality rating system known as care compare. 205

~~(5) Beginning July 1, 2025, to~~ (6) To retain eligibility 206
for private room rates, a nursing facility must do ~~both~~ all of 207
the following: 208

(a) Have a policy in place to prioritize placement in a 209
private room based on the medical and psychosocial needs of the 210
resident; 211

(b) Participate in the resident or family satisfaction 212
survey performed pursuant to section 173.47 of the Revised Code; 213

(c) Except for a new nursing facility that has not yet 214
received its first star rating, maintain a two-star or greater 215
overall rating in the United States centers for medicare and 216
medicaid services nursing facility five-star quality rating 217
system known as compare care; 218

(d) Not be listed on table A or table D of the SFF list, 219
as defined in section 5165.26 of the Revised Code. 220

~~(6) The department shall hold all applications for a~~ 221
~~private room incentive payment in a pending status until the~~ 222
~~United States centers for medicare and medicaid services~~ 223
~~approves private room incentive payments and the department~~ 224

~~determines a facility is qualified for the payment. An~~ 225
~~application in pending status shall be included in the payment~~ 226
~~cap described in division (C) (4) (d) of this section as if the~~ 227
~~application were approved.~~ 228

(7) If a nursing facility approved for private rooms under 229
this section becomes ineligible to receive private room 230
incentive payments under division (C) (6) of this section, the 231
nursing facility's approval for private rooms under this section 232
shall be deemed withdrawn as of the date the ineligibility 233
occurs. A nursing facility that becomes ineligible to receive 234
private room incentive payments shall not seek payment from the 235
department for such payments on or after the date on which the 236
nursing facility becomes ineligible. A nursing facility that 237
becomes ineligible to receive private room incentive payments 238
shall notify the department in writing not later than thirty 239
days after the date on which ineligibility occurs. 240

(a) A nursing facility that has its approval for private 241
rooms withdrawn under division (C) (7) of this section may 242
reapply for approval under this section when the nursing 243
facility again meets the eligibility requirements described in 244
this section. 245

(b) The department or its designee shall recoup any 246
private room incentive payments made for services provided on or 247
after the date on which a nursing facility becomes ineligible to 248
receive private room incentive payments. The department may 249
impose a penalty not to exceed five per cent of the amount 250
recouped. 251

(8) An applicant may request reconsideration of a denial 252
under division (C) of this section. 253

Sec. 5165.19. (A) (1) Semiannually, except as provided in 254
division (A) (2) of this section, the department of medicaid 255
shall determine each nursing facility's per medicaid day payment 256
rate for direct care costs by multiplying the facility's 257
semiannual case-mix score determined under section 5165.192 of 258
the Revised Code by the cost per case-mix unit determined under 259
division (C) of this section for the facility's peer group. 260

(2) Beginning January 1, 2024, during state fiscal years 261
2024 and 2025, the department shall determine each nursing 262
facility's per medicaid day payment rate for direct care costs 263
by multiplying the cost per case-mix unit determined under 264
division (C) of this section for the facility's peer group by 265
the case-mix score specified in division (A) (2) (a) or (b) of 266
this section, as selected by the nursing facility not later than 267
October 1, 2023. If the nursing facility does not make a 268
selection by October 1, 2023, the case-mix score specified in 269
division (A) (2) (a) of this section shall apply. The case-mix 270
score may be either of the following: 271

(a) The semiannual case-mix score determined for the 272
facility under division (A) (1) of this section; 273

(b) The facility's quarterly case-mix score from March 31, 274
2023, which shall apply to the facility's direct care rate from 275
January 1, 2024, to June 30, 2025. 276

(B) For the purpose of determining nursing facilities' 277
rates for direct care costs, the department shall establish 278
three peer groups. 279

(1) Each nursing facility located in any of the following 280
counties shall be placed in peer group one: Brown, Butler, 281
Clermont, Clinton, Hamilton, and Warren. 282

(2) Each nursing facility located in any of the following 283
counties shall be placed in peer group two: Allen, Ashtabula, 284
Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, 285
Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, 286
Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, 287
Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, 288
Sandusky, Seneca, Stark, Summit, Trumbull, Union, and Wood. 289

(3) Each nursing facility located in any of the following 290
counties shall be placed in peer group three: Adams, Ashland, 291
Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, 292
Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, 293
Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, 294
Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, 295
Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, 296
Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and 297
Wyandot. 298

(C) (1) Except as provided in division (C) (4) of this 299
section, the department shall determine a cost per case-mix unit 300
for each peer group established under division (B) of this 301
section. The cost per case-mix unit determined under this 302
division for a peer group shall be used for subsequent years 303
until the department conducts a rebasing. To determine a peer 304
group's cost per case-mix unit, the department shall do ~~both~~ all 305
of the following: 306

(a) Determine the cost per case-mix unit for each nursing 307
facility in the peer group for the applicable calendar year by 308
dividing each facility's desk-reviewed, actual, allowable, per 309
diem direct care costs for the applicable calendar year by the 310
facility's annual average case-mix score determined under 311
section 5165.192 of the Revised Code for the applicable calendar 312

year; 313

(b) Subject to division (C) (2) of this section, identify 314
which nursing facility in the peer group is at the seventieth 315
percentile of the cost per case-mix units determined under 316
division (C) (1) (a) of this section; 317

(c) For state fiscal year 2027, reduce the total cost per 318
case-mix unit in effect on June 30, 2026, by a percentage that 319
reduces the total expenditures on nursing facility per medicaid 320
day payment rates by seventy-one million dollars for that fiscal 321
year; 322

(d) For state fiscal year 2028, reduce the total cost per 323
case-mix unit in effect on June 30, 2027, by a percentage that 324
reduces expenditures on nursing facility per medicaid day 325
payment rates by seventy-one million dollars for that fiscal 326
year; 327

(e) For subsequent rebasings after state fiscal year 2028, 328
reduce the cost per case-mix units by the percentage determined 329
under division (C) of section 5165.36 of the Revised Code. 330

(2) In making the identification under division (C) (1) (b) 331
of this section, the department shall exclude both of the 332
following: 333

(a) Nursing facilities that participated in the medicaid 334
program under the same provider for less than twelve months in 335
the applicable calendar year; 336

(b) Nursing facilities whose cost per case-mix unit is 337
more than one standard deviation from the mean cost per case-mix 338
unit for all nursing facilities in the nursing facility's peer 339
group for the applicable calendar year. 340

(3) The department shall not redetermine a peer group's 341
cost per case-mix unit under this division based on additional 342
information that it receives after the peer group's per case-mix 343
unit is determined. The department shall redetermine a peer 344
group's cost per case-mix unit only if it made an error in 345
determining the peer group's cost per case-mix unit based on 346
information available to the department at the time of the 347
original determination. 348

(4) The department shall multiply each cost per case-mix 349
unit determined under division (C) (1) of this section by the 350
peer group average case-mix score in effect on December 31, 351
2025, divided by the peer group average case-mix score 352
determined under section 5165.192 of the Revised Code for the 353
semiannual period beginning January 1, 2026. The product 354
determined under this division for each nursing facility's peer 355
group shall be the cost per case-mix unit used to determine the 356
nursing facility's per medicaid day payment rate for direct care 357
costs under division (A) (1) of this section for the period 358
beginning January 1, 2026, and ending on the day before the 359
department's next rebasing conducted after that date takes 360
effect. 361

Sec. 5165.26. (A) As used in this section: 362

(1) "Base rate" means the portion of a nursing facility's 363
total per medicaid day payment rate determined under divisions 364
(A) and (B) of section 5165.15 of the Revised Code. 365

(2) "CMS" means the United States centers for medicare and 366
medicaid services. 367

(3) "Long-stay resident" means an individual who has 368
resided in a nursing facility for at least one hundred one days. 369

(4) "Nursing facilities for which a quality score was 370
determined" includes nursing facilities that are determined to 371
have a quality score of zero. 372

(5) "SFF list" means the list of nursing facilities that 373
the United States department of health and human services 374
creates under the special focus facility program. 375

(6) "Special focus facility program" means the program 376
conducted by the United States secretary of health and human 377
services pursuant to section 1919(f)(10) of the "Social Security 378
Act," 42 U.S.C. 1396r(f)(10). 379

(B) Subject to divisions (D) and (E) and except as 380
provided in division (F) of this section, the department of 381
medicaid shall determine each nursing facility's per medicaid 382
day quality incentive payment rate as follows: 383

(1) Determine the sum of the quality scores determined 384
under division (C) of this section for all nursing facilities. 385

(2) Determine the average quality score by dividing the 386
sum determined under division (B)(1) of this section by the 387
number of nursing facilities for which a quality score was 388
determined. 389

(3) Determine the sum of the total number of medicaid days 390
for all of the calendar year preceding the fiscal year for which 391
the rate is determined for all nursing facilities for which a 392
quality score was determined. 393

(4) Multiply the average quality score determined under 394
division (B)(2) of this section by the sum determined under 395
division (B)(3) of this section. 396

(5) Determine the value per quality point by determining 397

the quotient of the following: 398

(a) The sum determined under division (E) (2) of this 399
section. 400

(b) The product determined under division (B) (4) of this 401
section. 402

(6) Multiply the value per quality point determined under 403
division (B) (5) of this section by the nursing facility's 404
quality score determined under division (C) of this section. 405

(C) (1) Except as provided in divisions (C) (2) and (3) of 406
this section, a nursing facility's quality score for a state 407
fiscal year shall be the sum of the following: 408

(a) The total number of points that CMS assigned to the 409
nursing facility under CMS's nursing facility five-star quality 410
rating system for the following quality metrics, or CMS's 411
successor metrics as described below, based on the most recent 412
four-quarter average data, or the average data for fewer 413
quarters in the case of successor metrics, available in the 414
database maintained by CMS and known as nursing home compare in 415
the most recent month of the calendar year during which the 416
fiscal year for which the rate is determined begins: 417

(i) The percentage of the nursing facility's long-stay 418
residents at high risk for pressure ulcers who had pressure 419
ulcers; 420

(ii) The percentage of the nursing facility's long-stay 421
residents who had a urinary tract infection; 422

(iii) The percentage of the nursing facility's long-stay 423
residents whose ability to move independently worsened; 424

(iv) The percentage of the nursing facility's long-stay 425

residents who had a catheter inserted and left in their bladder. 426

If CMS ceases to publish any of the metrics specified in 427
division (C)(1)(a) of this section, the department shall use the 428
nursing facility quality metrics on the same topics that CMS 429
subsequently publishes. 430

(b) Seven and five-tenths points for fiscal year 2024 and 431
three points for fiscal year 2025 and subsequent fiscal years if 432
the nursing facility's occupancy rate is greater than seventy- 433
five per cent. For purposes of this division, the department 434
shall utilize the facility's occupancy rate for licensed beds 435
reported on its cost report for the calendar year preceding the 436
fiscal year for which the rate is determined or, if the facility 437
is not required to be licensed, the facility's occupancy rate 438
for certified beds. If the facility surrenders licensed or 439
certified beds before the first day of July of the calendar year 440
in which the fiscal year begins, the department shall calculate 441
a nursing facility's occupancy rate by dividing the inpatient 442
days reported on the facility's cost report for the calendar 443
year preceding the fiscal year for which the rate is determined 444
by the product of the number of days in the calendar year and 445
the facility's number of licensed, or if applicable, certified 446
beds on the first day of July of the calendar year in which the 447
fiscal year begins. 448

(c) Beginning with state fiscal year 2025, the total 449
number of points that CMS assigned to the nursing facility under 450
CMS's nursing facility five-star quality rating system for the 451
following quality metrics, or successor metrics designated by 452
CMS, based on the most recent four-quarter average data 453
available in the database maintained by CMS and known as nursing 454
home compare in the most recent month of the calendar year 455

during which the fiscal year for which the rate is determined 456
begins: 457

(i) The percentage of the nursing facility's long-stay 458
residents whose need for help with daily activities has 459
increased; 460

(ii) The percentage of the nursing facility's long-stay 461
residents experiencing one or more falls with major injury; 462

(iii) The percentage of the nursing facility's long-stay 463
residents who were administered an antipsychotic medication; 464

(iv) Adjusted total nurse staffing hours per resident per 465
day using quintiles instead of deciles by using the points 466
assigned to the higher of the two deciles that constitute the 467
quintile. 468

If CMS ceases to publish any of the metrics specified in 469
division (C)(1)(c) of this section, the department shall use the 470
nursing facility quality metrics on the same topics CMS 471
subsequently publishes. 472

(2) In determining a nursing facility's quality score for 473
a state fiscal year, the department shall make the following 474
adjustment to the number of points that CMS assigned to the 475
nursing facility for each of the quality metrics specified in 476
divisions (C)(1)(a) and (c) of this section: 477

(a) Unless division (C)(2)(b) or (c) of this section 478
applies, divide the number of the nursing facility's points for 479
the quality metric by twenty. 480

(b) If CMS assigned the nursing facility to the lowest 481
percentile for the quality metric, reduce the number of the 482
nursing facility's points for the quality metric to zero. 483

(c) If the nursing facility's total number of points 484
calculated for or during a state fiscal year for all of the 485
quality metrics specified in divisions (C) (1) (a), and if 486
applicable, division (C) (1) (c) of this section is less than a 487
~~number of points that is equal to the twenty-fifth percentile of~~ 488
~~all nursing facilities, calculated using the points for the July~~ 489
~~1 rate setting of that fiscal year thirty-two,~~ reduce the 490
nursing facility's points to zero until the next point 491
calculation. If a facility's recalculated points under division 492
(C) (3) of this section are below ~~the number of points determined~~ 493
~~to be the twenty-fifth percentile for that fiscal year thirty-~~ 494
~~two,~~ the facility shall receive zero points for the remainder of 495
that fiscal year. 496

(3) A nursing facility's quality score shall be 497
recalculated for the second half of the state fiscal year based 498
on the most recent four quarter average data, or the average 499
data for fewer quarters in the case of successor metrics, 500
available in the database maintained by CMS and known as the 501
care compare, in the most recent month of the calendar year 502
during which the fiscal year for which the rate is determined 503
begins. The metrics specified by division (C) (1) (b) of this 504
section shall not be recalculated. In redetermining the quality 505
payment for each facility based on the recalculated points, the 506
department shall use the same per point value determined for the 507
quality payment at the start of the fiscal year. 508

(D) A nursing facility shall not receive a quality 509
incentive payment if the Department of Health assigned the 510
nursing facility to the SFF list under the special focus 511
facility program and the nursing facility is listed in table A, 512
on the first day of May of the calendar year for which the rate 513
is being determined. 514

(E) The total amount to be spent on quality incentive 515
payments under division (B) of this section for a fiscal year 516
shall be determined as follows: 517

(1) Determine the following amount for each nursing 518
facility: 519

(a) The amount that is five and two-tenths per cent of the 520
nursing facility's base rate for nursing facility services 521
provided on the first day of the state fiscal year plus one 522
dollar and seventy-nine cents ~~plus sixty per cent of the per-~~ 523
~~diem amount by which the nursing facility's cost per case-mix-~~ 524
~~unit changed as a result of the rebasing conducted under section~~ 525
~~5165.36 of the Revised Code. The nursing facility's cost per-~~ 526
~~case-mix unit is determined under division (C) of section-~~ 527
~~5165.19 of the Revised Code and for purposes of this division-~~ 528
~~shall not be multiplied by the facility's semiannual case-mix-~~ 529
~~score determined under section 5165.192 of the Revised Code.~~ 530

(b) Multiply the amount determined under division (E) (1) 531
(a) of this section by the number of the nursing facility's 532
medicaid days for the calendar year preceding the fiscal year 533
for which the rate is determined. 534

(2) Determine the sum of the products determined under 535
division (E) (1) (b) of this section for all nursing facilities 536
for which the product was determined for the state fiscal year. 537

(3) To the sum determined under division (E) (2) of this 538
section, add one three hundred twenty-five sixty-six million 539
dollars. 540

(4) Unless there is a rebasing conducted under section 541
5165.36 of the Revised Code for state fiscal year 2028, 542
beginning in state fiscal year 2028, add seventy-one million 543

dollars to the sum determined under division (E) (3) of this section. 544
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(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. 546
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(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. 551
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(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. 560
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~~(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~~ 567
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~~2025. The general assembly acknowledges that the department~~ 574
~~calculated the quality incentive pool in the way the general~~ 575
~~assembly originally intended.~~ 576

Sec. 5165.36. (A) Beginning with state fiscal year 2024, 577
the department of medicaid shall conduct a rebasing at least 578
once every five state fiscal years. When the department conducts 579
the rebasing for a state fiscal year, it shall conduct the 580
rebasings for only the direct care and tax cost centers. 581

(B) For each rebasing of the direct care cost center 582
conducted on or after the effective date of this amendment, the 583
department shall increase the amount of the quality incentive 584
payment under section 5165.26 of the Revised Code by sixty per 585
cent of the total increase in estimated expenditures from the 586
rebasings of the direct care cost center, using the cost per 587
case-mix unit determined under division (C) (1) (b) of section 588
5165.19 of the Revised Code. The department shall use the most 589
recent calendar year cost report medicaid days when estimating 590
the total expenditures. 591

(C) For each rebasing of the direct care cost center 592
conducted on or after the effective date of this amendment, the 593
department shall determine a percentage for each peer group's 594
cost per case-mix unit determined under section 5165.19 of the 595
Revised Code that results in a reduction in total estimated 596
expenditures equal to the amount determined under division (B) 597
of this section. 598

Section 2. That existing sections 5165.06, 5165.151, 599
5165.158, 5165.19, 5165.26, and 5165.36 of the Revised Code are 600
hereby repealed. 601