Amendment No. AM_133_2582

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

_____ moved to amend as follows:

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

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

After line 4, insert:

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

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

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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 calendar year that precedes the first of the state fiscal years for which a rebasing is conducted.

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

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

~~(H)~~ (G) "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)~~ (H) "Change of operator" means an entering operator becoming 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 transfer of all the exiting operator's ownership interest in the operation of the nursing facility to the entering operator, 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 the exiting operator's termination of the exiting operator's lease;

(d) If the exiting operator is a partnership, dissolution of the partnership;

(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following

apply:

(i) The change in composition does not cause the partnership's dissolution under state law.

(ii) The partners agree that the change in composition does not constitute a change in operator.

(f) If the operator is a corporation, dissolution of the corporation, a merger of the corporation into another corporation that is the survivor of the merger, or a consolidation of one or more other corporations to form a new corporation.

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

(a) A contract for an entity to manage a nursing facility as the operator's agent, subject to the operator's approval of daily operating and management decisions;

(b) A change of ownership, lease, or termination of a lease of real property or personal property associated with a nursing facility if an entering operator does not become the operator in place of an exiting operator;

(c) If the operator is a corporation, a change of one or more members of the corporation's governing body or transfer of ownership of one or more shares of the corporation's stock, if the same corporation continues to be the operator.

~~(J)~~ (I) "Cost center" means the following:

(1) Ancillary and support costs;

(2) Capital costs;

(3) Direct care costs;

(4) Tax costs.

~~(K)~~ (J) "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)~~ (K)(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)~~ (L) "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)~~ (M) "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)~~ (M)(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)~~ (M)(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)~~ (N) "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

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

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

~~(S)~~ (R) "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)~~ (S) "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)~~ (T) "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)~~ (U)(1) Subject to divisions ~~(V)(2)~~ (U)(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)~~ (V) "Franchise permit fee" means the fee imposed by sections 5168.40 to 5168.56 of the Revised Code.

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

(1) All days during which a resident, regardless of payment source, occupies a bed in a nursing facility that is included in the nursing facility's medicaid-certified capacity;

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

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

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

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

more. "Maintenance and repair expenses" includes but is not 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) "Medicare skilled nursing facility market basket index" means the index established by the United States secretary of health and human services under section 1888(e)(5) of the "Social Security Act," 42 U.S.C. 1395yy(e)(5).~~

~~(EE)(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.

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

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

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

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

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

~~(JJ)(1)~~ (HH)(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.

~~(KK)~~ (II) "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.

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

~~(MM)~~ (KK) "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.

~~(NN)~~ (LL) "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.

~~(OO)~~ (MM) "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.

~~(PP)~~ (NN) "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.

~~(QQ)~~ (OO) "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.

~~(RR)~~ (PP) "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.

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

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

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

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

~~(WW)~~ (UU) "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.

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

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

~~(ZZ)~~ (XX) "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 5165.157 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 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) From the sum determined under division (B) of this section, subtract one dollar and seventy-nine cents.

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

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

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

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

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

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

(2) Each nursing facility located in any of the following counties shall be placed in peer group three or four: 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. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group three. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group four.

(3) Each nursing facility located in any of the following counties shall be placed in peer group five or six: 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. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group five. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group six.

(C)(1) The department shall determine the rate for ancillary and support costs for each peer group established under division (B) of this section. The rate for ancillary and support costs 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 rate for ancillary and support costs, the department shall do all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Each nursing facility located in any of the following counties shall be placed in peer group three or four: 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. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group three. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group four.

(3) Each nursing facility located in any of the following counties shall be placed in peer group five or six: 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. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group five. Each nursing facility located in any of those counties that has one hundred or more beds shall be

placed in peer group six.

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

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

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

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

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

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

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

(b) Exclude both of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(F) As used in this division:

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

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

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

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

27, 1992, is renewed under either of the following circumstances:

(a) The renewal is pursuant to a renewal option that was in existence on May 27, 1992;

(b) The renewal is for the same lease payment amount and between the same parties as the lease in existence on May 27, 1992.

(2) Subject to division (A) of this section, for a lease of a facility that was in existence but not operated under a lease on May 27, 1992, actual, allowable capital costs shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis, adjusted by one-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease.

(3) Subject to division (A) of this section, for a lease of a facility with a date of licensure on or after May 27, 1992, that is initially operated under a lease, actual, allowable capital costs shall include the annual lease expense if there was a substantial commitment of money for construction of the facility after December 22, 1992, and before July 1, 1993. If there was not a substantial commitment of money after December 22, 1992, and before July 1, 1993, actual, allowable capital costs shall include the lesser of the annual lease expense or the sum of the following:

(a) The annual depreciation expense that would be

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) The lease satisfies any other criteria specified in

the rules.

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

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

Sec. 5165.19. (A) Semiannually, 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.

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

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

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

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

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

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

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

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

the applicable calendar year;

(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 following index shall be used for the purpose of the calculation made under division (C)(1)(d) of this section:

(a) Except as provided in division (C)(3)(b) of this section, the employment cost index for total compensation, nursing and residential care facilities occupational group, published by the United States bureau of labor statistics;

(b) If the United States bureau of labor statistics ceases to publish the index specified in division (C)(3)(a) of this section, the index the bureau subsequently publishes that covers nursing facilities' staff costs.

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

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

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

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

(B) For ~~the second half of state fiscal year 2020 and all of each~~ state fiscal year ~~thereafter~~2021, and subject to divisions (D) ~~and~~, (E), and (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 following:~~

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

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

medicaid days for ~~the measurement period applicable to the state fiscal year~~ all of calendar year 2019 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 following:~~

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

~~(ii)~~ For ~~all of~~ state fiscal year 2021~~ and each state fiscal year thereafter~~, the sum determined under division ~~(E)(2)(b)~~ (F)(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 2021 shall be the sum of 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 based on the most recent four-quarter average data available in the database maintained by the U.S. centers for medicare and medicaid services and known as nursing home compare in May of 2020:

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

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

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

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

(2) In determining a nursing facility's quality score for ~~a~~ state fiscal year 2021, the department shall make the following adjustment to the number of points that CMS assigned to the nursing facility for each of the quality metrics specified in division (C)(1) of this section:

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

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

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

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

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

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

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

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

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

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

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

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

facility's licensed capacity are located.

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

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

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

(ii) Three hundred sixty-five.

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

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

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

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

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

the specific reason why they could not be used.

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

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

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

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

(F) The total amount to be spent on quality incentive payments for ~~a~~ state fiscal year 2021 shall be ~~the following~~determined as follows:

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

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

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

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

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

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

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

~~(i)~~ (a) The amount that is ~~two~~ five and ~~four-tenths~~ two-tenths per cent of the nursing facility's base rate for nursing facility services provided on the first day of the state fiscal year;

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

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

Sec. 5166.01. As used in this chapter:

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

"Administrative agency" means, with respect to a home and community-based services medicaid waiver component, the department of medicaid or, if a state agency or political subdivision contracts with the department under section 5162.35 of the Revised Code to administer the component, that state agency or political subdivision.

"Care management system" has the same meaning as in section 5167.01 of the Revised Code.

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

"Enrollee" has the same meaning as in section 5167.01 of the Revised Code.

"Expansion eligibility group" has the same meaning as in section 5163.01 of the Revised Code.

"Federal poverty line" has the same meaning as in section 5162.01 of the Revised Code.

"Home and community-based services medicaid waiver component" means a medicaid waiver component under which home and community-based services are provided as an alternative to hospital services, nursing facility services, or ICF/IID services.

"Hospital" has the same meaning as in section 3727.01 of the Revised Code.

"Hospital long-term care unit" has the same meaning as in section 5168.40 of the Revised Code.

"ICDS participant" has the same meaning as in section 5164.01 of the Revised Code.

"ICF/IID" and "ICF/IID services" have the same meanings as in section 5124.01 of the Revised Code.

"Integrated care delivery system" and "ICDS" have the same meanings as in section 5164.01 of the Revised Code.

"Level of care determination" means a determination of whether an individual needs the level of care provided by a hospital, nursing facility, or ICF/IID and whether the individual, if determined to need that level of care, would receive hospital services, nursing facility services, or ICF/IID services if not for a home and community-based services medicaid waiver component.

"Medicaid buy-in for workers with disabilities program" has the same meaning as in section 5163.01 of the Revised Code.

"Medicaid MCO plan" has the same meaning as in section 5167.01 of the Revised Code.

"Medicaid provider" has the same meaning as in section 5164.01 of the Revised Code.

"Medicaid services" has the same meaning as in section 5164.01 of the Revised Code.

"Medicaid waiver component" means a component of the medicaid program authorized by a waiver granted by the United States department of health and human services under the "Social Security Act," section 1115 or 1915, 42 U.S.C. 1315 or 1396n. "Medicaid waiver component" does not include the care management system.

"Medically fragile child" means an individual who is under eighteen years of age, has intensive health care needs, and is considered blind or disabled under section 1614(a)(2) or (3) of

the "Social Security Act," 42 U.S.C. 1382c(a)(2) or (3).

~~"Medicare skilled nursing facility market basket index" has the same meaning as in section 5165.01 of the Revised Code.~~

"Nursing facility" and "nursing facility services" have the same meanings as in section 5165.01 of the Revised Code.

"Ohio home care waiver program" means the home and community-based services medicaid waiver component that is known as Ohio home care and was created pursuant to section 5166.11 of the Revised Code.

"Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

"Residential treatment facility" means a residential facility licensed by the department of mental health and addiction services under section 5119.34 of the Revised Code, or an institution certified by the department of job and family services under section 5103.03 of the Revised Code, that serves children and either has more than sixteen beds or is part of a campus of multiple facilities or institutions that, combined, have a total of more than sixteen beds.

"Skilled nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

"Unified long-term services and support medicaid waiver component" means the medicaid waiver component authorized by section 5166.14 of the Revised Code.

Section 2. That existing sections 5165.01, 5165.15, 5165.16, 5165.17, 5165.19, 5165.26, and 5166.01 of the Revised Code are hereby repealed.

Section 3. That section 5165.361 of the Revised Code is

hereby repealed.

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

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

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

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

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

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

Sec. 333.10.

1	2	3	4	5
A		MCD DEPARTMENT OF MEDICAID		
B	General Revenue Fund			
C	GRF 651425	Medicaid Program Support - State	$ 164,132,342	$ 170,223,643

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

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

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

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

Section 7. That existing Section 333.10 of H.B. 166 of the 133rd General Assembly is hereby repealed."

In line 5, delete "**1**" and insert "**8**"

In line 130, delete "**2**" and insert "**9**"

In line 154, delete "**3**" and insert "**10**"

The motion was _____ agreed to.

SYNOPSIS

Medicaid rates for nursing facility services

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

Repeals provisions of current law that do the following:

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

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

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

(4) Provide for the budget reduction adjustment factor to

be, for the second half of FY 2020, 2.4%.

(5) Provide for the budget reduction adjustment factor to be, for FY 2021, equal to the Medicare skilled nursing facility market basket index for federal FY 2020.

Nursing facilities' quality incentive payments

R.C. 5165.26

Specifies that FY 2021 is the last year that nursing facilities will receive a quality incentive payment.

Removes references to calculating the quality insurance payment for the second half of fiscal year 2020.

Specifies that a nursing facility's quality incentive payment for state fiscal year 2021 is based in part on the number of points that the U.S. Centers for Medicare and Medicaid Services (CMS) assigns to the nursing facility under CMS's five-star quality rating system for the quality metrics based on the most recent four-quarter average data available in Nursing Home Compare in May of 2020.

Revises the method by which a nursing facility's licensed occupancy percentage is determined for the purpose of determining whether a nursing facility is eligible for a quality incentive payment.

Clarifies that, for FY 2021, a nursing facility is not disqualified from earning a quality incentive payment because its licensed occupancy percentage is below 80% if the nursing facility was initially certified for participation in the Medicaid program on or after January 1, 2019.

Provides generally that a nursing facility is not disqualified based on occupancy percentage if either of the

following apply:

(1) One or more of the beds that are part of a nursing facility's capacity could not be used for resident care during calendar year 2019 due to causes beyond the reasonable control of the nursing facility's operator.

(2) The nursing facility underwent a renovation between January 1, 2018, and January 1, 2020, to which both of the following apply:

-- The renovation involved capital expenditures of at least $50,000, excluding expenditures for equipment, staffing, or operational costs.

-- The renovation directly impacted the area where the facility's licensed beds are located.

Prohibits a nursing facility from receiving a quality incentive payment for state fiscal year 2021 if the facility obtains its initial Medicaid provider agreement or undergoes a change of operator during calendar year 2019 or state fiscal year 2021.

For FY 2021, increases the amount to be spent on quality incentive payments by adjusting to 5.2% of nursing facilities' base rate for nursing facility services provided on the first day of the state fiscal year (from 2.4%) one of the factors used to determine the total amount to be spent on quality incentive payments for the state fiscal year.

Department of Medicaid

Sections 6 and 7 (amends Section 333.10 of H.B. 166 of the 133rd General Assembly)

Increases GRF appropriation item 651525, Medicaid Health

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