August 9, 2023

Delivered via email

Director Maureen Corcoran
Ohio Department of Medicaid
Fiscal Operations - LTC Rate Methodology Unit
P.O. Box 182709
Columbus, Ohio 43215-3414

Re: Request for rate reconsideration due to error in calculation of the rate

Submitted on behalf of all SNFs eligible to receive a quality incentive payment as part of their rate for the period beginning July 1, 2023

Dear Director Corcoran:

The Ohio Health Care Association, the Academy of Senior Health Sciences, and LeadingAge Ohio request reconsideration of the Medicaid rates for skilled nursing facilities (SNFs) for the state fiscal year beginning July 1, 2023. These rates were posted to the facilities' online portals beginning the evening of August 1, 2023.

A. Basis for Request

This request is made pursuant to section 5165.38 of the Revised Code and rule 5160-3-24 of the Administrative Code, which confer standing on associations representing SNFs to request rate reconsideration. As provided in section 5165.38, we request reconsideration because the rates were not calculated in accordance with Chapter 5165. of the Revised Code, as specifically described below.

The rate calculation not only fails to comport with statute and the legislative intent embodied in the statute, it also runs counter to Governor DeWine's policy direction, expressed beginning with his State of the State address in early 2023 and running through his post-budget press conference, that funding for SNFs be tied tightly to quality. The rate calculation upends this policy by minimizing the proportion of funding going to quality to an amount far below what was intended.

B. Interested Parties

We make this request on behalf of all SNFs eligible to receive a quality incentive payment under section 5165.26 of the Revised Code as part of their rate for the period beginning July 1, 2023.

C. Request for Expedited Processing

We request expedited processing of this request because of the large number of providers affected (approximately 822) and the administrative burden to providers, the Department of Medicaid (ODM), and managed care plans if the rates are not corrected quickly and as a result require retroactive adjustment.

D. ODM's initial rate calculations are based on an error in applying the language of the newly-revised quality incentive payment statute

As provided in section 5165.38, we request reconsideration because the rates were not calculated in accordance with Chapter 5165. of the Revised Code. ODM's rate calculations are based on an error in applying the language of the newly-revised quality incentive payment statute. Specifically, ODM did not calculate the value per quality point used in determining the quality incentive for each SNF in accordance with division (B)(5) of section 5165.26 of the Revised Code. The value per point is erroneous because ODM did not correctly determine the total amount of funding to be allocated to quality incentive payments under division (E) of section 5165.26, which is one of two elements in calculating the value per point.

Section 5165.26(B)(5) requires ODM to determine the value per quality point by dividing the total dollars available for the quality incentive by the product of the average number of quality points that all SNFs received for the relevant time period multiplied by those SNFs' Medicaid days.

Also amended by HB 33, division (E) of section 5165.26 specifies the number of dollars available for the quality incentive:

> (E) The total amount to be spent on quality incentive payments under division (B) of this section for a fiscal year shall be determined as follows:
>
> (1) Determine the following amount for each nursing facility:
>
> (a) The amount that is five and two-tenths per cent of the nursing facility's base rate for nursing facility services provided on the first day of the state fiscal year plus one dollar and seventy-nine cents plus sixty per cent of the per diem amount by which the nursing facility's rate for direct care costs determined for the fiscal year under section 5165.19 of the Revised Code changed as a result of the rebasing conducted under section 5165.36 of the Revised Code.
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> (b) Multiply the amount determined under division (E)(1)(a) of this section by the number of the nursing facility's medicaid days for the calendar year preceding the fiscal year for which the rate is determined.

> (2) Determine the sum of the products determined under division (E)(1)(b) of this section for all nursing facilities for which the product was determined for the state fiscal year.
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> (3) To the sum determined under division (E)(2) of this section, add one hundred twenty-five million dollars.

In performing the calculation under division (E) for the July 1, 2023, rates, ODM erroneously determined the amount required by the second part of division (E)(1)(a) - the part that refers to moving 60% of the funding from rebasing under section 5165.36 into the quality incentive.

Instead of calculating 60% of the per diem amount by which each nursing facility's **direct care rate** changed, as required by the statute, ODM mistakenly calculated the amount by which the **direct care cost per case-mix unit** (commonly referred to as the "direct care price") changed for each nursing facility's peer group. ODM omitted the step of multiplying by case-mix score, which is what converts each facility's price into its rate.

This error was highly material, because the increase in the direct care rate is not the same as the increase in the direct care price. Instead, the rate is the product of the price and the facility's case-mix score. The rate is significantly more than the price because case-mix scores among Ohio SNFs are on average close to 3, so the rate increase is nearly triple the price increase.

Division (E)(1)(a) makes it extremely clear that the legislature intended ODM to use the rate, not the price, through the words, "the per diem amount by which the nursing facility's **rate for direct care costs** determined for the fiscal year under section 5165.19 of the Revised Code changed as a result of the rebasing conducted under section 5165.36 of the Revised Code."

Division (A)(1) of section 5165.19, which the legislature incorporated into section 5165.26 to clarify what it meant by the rate for direct care costs, reads:

> Semiannually, except as provided in division (A)(2) of this section,[1] 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.

By using the identical words, "rate for direct care costs," these interlocking statutory directives demonstrate that the rate to be used for each facility under section 5165.26(E)(1)(a) is the

[1] Division (A)(2), which deals with case-mix score, is not relevant to this issue.

product of its peer group cost per case-mix unit (price) and its semiannual case-mix score, not the price alone.

In sum, ODM's calculation of the value per quality point is not in accordance with statute because *the statute requires ODM to use the direct care rate, not the price*.

E. The General Assembly intended to divide the additional funding generated by rebasing SNF rates with 40% going to the base rate and 60% to the quality incentive

The clear instruction of section 5165.26(E)(1)(a) is further supported by another statutory provision, which also was enacted in HB 33. As was widely discussed while the General Assembly considered HB 33 and even before the bill was introduced,[2] the legislature intended to divide the additional funding generated by rebasing SNF rates between the base rate and the quality incentive. At all relevant times, the legislature intended that 40% was to go to the base rate and 60% was to go to the quality incentive. This funding allocation also reflected Governor DeWine's policy goals for HB 33 relative to SNFs, as confirmed by his post-budget comments and his decision not to veto any portion of the SNF language in the bill.

While section 5165.26(E)(1)(a) addressed the 60% going to quality, another provision of HB 33 addressed the 40% for the base rates:

> SECTION 333.300. NURSING FACILITY BASE RATES
> For fiscal years 2024 and 2025, the Department of Medicaid shall include in each nursing facility's base rate only forty per cent of the increase in its **rate for direct care costs** due to the rebasing conducted pursuant to section 5165.36 of the Revised Code.

This language is virtually identical to the language in 5165.26(E)(1)(a) except it contains the 40% figure instead of the 60%. Both apply the percentage to the "rate for direct care costs," not the price (cost per case-mix unit):

> Section 5165.26(E)(1)(a): "sixty per cent of the per diem amount by which the nursing facility's **rate for direct care costs** … changed as a result of the rebasing conducted under section 5165.36 of the Revised Code."
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> Section 333.300: "forty per cent of the increase in its **rate for direct care costs** due to the rebasing conducted pursuant to section 5165.36 of the Revised Code."

[2] See House Bill 45 (134th General Assembly), section 280.28, in which the same 60/40 split was used for a different pot of money. Our associations originally proposed applying this split to rebasing in the legislative Nursing Facility Payment Commission in the summer of 2022.

Taken together, these two statutory provisions make the legislative intent crystal clear. The starting point is the amount by which each SNF's *direct care rate* increased by virtue of the rebasing. This amount was on average approximately $56 per day – the average price increase times the average case-mix score. Each individual facility's dollar amount would be different, depending on its peer group price and case-mix score, but $56 is the statewide average. Then the statutory provisions require ODM to divide that roughly $56 amount between quality (60% or approximately $33.60) and the base rate (40% or approximately $22.40). There is no other way to read the identical language in the two sections of statute and the consonant legislative intent than as referring the total amount of additional funding generated by rebasing.

Unfortunately, ODM did not apply the statutory language in a manner that correctly implements the legislative intent. Instead of calculating the whole pie (total price increase times case-mix score and then dividing it 60/40), ODM attempted to determine each slice separately and inconsistently with the statutory language, with the result that the two slices do not add up to the whole pie. ODM first divided the price increase into 60% and 40% portions, then multiplied the 40% portion by case-mix score, *but failed to do the same for the 60% portion despite the statutory language directing them to do so*. While the base rate portion is correct – an average of around $22.40 per day – the portion that went to quality is not, averaging only about $11.22. The two slices obviously do not add up to the whole pie: $33.62 instead of $56. Contrary to the intent of the legislature and the Governor, it is quality that is shortchanged by this erroneous application of statute.

The impact of ODM's mistake is borne out in the total funding equation, which is similarly out-of-whack with the intended result. According to ODM's figures, the total increased funding for the quality incentive is approximately $169 million, while the added funding for the base rate is approximately $415 million. *Instead of 60% of the funding increase going to quality as the legislature and Governor intended, under ODM's interpretation it is only 29%.*

F. ODM's arguments in support of its calculation are flawed

ODM has advanced two arguments to support its calculation: 1) it interpreted the new language in section 5165.26(E)(1)(a) to mean that the amount added to the quality incentive is 60% of the rebasing (the change in price) under 5165.36; and 2) its approach would keep the total increase in spending on SNFs under HB 33 below the amount appropriated for that purpose.

The first argument ignores most of the language that the legislature added to section 5165.26(E)(1)(a). The plain language of the statute applies the 60% allocation to the amount by which the *rate for direct care costs changed as a result of the rebasing* – the funding generated by rebasing – not to the rebasing itself (the change in the price). Giving meaning to all words in a statute is a fundamental tenet of statutory construction.

The second argument is inapposite because the statute does not specify a cap on the increase in SNF spending generated by the statutory formula as adjusted by HB 33.[3] The funding amount cited by ODM is an (erroneous) estimate of how much it would cost to implement the statute as amended by the legislature. It is not a cap on spending. Actual spending always will be different – higher or lower – than any estimate used for budgeting purposes unless the legislature mandates that the estimate really is a cap. The legislature did not do so in this instance.

It is true that the SNF estimate became one component of a multi-faceted appropriation for a broad range of Medicaid services that amounts to more than $17 billion for state fiscal year 2024. That fact, however, does not change the requirement that ODM must follow the statute in calculating SNF rates even if its updated estimate of the cost does not comport with an earlier, mistaken estimate used in building the state budget.

While there is no provision of law prohibiting ODM from spending more on SNFs than the incorrect estimate, it is true that ODM cannot spend more than the $17 billion total Medicaid appropriation in HB 33. If, at some time later in the fiscal year, ODM identifies that it is on target to spend more than the total appropriation because of expenditures for SNFs or other parts of the Medicaid program, there are mechanisms to remedy the funding shortfall. These mechanisms include tapping the Health and Human Services Fund, requesting the Controlling Board to increase appropriations, and asking the legislature for a supplemental appropriation. However, these remedies only come into play when actual expenditures appear likely to exceed the total Medicaid appropriation, which would be much later in the fiscal year. The permissible remedies do not include calculating SNF rates in a manner contrary to statute at the beginning of the fiscal year, when there is no way to know whether total Medicaid expenditures actually will end up exceeding the total appropriation.

G. ODM must recalculate its initial rates in accordance with the law

As required by section 5165.38 of the Revised Code, we request that ODM correct the rates of the affected SNFs, which are all SNFs that qualify for the quality incentive. As further required by section 5165.38, if any claims are paid using the inaccurate rates before they are corrected, we request that ODM pay these SNFs the difference between the amount each SNF was paid and the amount it should have been paid.

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[3] Compare section 333.240(C) of the previous budget bill, HB 110 (134th General Assembly): "Of the foregoing appropriation item 651525, Medicaid Health Care Services, $125,000,000 in each fiscal year shall be used by the Department of Medicaid to pay for rebasing determinations of nursing facilities' Medicaid rates under this section." This provision demonstrates that the legislature knew how to cap the amount spent for rebasing, but chose not to do so in HB 33.

The value per quality point that ODM erroneously determined is $1.88. Using data supplied by ODM (peer group direct care prices of $61.80, $60.16, and $53.10; 18.47 average quality points; and 15,055,888 Medicaid days), we estimate the value per point required by the statute to be $3.04, a difference of $1.16. The rates for all SNFs that qualified for the quality incentive should be recalculated to include the additional amount per quality point.

Sincerely,

Pete Van Runkle, Executive Director, OHCA
Chris Murray, CEO, ASHS
Susan Wallace, President & CEO, LAO