IN THE SUPREME COURT OF OHIO

Case No. 2024-0238

Original Action in Mandamus

STATE OF OHIO *ex rel.* LEADINGAGE OHIO, *et al.*

Relators

v.

OHIO DEPARTMENT OF MEDICAID, *et al.*

Respondents

RESPONDENTS' MOTION FOR DISCOVERY AND SCHEDULING ORDER

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Pursuant to Supreme Court Rules of Practice 4.01, 12.05, and 12.06, Respondents Ohio Department of Medicaid and Maureen M. Corcoran, Director (collectively, "ODM") move the Court to enter an order permitting discovery and adopting the proposed case schedule ***attached as Exhibit A***. This original action involves allegations by Relators LeadingAge Ohio, The Ohio Health Care Association, and the Academy of Senior Health Sciences (collectively, "Relators") that ODM has failed to pay nursing facilities hundreds of millions of dollars in Medicaid reimbursements. Relators seek relief with enormous monetary and budgetary implications, making it vital that ODM be given the opportunity to give a fully informed response. Because of the need to conduct discovery regarding those issues and to allow for that response, ODM also seeks a scheduling order from this Court that allows adequate time to conduct discovery.

Respectfully submitted,

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MEMORANDUM IN SUPPORT

I. INTRODUCTION

It has been said that Medicaid statutes are "an 'enormously complicated program. The system is a web; a tug at one strand pulls on every other.'" *West Virginia v. U.S. Dept. Health and Human Serv.*, 289 F.3d 281, 294 (4th Cir.2002), quoting *Stephenson v. Shalala*, 87 F.3d 350, 356 (9th Cir.1996). This case—involving Ohio Medicaid reimbursement rates for nursing facilities—is no different. As one Ohio court observed: "The complexity of the Medicaid reimbursement system [for nursing facilities] is difficult to overstate." (Internal quotation marks omitted.) *See State ex rel. Peregrine Health Servs. of Columbus, LLC v. Sears , Dir., Ohio Dep't of Medicaid*, 2020-Ohio-3426, ¶ 80. "[T]he administrative system for Medicaid reimbursement is highly specialized, and the statutes and rules governing reimbursement to nursing facilities . . . are extremely complex." *Champaign Cnty. Nursing Home v. Ohio State Dept. of Human Services, Director,* 10th Dist. Franklin No. 00AP-91, 2003-Ohio-1706, ¶ 46.

It is from this statutory riddle that Relators seek the "extraordinary remedy" of mandamus relief. *See State ex rel. Ferrara v. Trumbull Cnty. Bd. of Elections*, 166 Ohio St.3d 64, 2021-Ohio-3156, 182 N.E.3d 1142, ¶ 7. Relators are attempting to use one of Ohio's most complex administrative and statutory schemes to claim "a clear legal right" to hundreds of millions of additional, unbudgeted dollars in funding. *See id.* In light of the complexity of the issues and the magnitude of the requested relief, ODM needs ample opportunity to conduct discovery to ensure a complete and accurate response. ODM thus requests a scheduling order that permits adequate time to conduct discovery.

II. BACKGROUND

This case involves Ohio Medicaid reimbursement rates for nursing homes. The formulas for calculating these reimbursement rates are found in Revised Code Chapter 5165. At a high level, a nursing home's total "per [M]edicaid day rate" is comprised of seven cost centers: (1) ancillary and support costs; (2) capital costs; (3) direct care costs; (4) tax costs; (5) critical access nursing payments (if applicable); (6) quality incentive payments; and (7) a flat payment of $16.44. *See* R.C. 5165.15(A) and (C); R.C. 6165.15(B). Most payment types are tiered by "peer group," to account for differences in cost due to location and quantity of beds. *See, e.g.*, R.C. 5165.17(B) ("For the purpose of determining nursing facilities' rates for capital costs, the department shall establish six peer groups."). Moreover, at least once every five years, ODM conducts a "rebasing," which is a redetermination of the base prices for four of the six payment types—ancillary and support costs, capital costs, direct care costs, and tax costs. *See* R.C. 5165.01(SS). Below is a high-level description of the calculation of each payment type, followed by a summary of the recent change in the statutory scheme underlying this dispute.

A. Overview of payment types.

Ancillary and support costs. In simple terms, the per Medicaid day rate for ancillary and support costs is calculated by first determining "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 percent." *See* R.C. 5165.16(C)(1). Second, ODM then "identif[ies] which nursing facility in the peer group is at the [25th] percentile," excluding those facilities that have participated less than 12 months and those "whose ancillary and support costs are more than one standard deviation from

the mean." *See* R.C. 5165.16(C)(2). Until the next rebasing, that 25th percentile represents the per Medicaid day price for ancillary and support costs for every facility within a given peer group. *See* R.C. 5165.16(C)(1) ("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.").

Capital costs. The per Medicaid day rate for capital costs is calculated similarly to ancillary and support costs: "[a] peer group's rate for capital costs shall be the rate for capital costs for the nursing facility in the peer group that is at the [25th] percentile of the rate for capital costs for the applicable calendar year." *See* R.C. 5165.17(C)(1). Among other things, in determining the 25th percentile, ODM is required to "[u]se 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." *See* R.C. 5165.17(C)(2). But just as with ancillary and support costs, this 25th percentile represents the per Medicaid day price for capital costs until the next rebasing. *See* R.C. 5165.17(C)(1) ("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.").

Direct care costs. With respect to direct care costs, "each nursing facility's per [M]edicaid day payment rate for direct care costs" is determined "by multiplying the facility's semiannual case-mix score" by that facility's peer group's "cost per case-mix unit." *See* R.C. 5165.19(A)(1).

Case-mix score, sometimes referred to as "acuity," is a measure of the severity or intensity of a patient's level of care. *See* R.C. 5165.01(H) ("'Case-mix score' means a measure determined under section 5165.192 of the Revised Code of the relative direct-care resources needed to provide care and habilitation to a nursing facility resident."); *see also* R.C. 5165.192 (providing methodology for determining facilities' case-mix scores).

A peer group's "cost per case-mix unit" is commonly referred to in the industry as the "Price." And the Price (cost per case-mix unit) is calculated first "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." *See* R.C. 5165.19(C)(1)(a). ODM then "identif[ies] which nursing facility in the peer group is at the [70th] percentile of the cost per case-mix units." *See* R.C. 5165.19(C)(1)(b). Until the next rebasing, that 70th percentile represents the per Medicaid day price for direct care costs for every facility within a given peer group. *See* R.C. 5165.19(C)(1) ("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.").

Tax costs. "To determine a nursing facility's rate for tax costs, the department shall divide the nursing facility's desk-reviewed, actual, allowable tax costs paid for the applicable calendar year by the number of inpatient days the nursing facility would have had if its occupancy rate had been [100] percent during the applicable calendar year." R.C. 5165.21. The payment rate for tax costs is also static until ODM conducts a rebasing. *See id.* ("The rate for tax costs determined under this division for a nursing facility shall be used for subsequent years until the department conducts a rebasing.").

Critical access nursing payments. There are several exceptions and criteria to be eligible for critical access nursing payments. *See generally* R.C. 5165.23. But assuming all those criteria are satisfied, "[a] critical access nursing facility's critical access incentive payment for a state fiscal year shall equal five percent of the portion of the nursing facility's total per [M]edicaid day payment rate for the state fiscal year that is the sum of the rates [for ancillary and support costs, capital costs, direct care costs, and tax costs] identified in divisions (A)(1) to (4) of section 5165.15

of the Revised Code." *See* R.C. 5165.23. Critical access nursing payments are not subject to rebasing procedures. *See generally id.*; *see also* R.C. 5165.01(SS).

Quality incentive payments. Regarding quality incentive payments, they payments are calculated by multiplying a "nursing facility's quality score determined under [R.C. 5165.26(C)]" by the current "value per quality point." *See* 5165.26(B). The facility's quality score is determined from a rating system established by the U.S. Centers for Medicare & Medicaid Services ("CMS"). The value per quality point is the average quality score of all qualifying nursing homes times the prior year's total number of Medicaid days, divided into the quality pool of funds determined under R.C. 5165.26.26(E)(2). *See* R.C. 5165.26(B). Quality incentive payments also do not get rebased. *See generally id.*; *see also* R.C. 5165.01(SS).

B. Recent changes in statutory scheme and Relators' claims.

The State of Ohio's most recent biennium budget was passed by the 135th General Assembly on June 30, 2023, and signed by Governor Mike DeWine on July 4, 2023. *See* 2023 Am. Sub. H.B. No. 33. This budget included significant changes to how nursing facilities are reimbursed by ODM. As relevant here, in an effort to increase quality of care, the legislature diverted 60% of the rebasing for direct care costs to the quality incentive pool.

> The total amount to be spent on quality incentive payments . . . shall be determined by . . . [including] sixty percent 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.

See R.C. 5165.26(E)(1)(a).

The 2023 rebasing resulted in historically high increases in each peer group's cost per case-mix unit—their Price—including some increases as high as 48%. But instead of allocating the entire increase to direct care costs, the new statute splits that increase 60/40: 60% of the increase

goes to the quality incentive pool, and 40% of the increase goes to Price. *See* R.C. 5165.26(E)(1)(a); *see* 2023 Am. Sub. H.B. No. 33, Section 333.300.

Relators primarily argue that ODM has been incorrectly calculating the quality incentive payments after the most recent rebasing. In their view, ODM should be spending hundreds of millions of dollars more than what the General Assembly budgeted. These are big claims with big monetary and budgetary implications. And they are made in the context of one of Ohio most complex administrative and statutory schemes. As a result, an informed response must necessarily account for all factual and legal aspects of the Relators' claim for relief. ODM thus requests time to issue interrogatories and requests for production of documents to Relators, and to conduct depositions and prepare expert testimony as necessary. Among other things, these discovery items will confirm ODM's understanding of the factual allegations and shed light on Relators' involvement in the legislative and administrative processes.

III. PROPOSED DISCOVERY PLAN

ODM proposes the following case schedule (also attached as Exhibit A) to permit reasonable discovery and time to fully prepare an informed response to Relators' complaint:

DEADLINE	DESCRIPTION
May 1	Deadline to serve interrogatories and document requests
June 1	Responses to interrogatories and document requests due
July 1	Deadline to conduct Depositions
July 15	Fact discovery cutoff and expert disclosures
August 1	Affirmative expert disclosures/reports
September 1	Rebuttal expert disclosures/reports

October 1	Relators' merits brief
November 1	ODM's merits brief
December 15	Relators reply brief
January 15, 2025	Parties' evidentiary objections/motions *in limine*
February 1, 2025	Parties' responses to evidentiary objections/motions *in limine*

IV. CONCLUSION

For these reasons, ODM requests that the Court allow discovery and adopt the schedule attached as Exhibit A.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the 9th day of April 2024, a copy of the foregoing was served by email upon the following:

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EXHIBIT A

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