IN THE SUPREME COURT OF OHIO

STATE OF OHIO *EX REL.* LEADINGAGE OHIO 2233 North Bank Drive Columbus, Ohio 43220, and OHIO HEALTH CARE ASSOCIATION 9200 Worthington Road, Suite 110 Westerville, Ohio 43082, and THE ACADEMY OF SENIOR HEALTH SCIENCES, INC. 17 S High St., #770 Columbus, OH 43215, Plaintiffs/Relators, v. THE OHIO DEPARTMENT OF MEDICAID 50 West Town Street, Suite 400 Columbus, Ohio 43215 and MAUREEN M. CORCORAN, in her official capacity as the Director of the Ohio Department of Medicaid, 50 West Town Street, Suite 400 Columbus, Ohio 43215, Defendants/Respondents.	)	CASE NO. **MEMORANDUM IN SUPPORT OF REALTORS' PETITION FOR WRIT OF MANDAMUS** **ORAL ARGUMENT REQUESTED**

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INTRODUCTION

Ohio's three nursing facility trade associations—LeadingAge Ohio ("LeadingAge"), The Ohio Health Care Association ("OHCA"), and The Academy of Senior Health Sciences (the "Academy") (collectively, "Relators")—submit this petition for a writ of mandamus to compel the Ohio Department of Medicaid ("ODM") to comply with unambiguous directives in House Bill 33 (the budget legislation for state fiscal years 2024-2025; hereinafter, the "Budget Legislation") regarding the calculation of Medicaid rates paid to more than 800 of the state's nursing facilities, which care for more than 40,000 Ohio Medicaid beneficiaries.

In an effort to incentivize high-quality care in Ohio's nursing facilities, the Budget Legislation sets forth a mandatory calculation formula that requires ODM to allocate 60% of this year's statutorily determined increase in nursing home Medicaid reimbursement toward "quality incentive" payments awarded to the state's highest quality nursing homes, and only 40% toward the "base rate" paid to all eligible nursing homes. However, in calculating the "quality incentive" component under the statute, ODM openly and erroneously conflated two defined statutory terms, causing the quality incentive payments to be much lower than they should be. Crucially (and curiously), ODM did not make this same mistake when applying the same defined statutory terms for purposes of calculating the "base rate." The result: While ODM correctly calculated the increase in the "base rate," it significantly shortchanged the increase in the "quality incentive" payment rate. Indeed, the "quality incentive" increase ended up *much smaller* than the "base rate" increase. This is the opposite of what the statute requires. Furthermore, because the "quality incentive" component is being shortchanged, the aggregate increase in Medicaid reimbursement for nursing home care is much lower than it should be under the statute.

The three elements for mandamus relief are easily satisfied here: (1) a clear legal right to the requested relief; (2) a corresponding clear legal duty on the part of the defendant/respondent

to provide it; and (3) the lack of an adequate remedy in the ordinary course of the law. *State ex rel. Lane v. Pickerington*, 130 Ohio St.3d 225, 2011-Ohio-5454, 957 N.E.2d 29, ¶ 10. This is not a case involving an unclear or ambiguous statute. The statute's mandatory calculation formula is clear; ODM's obligation to implement it is clear; and Relators have exhausted the administrative process and have no further legal remedy. Relators are therefore entitled to a writ of mandamus directing ODM to implement the Budget Legislation as written.

BACKGROUND

A. Ohio's Statutory Framework for Nursing Facility Medicaid Payment Rates

In Ohio, the methodology for setting Medicaid payment rates for nursing facilities is set by the General Assembly in statute, Revised Code chapter 5165. The predecessors of the current statutes on nursing facility rates go back to 1980 and have been amended numerous times over the intervening years, typically through budget legislation, as the legislature has adjusted the state's Medicaid rate-making policy. For many years, the statutory scheme has covered virtually every detail of rate calculation and implementation, leaving little to the discretion of ODM, the agency charged by law with administering the statutory rate structure as the legislature prescribed it.

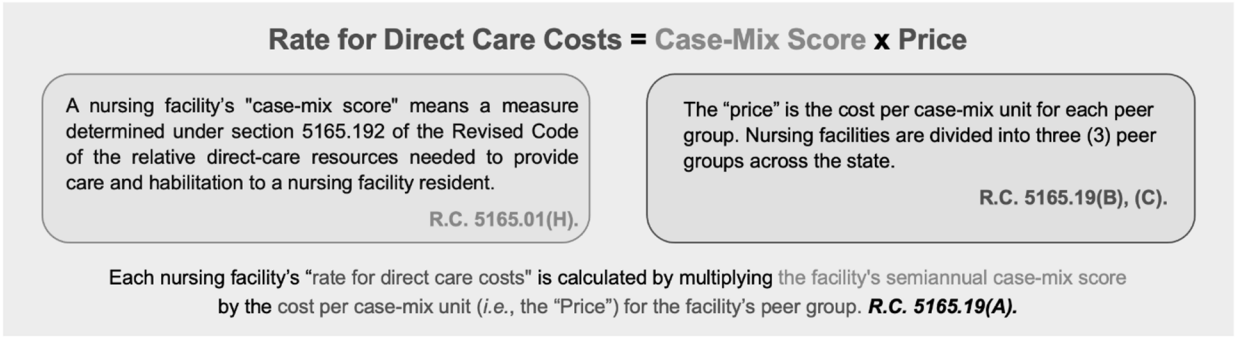
Medicaid reimbursement for nursing facility care in Ohio is made up of two components: a "base rate" and a "quality incentive payment rate." R.C. 5165.15, R.C. 5165.26. The "base rate" is received by all eligible Medicaid nursing facility providers based on the cost of providing care and is not dependent on facilities' performance on quality metrics. *Id.* The "quality incentive payment rate" is received only by providers who achieve certain quantifiable quality standards and is calculated pursuant to Revised Code section 5165.26.

Currently, the statutory methodology for calculating both the base rate and the quality incentive payment rate includes several cost-related components, each based on aggregated cost data for expenses incurred in caring for nursing facility residents. Because facilities' costs change

over time, ODM is required every few years to update its data regarding nursing facilities' costs of providing care through a process called "rebasing." R.C. 5165.36, 5165.19, 5165.01(SS)(3). Increased costs reflected in rebasing serve as the basis for increases in the Medicaid reimbursement rates Ohio pays to nursing facilities.

For purposes of this case, the critical cost-related component at issue is the "rate for direct care costs." This is a statutorily defined term, and it is calculated for each nursing facility by multiplying the facility's semiannual "case-mix score" by the "cost per case-mix unit" (commonly referred to as the "price") for the facility's peer group.[1] R.C. 5165.19(A). (See *Figure 1*, below.) Specifically, the statute provides that 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** … by the **cost per case-mix unit** … for the facility's peer group." R.C. 5165.19(A)(1) (emphasis added).

Figure 1



A nursing facility's "case-mix score" is the result of an individualized calculation ODM makes for each facility that reflects the clinical acuity of the facility's residents (and by extension,

[1] A "peer group" is a grouping of nursing facilities that share similarities based upon their respective metropolitan statistical areas. The use of peer groups is intended to ensure that the "price" reflects the differing costs of providing care to residents depending upon the location of a nursing facility (*i.e.*, the cost of providing care in urban areas and in rural areas differs). R.C. 5165.19(B).

the cost of providing care to that facility's residents). *See* R.C. 5165.192. As the statute itself puts it, the "case-mix score" is "a measure … of the relative direct care resources needed to provide care and habilitation to a nursing facility resident." R.C. 5165.01(H).

The "cost per case-mix unit" (*i.e.*, the "price") is a dollar figure representing the cost of providing direct care services to a single hypothetical nursing facility resident in a certain geographic area of the state. *See* R.C. 5165.19(C). The statute directs ODM to calculate this figure for each of three different geographic "peer groups" that are organized by county; within each group, all facilities have the same "price." *See* R.C. 5165.19(B)–(C).

It is essential to distinguish between a nursing facility's "rate for direct care costs" (which per the statute is the product of **multiplication**) and a nursing facility peer group's "price" (which per the statute is one of the two **factors** in the multiplication that produces the rate for direct care costs). Figure 1, above, illustrates this relationship. The "rate for direct care costs" and the "price" are the two defined statutory terms that ODM is erroneously conflating when calculating nursing facilities' quality incentive rates.

B. Budget Legislation Amendments to Nursing Facility Medicaid Reimbursement

In an effort to boost the incentive to provide high-quality care, the Budget Legislation purposefully shifts total Medicaid reimbursement for nursing facilities more toward the quality incentive payment rate by mandating that 60% of the increase in funding from this year's "rebasing" be allocated toward the quality incentive payment rate, while 40% of the increase be allocated toward the base rate. The Budget Legislation amends the formula for determining the "total amount to be spent on quality incentive payments" that is contained in Section 5165.26(E) as follows:

> (E) The total amount to be spent on quality incentive payments …
> 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**.
>
> (b) Multiply the amount determined under division (E)(1)(a) of this section by the number of the nursing facility's medicaid days for the calendar year preceding the fiscal year for which the rate is determined.
>
> (2) Determine the sum of the products determined under division (E)(1)(b) of this section for all nursing facilities for which the product was determined for the state fiscal year.
>
> (3) To the sum determined under division (E)(2) of this section, add one hundred twenty-five million dollars.

R.C. 5165.26(E) (emphasis added). Correspondingly, as to the base rate,[2] Section 333.300 of the Budget Legislation specifies:

> 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**.

Critically, the same term—"rate for direct care costs"—is used in both R.C. 5165.26(E)(1)(a) and Section 333.300 of the Budget Legislation. Taken together, these two statutory provisions make

[2] The statute defines a nursing facility's "base rate" to mean its total payment rate *other than* its quality incentive payment rate. *See* R.C. 5165.26(A)(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."); R.C. 5165.15(A)–(B) (providing that a nursing facility's "total per medicaid day payment rate" is the sum of several subsidiary rates, including the "per medicaid day payment rate for direct care costs determined for the nursing facility under section 5165.19 of the Revised Code"); R.C. 5165.15(C) (providing that a nursing facility's "total per medicaid day payment rate" also includes "the per medicaid day quality incentive payment rate determined for the nursing facility under section 5165.26 of the Revised Code").

clear how the increase in each nursing facility's "**rate for direct care costs**" as a result of rebasing is to be divided: 60% toward the quality incentive payment rate, and 40% toward the base rate.

C. ODM's Egregious Misinterpretation of the Budget Legislation

ODM has refused to follow the Budget Legislation's unambiguous statutory command and has adopted an incorrect calculation formula that significantly shortchanges the increase in the quality incentive payment rate. In calculating the "total amount to be spent on quality incentive payments," ODM did not take 60% of the amount by which each nursing facility's "**rate for direct care costs**" changed due to rebasing, as required under R.C. 5165.26(E). Instead, ODM merely took 60% of the amount by which each peer group's "**price**" changed as a result of rebasing. As explained above, the "price" is only one of two factors that, when multiplied, produce each nursing facility's "rate for direct care costs." (*See* Figure 1). As a result of ODM's error, the amount of the increase in quality incentive payments is much smaller than it is supposed to be under the statute.

Remarkably, even though ODM made this error when calculating the quality incentive payment rate, it did not make the same error when calculating the base rate, even though that statutory section uses the same exact term—"rate for direct care costs." ODM **correctly** included in each facility's base rate 40% of the change in each nursing facility's total "**rate for direct care costs**"—*i.e.*, 40% of the full **product** of each nursing facility's "case-mix score" and "price." The upshot of this erroneous inconsistency: a much greater proportion of the resulting funding increase is going toward the base rate than is going toward the quality incentive rate, undermining the General Assembly's considered choice to emphasize quality. Furthermore, because the quality incentive component is being shortchanged, ODM is depriving Ohio's nursing facilities—and thus the vulnerable residents of those facilities—of Medicaid funding that the legislature has specifically *required* ODM to spend.

Upon realizing ODM's error, Relators submitted a formal rate reconsideration request urging ODM to correct its rate calculations.[3] Notably, a rate reconsideration request is the sole statutory and regulatory method for providers and associations to challenge rate calculation errors administratively. *See* R.C. 5165.38; Ohio Administrative Code 5160-3-24.

Despite the clear language of the statute, ODM denied Relators' Rate Reconsideration Request and continues to insist upon its erroneous calculation formula.[4] As discussed in greater detail below, the key portion of ODM's response illustrates the conspicuousness of the agency's error:

> The amendment to Ohio Revised Code, 5165.26(E), in HB 33 requires the addition of 60% of the amount by which the nursing facility's rate for direct care costs changed **as a result of rebasing** to the quality pool of funds. As noted above, **the change to the rate as a result of rebasing is a change to the price**. Sixty percent was properly applied to the change in price.

Exhibit B (second emphasis added).

It is simply not true that "the change to the rate as a result of rebasing is a change to the price." As explained above, the statutory language makes it abundantly clear that the rate and the price are two different things. The price is a **component** of the rate; it is **not the same thing** as the rate. (*See* Figure 1). **Quite simply, ODM's inexplicable conflation of these two precisely defined statutory terms has now led to this petition.**

Because Relators have no further administrative or legal remedy, they now turn to this Court to issue a writ of mandamus compelling ODM to comply with the law as written.

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[3] Relator's Rate Reconsideration Request is attached to their Verified Petition as Exhibit A.

[4] ODM's response denying Relator's Rate Reconsideration Request is attached to Relator's Verified Petition as Exhibit B.

LAW AND ARGUMENT

A. Legal Standard for a Writ of Mandamus

This Court has original jurisdiction in mandamus actions. Ohio Constitution, Article IV, Section 2(B)(1)(b); R.C. 2731.02. A writ of mandamus is proper upon demonstration of (1) a clear legal right to the requested relief; (2) a corresponding clear legal duty on the part of the defendant/respondent to provide it; and (3) the lack of an adequate remedy in the ordinary course of the law. *State ex rel. Lane*, 130 Ohio St.3d 225, 2011-Ohio-5454, 957 N.E.2d 29, at ¶ 10. All three of those factors are easily satisfied here.

B. Relators Have a Clear Legal Right to the Requested Relief, and ODM Has a Corresponding Clear Legal Duty to Provide It

1. Relators have standing to bring this petition.

As an initial matter, Relators note that they all have standing to bring this petition and that they all are entitled to the requested mandamus relief. "To have standing in a mandamus case, a relator must be 'beneficially interested' in the case." *State ex rel. Ames v. Portage Cty. Bd. of Revision*, 166 Ohio St.3d 225, 2021-Ohio-4486, 184 N.E.3d 90, ¶ 10, quoting *State ex rel. Hills & Dales v. Plain Local School Dist. Bd. of Edn.*, 158 Ohio St.3d 303, 2019-Ohio-5160, 141 N.E.3d 189, ¶ 9. "[T]he applicable test is whether [a] relator[] would be directly benefited or injured by a judgment in the case." *Id.*, quoting *State ex rel. Sinay v. Sodders*, 80 Ohio St.3d 224, 226, 1997-Ohio-344, 685 N.E.2d 754.

Relators LeadingAge, OHCA, and the Academy, are "beneficially interested" in this case and have standing to bring this petition as trade associations on behalf of their nursing facility members. "[A]n association has standing on behalf of its members when '(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires

the participation of individual members in the lawsuit.'" *State ex rel. Am. Subcontractors Assn. v. Ohio State Univ.*, 129 Ohio St.3d 111, 2011-Ohio-2881, 950 N.E.2d 535, ¶ 12, quoting *Ohio Contractors Assn. v. Bicking*, 71 Ohio St.3d 318, 320, 643 N.E.2d 1088 (1994).

Here, all three trade associations' members include nursing facilities that have received – and, absent this Court's action, will continue to receive – quality incentive payments that are lower than the Budget Legislation requires under Revised Code section 5165.26. Accordingly, their members would have standing to sue in their own right. The interests the trade associations seek to protect in this lawsuit are also germane to their organizations' purposes, which include advocating for the interests of their member nursing facilities and the populations they serve. Finally, neither the claim asserted nor the relief requested in this lawsuit requires the participation of each individual member, given that ODM's error is in the calculation of the statewide "total amount to be spent on quality incentive payments." R.C. 5165.26(E).

2. The statute clearly requires ODM to take 60% of each nursing facility's "rate for direct care costs"—not 60% of each peer group's "price"—in calculating the "total amount to be spent on quality incentive payments."

There can be no doubt that Relators are entitled to the relief sought and that ODM has a legal duty to provide it. Unlike Ohio's Medicaid payments for other types of healthcare providers, Medicaid payments for Ohio nursing facilities are mandatory and spelled out in statute; it is not left to the discretion of ODM or to administrative regulation. ODM is statutorily required to calculate and provide nursing facility payments precisely as directed under Revised Code chapter 5165—including quality incentive payments under Revised Code section 5165.26. That section unambiguously mandates that "the department of medicaid **shall** determine each nursing facility's per medicaid day quality incentive payment rate as follows…." R.C. 5165.26(B) (emphasis added). "It is axiomatic that when it is used in a statute, the word 'shall' denotes that compliance with the

commands of that statute is *mandatory*." *Dept. of Liquor Control v. Sons of Italy Lodge 0917*, 65 Ohio St.3d 532, 534, 605 N.E.2d 368 (1992) (emphasis in original).

It is also important to note that in Ohio courts are not obliged to give any deference to an agency's interpretation of the law. As this Court recently confirmed, "it is the role of the judiciary, not administrative agencies, to make the ultimate determination about what the law means. Thus, the judicial branch is *never* required to defer to an agency's interpretation of the law." *TWISM Enters. v. State Bd. of Registration for Prof'l Eng'rs & Surveyors*, 2022-Ohio-4677, ¶ 3 (2022) (emphasis in original).

As to the statutory formula for calculating the "total amount to be spent on quality incentive payments," the Budget Legislation expressly requires ODM to take "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." R.C. 5165.26(E)(1)(a). Each nursing facility's **individualized** "rate for direct care costs" is determined under section 5165.19 by **multiplying** the facility's semiannual "case-mix score" by its peer group's "price" (*i.e.*, the peer group's "cost per case-mix unit"). There is simply no textual basis for ODM's erroneous conclusion that 60% of the change in the "rate for direct care costs" actually means 60% of the change in the "price."

ODM's error is further highlighted by its inconsistency. Despite the fact that the same term—"rate for direct care costs"—is used in both R.C. 5165.26(E)(1)(a) and Section 333.300 of the Budget Legislation, ODM is not giving that term the same meaning under each section. In calculating facilities' base rates under Section 333.300, ODM correctly included 40% of the change in the "rate for direct care costs"—*not* the change in the "price." Yet inexplicably, in calculating quality incentive rates under R.C. 5165.26(E)(1)(a), ODM incorrectly included 60%

of the change in "price" instead of the change in the "rate for direct care costs." As a result of this inconsistent and nonsensical interpretation, the increase in the quality incentive rate ended up being *less* than the increase in the base rate—directly contrary to what the General Assembly mandated.

The error in ODM's interpretation is also underscored by the fact that the "price" is a generalized number that applies to all nursing facilities in a given peer group. Section 5165.26, on the other hand, directs ODM to "[d]etermine for **each** nursing facility … sixty per cent of the per diem amount by which **the nursing facility's** rate for direct care costs … changed." R.C. 5165.26(E)(1). If the General Assembly intended that the calculation be applied to the peer group price (as ODM insists), it would not have needed to require ODM to perform separate calculations for every facility. Instead, it would have written the statute to perform the calculation using peer group prices (which would have required 3 calculations instead of 900+).

3. ODM's Response to Relators' Request for Rate Reconsideration confirms that the agency's approach is unsupported and internally inconsistent.

In its response to Relators' Request for Reconsideration, ODM lays out its rationale. The agency's argument begins on page 2 and comprises just two paragraphs. It contends:

> Pursuant to Ohio Revised Code, 5165.01(SS), rebasing for direct care costs is a redetermination of the peer group cost per case-mix unit, also known as the price. Rebasing is not a redetermination of the rate for an individual facility. Therefore, the change to the rate as a result of rebasing is a change to the price and 60% of the change in price is to be added to the quality pool of funds.
>
> Your reconsideration request focuses on the term, "rate," without consideration of the remainder of the sentence that focuses on the change as a result of rebasing. The plain language of the statute does not require the addition of 60% of the **funding generated by rebasing** to the quality pool of funds. Rather, as noted in division (E)(1)(a) above, the quality pool of funds includes sixty percent of the amount by which the nursing facility's rate for direct care costs

> changed **as a result of rebasing.** Had the General Assembly wanted 60% to apply to the funding generated by rebasing, it would have included that language in the statute. It did not. Instead, it required that 60% of the change in price be applied to the quality pool of funds.

Exhibit B (emphasis in original).

A point-by-point analysis of ODM's argument lays bare the agency's illogical and self-contradictory interpretation.

> *ODM: Pursuant to Ohio Revised Code, 5165.01(SS), rebasing for direct care costs is a redetermination of the peer group cost per case-mix unit, also known as the price. Rebasing is not a redetermination of the rate for an individual facility.*

The statute does indeed provide that "'Rebasing' means a redetermination of," among other things, "[e]ach peer group's cost per case-mix unit" (*i.e.,* a redetermination of the peer group's price). R.C. 5165.01(SS). This is irrelevant, however, because section 5165.26 does not refer to "rebasing" in the abstract; it expressly refers to the "amount by which the nursing facility's **rate for direct care costs** … **changed as a result of the rebasing**." R.C. 5165.26(E)(1)(a). Rebasing re-determines the price for each peer group, and the statute recognizes that each individual facility's "rate for direct care costs" changes ***as a result of*** that redetermination because each facility's "rate for direct care costs" is equal to the price multiplied by the facility's "case-mix score." R.C. 5165.19(A)(1). In other words, the "rate" for each facility in a peer group will **necessarily** change due to a rebasing-caused redetermination of the peer group's price.

> *ODM: Therefore, the change to the rate as a result of rebasing is a change to the price and 60% of the change in price is to be added to the quality pool of funds.*

This is incorrect. The change in the "rate" is the change in the "rate"—it is not the same thing as the change in the "price." The explicit statutory definitions make it crystal clear that an individual facility's "rate for direct care costs" is not the same thing as the "price" for that facility's peer

group. The Budget Legislation specifically requires ODM to use the change in an individual "nursing facility's rate for direct care costs" that results from rebasing—not merely the change in the overall peer group's "price" that results from rebasing. ODM is obviously aware of this distinction because it correctly used the change in each nursing facility's "rate for direct care costs" in calculating the base rates, but chose not to do so in calculating the quality incentive rates. There is nothing in the statute that would suggest that ODM should interpret this identical language differently in these two contexts.

> *ODM: Your reconsideration request focuses on the term, "rate," without consideration of the remainder of the sentence that focuses on the change as a result of rebasing. The plain language of the statute does not require the addition of 60% of the* ***funding generated by rebasing*** *to the quality pool of funds.*

The plain language of the statute does indeed require the addition of 60% of the funding generated by rebasing. The statute is clear as to what it requires. ODM must calculate for each nursing facility 60% of the amount "by which the nursing facility's rate for direct care costs changed … as a result of the rebasing." R.C. 5165.26(E)(1). The General Assembly correctly recognized that this "change" would inevitably be an **increase** in each facility's "rate for direct care costs," and it directed ODM to then sum together the facility-specific figure "for all nursing facilities." R.C. 5165.26(E)(2).

> *ODM: Rather, as noted in division (E)(l)(a) above, the quality pool of funds includes sixty percent of the amount by which the nursing facility's rate for direct care costs changed* ***as a result of rebasing****.*

Remarkably, this ODM sentence correctly states Relators' point: the pool of funds for quality incentive payments includes 60% of the amount by which each "nursing facility's rate for direct care costs changed"—not merely 60% of the amount by which **each peer group's price** changed—"as a result of rebasing."

> *ODM: Had the General Assembly wanted 60% to apply to the funding generated by rebasing, it would have included that language in the statute. It did not. Instead, it required that 60% of the change in price be applied to the quality pool of funds.*

This directly contradicts ODM's (correct) immediately preceding statement, that the General Assembly required ODM to take "sixty percent of the amount by which the nursing facility's **rate for direct care costs** changed as a result of rebasing"—not 60% of the change in **price**. Indeed, section 5165.26 **nowhere mentions price (or "cost per case-mix unit") at all**.

***

After making the above faulty statutory arguments, ODM's response to Relators' Rate Reconsideration Request concludes with several assertions that may shed light on why ODM is insisting upon such a clearly erroneous interpretation of the statute:

> *ODM: The funds appropriated from the General Assembly to the department align with the department's calculation. Specifically, the Legislative Budget Office (LBO) estimated the nursing home provisions would increase costs for Medicaid services by $627,600,000 in FY 2024 and $747.600,000 in FY 2025. The statutory language, when applied as the department did, produced this monetary result. The fiscal assessment by the LBO of the cost of the full nursing facility HB 33 budget package matches the result of a change in price. It does not match a change in the rate. The total expenditures estimated by the LBO were known to all parties during the budget process. No concerns were raised.*
>
> *Applying terms in the manner you have suggested would result in an expenditure of $285.6 million more per year than was authorized by the General Assembly.*

The implied reasoning here is faulty for several reasons.

First, there is no specific nursing facility allocation provided by the General Assembly. The General Assembly has allocated $36 billion to ODM, and it has allocated those funds on an agency-wide basis; there is no portion of that allocated amount that is specifically designated for a "nursing facility" budget (or for any other provider type or program within ODM).

Second, there is no cap on what amount of the overall ODM budget may be allocated to nursing facilities. The statute provides a mandatory methodology for determining the *rates* that

will be paid to nursing facilities, but not a floor or a limit to what ultimate *dollar amount* will be provided, which is obviously dependent upon numerous factors, such as the number of Medicaid residents served, the lengths of their stays, and the services provided to them. It is therefore curious that ODM purports to predict *precisely* how much it will exceed its projected budget—by $285.6 million—when there is no possible way of knowing how much ODM will actually end up spending on nursing facility care for Medicaid beneficiaries over the course of the fiscal biennium.

Third, there is likewise no possible way of knowing whether ODM will hit its *agency-wide* appropriation limit of $36 billion until the end of the fiscal biennium. While Ohio law does prohibit state agencies from *actually* spending more than is appropriated to them (*see* R.C. 131.33(A)), it does not authorize state agencies to refuse to make particular *statutorily mandated* expenditures at the beginning of a fiscal period simply because they project their overall appropriation may not cover all their anticipated spending (including discretionary spending) for the entire period. It is important to note that, while other parts of the Medicaid budget are discretionary, the calculation and payment of nursing facility reimbursement rates, including quality incentive payments, are mandatory and must be made as directed under Revised Code chapter 5165. *See* R.C. 5165.26(B).

Fourth, ODM's reference to budgetary projections provided by the Legislative Budget Office ("LBO")—which ODM insists are consistent with ODM's position—provides no support for ODM's contradictory interpretation of the statute. Based upon Relators' communications with the LBO, it is Relators' understanding that the LBO did not independently calculate the projections, and that the LBO's projections instead relied entirely on calculations *ODM* provided. ODM's invocation of the LBO's projections is thus nothing more than a tautology. And regardless, the LBO is not the General Assembly, and LBO projections are not the law. ODM was obligated to follow the clear text of the statute. It has refused to do so.

4. Ohio Courts Consistently Grant Mandamus Petitions Against Agencies that Fail to Execute Mandatory Expenditures.

This Court and the state's courts of appeals have consistently held that a government body cannot refuse to make a statutorily required expenditure simply because it may result in hardship to other, discretionary parts of its budget. This Court has expressly "refused to excuse a governmental body from fulfilling its mandatory duty based upon a claim of hardship." *State*, *ex rel. Durkin*, v. *Youngstown City Council*, 9 Ohio St.3d 132, 134 (1984); *see also State ex rel. Foster v. Bd. of County Commrs*., 16 Ohio St.2d 89, 91, 242 N.E.2d 884 (1968); *State, ex rel. Motter v. Atkinson*, 146 Ohio St. 11, 15, 63 N.E.2d 440 (1945). In *State ex rel. Moorehead, v. Reed*, 177 Ohio St. 4, 6, 201 N.E.2d 594 (1964), this Court held that required expenditures must be made even if "there are no unappropriated or unencumbered funds out of which the additional funds could be appropriated, and…to comply with…[the court's] request would work an undue hardship and burden on other offices and agencies." *Id.* at 6; accord, *State ex rel. Clarke v. Lawrence Cty. Bd. of Comm'rs*., 141 Ohio St. 16, 46 N.E.2d 410 (1943). In *State ex rel. Motter*, this Court rejected as a defense that there was not enough money to cover relator's request and at the same time keep open and operate other offices. 146 Ohio St. at 14. Courts of appeals have held likewise. *See, e.g., State ex rel. Cottrill v. Meigs Cty. Bd. of Mental Retardation & Dev. Disabilities*, 86 Ohio App.3d 596, 602-603, 621 N.E.2d 728 (4th Dist.1993), *State ex rel. Smith v. Culliver*, 186 Ohio App.3d 534, 2010-Ohio-339, 929 N.E.2d 465, ¶ 36 (5th Dist.), *State ex rel. Stacey v. Halverstadt*, 7th Dist. Columbiana No. 87-C-30, 1987 Ohio App. LEXIS 9295, at *6-10 (Oct. 23, 1987).

In *State ex rel. Cottrill*, the Fourth District considered an appeal of a writ of mandamus ordering the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD, now Department of Developmental Disabilities) to provide certain statutorily mandated funding to the Meigs County Board of Mental Retardation and Developmental Disabilities (MRDD). Like

ODM in this case, ODMRDD argued that it should not be compelled to provide the funding because it would be "impossible," given its other budget constraints. The court rejected ODMRDD's argument, explaining that, "although there are other programs on which ODMRDD might prefer to spend those funds, that spending is discretionary but the programs MRDD sought funds for were mandated programs." *Id.* at 603. The court continued:

> We note here, parenthetically, that the legislature does a lot more mandating than it does appropriating. This court does not fault ODMRDD, or the Meigs County MRDD, and recognizes that each agency is trying to do the best it can under the current appropriation. In a similar vein, this court can only do what it can under the current state of the law. We further recognize that our decision here will not resolve the underlying problem and that an ultimate resolution awaits legislative action. Nonetheless, we must apply the law as it is now.

Id.

The same reasoning applies here. To the extent ODM believes that performing the quality incentive calculation pursuant to the unambiguous language of the Budget Legislation will cause its overall appropriation for the 2024-2025 fiscal period to be insufficient to cover all its mandatory and discretionary expenses (a conclusion which, at this point, is speculative at best), it has several available recourses under Ohio law. If a state agency runs out of money (appropriations) for a particular program, it may either stop any spending for that program (if the program is discretionary), it may exercise one of the existing statutory options through the Controlling Board (which are more flexible for Medicaid because of the state's Health and Human Services Reserve Fund), or it may request a supplemental appropriation from the General Assembly. What ODM *cannot* do, however, is simply refuse to make a statutorily required expenditure—or rewrite a statute to accommodate its policy views and budgetary objectives.

C. Relators Lack an Adequate Remedy in the Ordinary Course of the Law.

Relators have exhausted their administrative remedies by filing a rate reconsideration request pursuant to Revised Code section 5165.38 and Administrative Code section 5160-3-24. Relators' Rate Reconsideration Request was denied. Relators do not have any further administrative remedy or remedy at law pursuant to division (B) of Administrative Code section 5160-3-24, which provides:

> ODM's decision at the conclusion of the rate reconsideration process is final and shall not be subject to any administrative proceedings under Chapter 119 or any other provision of the Revised Code or Administrative Code.

This Court has expressly held that, "when nursing homes and their trade association seek to challenge a state agency's denial of requests for reconsideration of Medicaid reimbursement rates…the exclusive avenue of relief available to the nursing homes is to pursue a writ of mandamus." *Ohio Academy of Nursing Homes v. Ohio Dept. of Job & Family Servs.*, 114 Ohio St.3d 14, 2007-Ohio-2620, 867 N.E.2d 400, ¶ 1. This is especially true where, as here, mandatory relief is necessary to compel ODM to affirmatively calculate the total amount to be spent on quality incentive payments as required by statute. *See State ex rel. Arnett v. Winemiller*, 80 Ohio St.3d 255, 259, 685 N.E.2d 1219 (1997). Accordingly, Relators' only avenue to compel ODM to comply with its statutory duties in calculating the quality incentive payment rates is to seek mandamus relief from this Court.

CONCLUSION

The statutory language at issue is unambiguous. It requires ODM to use 60% of each nursing facility's "rate for direct care costs"—not 60% of each peer group's "price"—in calculating the "total amount to be spent on quality incentive payments." ODM's failure to apply the language of the Budget Legislation as written has resulted in fewer dollars going to quality

incentive payments than the legislature required. It has also resulted in more of the increase in funding from rebasing going toward the base rate than toward the quality incentive rate—the opposite of what the legislature intended and mandated. ODM is not entitled to rewrite the statute to accommodate its own funding preferences—especially when it would cause such profound consequences, and when the statute is so unmistakably clear.

For these reasons, Relators respectfully request that this Court issue a writ of mandamus ordering ODM to calculate and pay quality incentive reimbursement rates as required pursuant to the plain, unambiguous language of Revised Code section 5165.26 as amended by the Budget Legislation, and specifically to use the "rate for direct care costs," rather than the "price," in performing the calculation under division (E)(1)(a) of section 5165.26.

Respectfully submitted,

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