

**Unified Long-Term Care System Advisory Group
NURSING FACILITY REIMBURSEMENT SUBCOMMITTEE**

**REPORT TO THE OHIO GENERAL ASSEMBLY
December 21, 2012**

Background

House Bill 153 of the 129th Ohio General Assembly re-established a Unified Long-Term Care System Advisory Workgroup and in Section 209.50 instructed the Workgroup to convene a subcommittee to “...study Medicaid reimbursement for nursing facility services, including issues related to the composition of peer groups, methodologies used to calculate reimbursement for capital costs, and the proportion of the total nursing facility reimbursement rate that should be based on the quality of care nursing facilities provide.” Section 209.50 also instructed the subcommittee to “...complete a report of its study not later than December 31, 2012.” This is the Nursing Facility Reimbursement Subcommittee’s report to the Ohio General Assembly.

Membership

- John Alfano, LeadingAge Ohio
- Bob Applebaum, Scripps Gerontology Center
- Linda Black-Kurek, provider representative for the Ohio Health Care Association
- Mary Butler, Ohio Statewide Independent Living Council
- Jim Griffiths, provider representative for the Ohio Academy of Senior Health Services
- Bonnie Kantor-Burman, Ohio Department of Aging
- Beverley Laubert, State of Ohio Long Term Care Ombudsman
- John McCarthy, Ohio Office of Medical Assistance (Medicaid)
- Will McHugh, Ohio Department of Health
- Greg Moody, Governor’s Office of Health Transformation (Chair)
- Chris Murray, The Academy of Senior Health Sciences, Inc.
- John Spieler, provider representative for LeadingAge Ohio
- Bill Sundermeyer, AARP Ohio
- Pete VanRunkle, Ohio Health Care Association
- The Honorable Barbara Sears, Ohio House of Representatives
- The Honorable Nickie Antonio, Ohio House of Representatives
- The Honorable David Burke, Ohio Senate
- The Honorable Capri Cafaro, Ohio Senate

Meeting Schedule

- July 13, 2012 – Nursing Facility Reimbursement Subcommittee
- August 14, 2012 – Nursing Facility Reimbursement Subcommittee
- September 13, 2012 – Nursing Facility Reimbursement Subcommittee
- October 4, 2012 – Nursing Facility Reimbursement Subcommittee
- October 16, 2012 – Nursing Facility Quality Measures Subcommittee
- November 15, 2012 – Unified Long Term Care System Advisory Workgroup
- December 12, 2012 – Nursing Facility Reimbursement Subcommittee

Process

The Nursing Facility Reimbursement Subcommittee (A) identified guiding principles for payment innovation, (B) reviewed recent payment changes that impact nursing facilities, (C) made recommendations for additional Medicaid fee-for-service reimbursement reforms, (D) reviewed other Kasich Administration initiatives that support payment innovation and (E) reported findings and recommendations to the Ohio General Assembly.

A. Guiding Principles for Payment Innovation

The Nursing Facility Reimbursement Subcommittee used the following principles and practical considerations to guide its work and the recommendations in this report.

Guiding Principles from the Governor's Office of Health Transformation:

- Individuals will receive person-centered care through a delivery system designed to address all of the individual's physical health, behavioral health, long-term care, and social needs.
- Individuals will have access to the services they need in the setting they choose.
- The delivery system will be easy to navigate both for the individuals receiving services and for the providers delivering the services.
- Individuals will be able to transition seamlessly among settings and programs as their needs change.
- Incentives in the system will be focused on performance outcomes related to better health, better care, and lower costs through improvement.

Any system that links nursing facility payment to better outcomes for residents needs to be:

- Resident focused/consumer driven.
- Objective/easy to validate.
- Evidence-based/correlated to quality/ideally used by multiple valid sources.
- Advantageous for residents and operators.
- Low cost to implement/easy to collect.

B. Recent Payment Changes that Impact Nursing Facilities

Governor Kasich's first budget (HB 153) enacted several significant reimbursement reforms related to nursing facilities, described below. The Administration's goal is to achieve better health, better care and reduce costs, and create incentives to continuously improve service features and characteristics to meet or exceed customer needs and expectations for quality.

Convert Medicaid Nursing Facility Reimbursement to a Price-Based System

HB 153 completed the transition from a cost-based Medicaid payment system for nursing facilities to a price based system, a change that was initiated by the legislature in 2005 (HB 66) to reward efficiency. The final budget reduced nursing facility rates 5.8 percent on average in 2012 and is estimated to save Ohio taxpayers \$360 million over two years. A summary of the current nursing facility reimbursement methodology is attached (Appendix A).

Payments for Low Acuity Individuals

HB 153 modified the method to calculate payments for services provided to the lowest acuity individuals in Ohio's nursing facilities. Instead of using facility specific rates, all nursing facilities are paid \$130 per day for each of these individuals. This both better connects reimbursement to the services needed by these individuals and incents discharge planning to community settings.

Link Nursing Facility Reimbursement to Quality Outcomes

HB 153 also linked more of the Medicaid payment to direct care for residents and quality. It increased Medicaid quality incentive payments for nursing facilities from 1.7 percent of the average Medicaid nursing facility rate in 2011 to 9.7 percent in 2013. A Nursing Facility Quality Measurement Subcommittee was created and achieved consensus recommendations on 20 specific accountability measures enacted by the General Assembly in December 2011. The Subcommittee also recommended and the legislature enacted a method for calculating quality incentive payments. The goal was to create a system that rewards performance on specific quality measures and gives all facilities a fair opportunity to earn the full incentive payment.

Integrate Care Delivery for Medicare-Medicaid Enrollees

HB 153 authorized Ohio Medicaid to seek approval through the federal Center for Medicare and Medicaid Integration (CMMI) to design and implement a Medicare-Medicaid Integrated Care Delivery System (ICDS). The goal of the ICDS program is to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid enrollees, including long-term services and supports.

Currently Medicaid and Medicare are managed with almost no connection and services are poorly coordinated. The result is a diminished quality of care, which is reflected in high costs to the Medicaid system and to taxpayers. Ohio's ICDS program will convert separate Medicaid and

Medicare fee-for-service programs into an integrated managed care program for Medicare-Medicaid enrollees in seven regions of the state. Under ICDS, nursing facilities and other health care providers will contract with health plans to provide long-term services and supports to participating Medicare-Medicaid enrollees.

CMMI approved Ohio's ICDS program on December 12, 2012 and program implementation is underway. Ohioans will begin enrolling in the new program September 1, 2013.

C. Recommendations for Additional Fee-for-Service Payment Changes

The Nursing Facility Reimbursement Subcommittee recommends a period of adjustment for HB 153 reforms to stabilize, and cautions against significant additional disruptions to the system in the next budget. However, there are some modest adjustments to the current Medicaid nursing facility fee-for-service reimbursement system that the Subcommittee recommends to improve system performance, described below and summarized in Appendix B.

Recommendation 1: Update the quality incentive rate component

The Subcommittee recommends three changes in the nursing facility quality incentive payment program. First, the Subcommittee recommends increasing the level of attainment for some of the existing 20 accountability measures, replacing others, and leaving some the same (see Appendix C). The revised measures, which would go into effect in fiscal year 2015, represent a strategy of continuous improvement.

Second, the Subcommittee recommends that at least one of the quality points a nursing facility uses to claim its full incentive payment must be a clinical measure. And third, the Subcommittee agreed that certain special focus facilities should not be eligible for quality points related to the certification surveys conducted by the Ohio Department of Health.

Otherwise, the Subcommittee recommends keeping the existing quality incentive payment program intact.

Recommendation 2: Prioritize post-acute rehabilitation at home or in nursing facilities

Some nursing facilities have the capacity to serve a population that is often served in more expensive rehabilitation hospitals and long term acute care hospitals (LTACHs). This includes some individuals with traumatic brain injury, some individuals on ventilators who could be weaned off them, and some individuals in need of intensive rehabilitation services.

Today the average Medicaid payment for individuals served in LTACHs and rehabilitation hospitals is approximately \$1,388 per patient day. Medicaid currently purchases approximately 1,500 discharges with an average length of stay of approximately 29 days in these settings. A January 2010 Permedion analysis of post-acute recovery services for Ohio Medicaid beneficiaries shows that 63% of patients in LTACHs and 70% of patients in rehabilitation

hospitals did not require daily physician visits, but instead could have been seen a physician every 5 to 6 days, which is more in line with nursing facility requirements. This same analysis indicated that of the patients who received rehabilitation, 12% of LTACH, 47% of rehabilitation hospital, and 32% of nursing facility patients could have benefited from high-intensity rehabilitation but did not receive it. This demonstrates the need to link expected outcomes to payment in each of these settings.

The Subcommittee recommends Medicaid payment changes that prioritize post-acute rehabilitation at home or in nursing facilities, not hospitals, when appropriate based on individual health care needs. This could include creating a specialty nursing facility service in Ohio for individuals otherwise served in LTACHs and rehabilitation hospitals, and developing ventilator weaning programs.

Recommendation 3: Enhance community mental health benefits

The Subcommittee recommends addressing specific challenges that exist when an individual with mental illness under age 60 is living in a nursing facility but his or her clinical needs could actually be met in a less restrictive, more community-based environment.

Currently, Ohio Medicaid spends approximately \$102,500 per year for Medicaid services for an individual under age 60 who is reasonably physically healthy, has a diagnosis related to severe and persistent mental illness, and is identified as having a long term placement in a nursing facility. Many of these individuals could be served in less restrictive, clinically appropriate settings at lower taxpayer expense. Data analysis by Ohio Medicaid and the Ohio Department of Mental Health of 400 successful Home Choice placements in FY 2011 found that the average cost avoidance of moving one of these individuals into a community based setting was approximately \$35,250 per year. By proactively shifting funds to community based services, the state can accumulate long-term savings through cost avoidance related to the transition.

Strategies to enhance community mental health benefits as an alternative to nursing facilities must address the “front door” by making administrative changes to the way Pre-Admission Screening and Resident Review (PASRR) is handled to identify eligible individuals and assist with discharge planning, and enhancing community options by extending HOME Choice and converting Medicaid institutional savings into community mental health supports.

Recommendation 4: Convert veterans who reside in nursing facilities to federal benefits

Many low-income U.S. military veterans and their families rely on Medicaid and may not realize they are eligible for comprehensive federal health care and benefit programs that provide better benefits while preserving their homes and financial assets. The Subcommittee recommends connecting Medicaid recipients with their federal veterans’ benefits using available federal and state data from the Public Assistance Reporting Information System (PARIS). Ohio Medicaid saves money every time a veteran who currently receives Medicaid services (36% of which is paid by Ohio) converts to veterans services (100% of which is paid by

the federal government). The first priority should be to convert veterans living in nursing facilities to federal benefits without uprooting them from their current residence. Over time, the system needs to be streamlined so veterans are more easily matched to the services they earned and qualified providers are promptly approved to provide those services and benefits.

Recommendation 5: Consider some modifications in the base rate methodology

For the purposes of discussion, the Subcommittee assumed that rates would be flat in the next budget. From that position, the Subcommittee agreed that the following reimbursement changes would be warranted.

- 5A. Update peer groups so that at least two counties, Stark and Mahoning, are moved from peer group three to peer group two without impacting current rates of providers in other counties. The goal is to better align provider rates in Stark and Mahoning counties with the business environment and costs impacting their operations.
- 5B. Shift the determination of the facility specific leave day pricing percentage from calendar year to state fiscal year to avoid having to make retroactive rate adjustments.
- 5C. Continue the rate add-on for critical access nursing facilities. HB 153 enacted a 5% rate boost to nursing facilities in federally designated empowerment zones so long as they meet both minimum occupancy requirements and minimum Medicaid utilization requirements. The Subcommittee recommends requiring that a qualifying facility earn the maximum quality incentive payment and achieve one quality point related to a clinical measure to receive the critical access rate add-on.

Recommendation 6: If resources allow, consider some targeted investments

Despite assuming that nursing facility reimbursement rates would be flat in the next budget, the Subcommittee created a list of targeted investments that, if resources allow, merit consideration. The Subcommittee did not prioritize or rank these options.

- 6A. Consider additional funding for the quality bonus payment program established in current statute.
- 6B. The Subcommittee agreed that the current capital component of the rate could be modified to create incentives for smaller homes, renovations, and bed forfeiture in over-capacity areas.
- 6C. Identify a funding source to include nursing facilities among the providers that are qualified to receive Medicaid meaningful use payments for adopting electronic medical records (currently this is not an option under the federal program).

- 6D. Develop an alternative rate structure for certain nursing facilities that “specialize” in care for specific diagnoses or conditions. In some cases, providing this service in a nursing facility may result in Medicaid savings compared to another setting (see Recommendation 2).
- 6E. Support payment innovation pilot projects that change reimbursement to reward the value of services and care coordination across care settings.

D. Other Related Initiatives

In addition to reimbursement, the Subcommittee recommends the state align other policy levers to ensure that Ohioans have access to the long term services and supports they need in the settings they choose. These strategies include regulatory and programmatic incentives to provide better care while also reducing costs.

Recommendation 7: Participate in the Federal Balancing Incentive Payments Program

The Subcommittee recommends that Ohio participate in the federal Balancing Incentive Payments Program (BIPP), which offers states enhanced federal matching funds for Medicaid services if the state commits to a 50/50 balance in spending on institutional and home- and community-based services by 2015. To receive enhanced federal match, Ohio also must agree to implement a “no wrong door” approach to accessing long-term services and supports, implement “conflict free” case management in its long-term services and supports programs, and ensure a consistent data set is used to assess individuals who access those services. There are some administrative costs to implement a front door policy, but the enhanced match is available immediately, and the potential net savings to the state exceeds \$50 million annually.

Recommendation 8: Clarify definitions for specialized facilities

The Subcommittee recommends the Ohio Department of Aging (ODA) update the Ohio Long-Term Care (LTC) Consumer Guide to be more accurate in its description of specialized facilities. Currently there are no requirements for nursing facilities that self-identify as “specializing” in care for specific diagnoses or conditions. ODA should define the services featured in the LTC Consumer Guide and create an online attestation for facility’s that claim a specialization.

Recommendation 9: Ensure core competencies in the direct care workforce

Currently, no standardized certification program exists for direct care workers providing care in the homes and residences of consumers receiving home- and community-based services (HCBS) reimbursed by Medicaid. While many of these workers are employed by agencies, many others provide these services as independent providers. These services are provided across all the aging and disability Medicaid waiver programs and in home health state plan services. Given the anticipated increasing demand for home- and community-based services, it is important to

assure that direct care workers have the core competencies necessary to provide these services inside the home of Ohio's seniors and people with disabilities.

The Subcommittee recommends the Administration explore options for assuring the quality of direct care services in consumers' homes and residences.

Recommendation 10: Modernize the Board of Nursing Home Administrators

The Ohio Board of Examiners of Nursing Home Administrators (BENHA) was created in response to the federal mandate that established licensure of nursing home administrators through state licensing authority. The structure and role of BENHA have changed little over the last 42 years, despite dramatic change in how long term services and supports are provided. Services and care are now provided in many different settings throughout the community. The emphasis of the administrator has shifted from a facility focus to enhancing quality of care and quality of life for individuals through person-centered care and caring.

BENHA is in a position to directly support and enhance a complete continuum of care and caring. The Administration should expand the Board's scope and authority so it can provide education, training, credentialing and, if directed to do so by the Ohio General Assembly, licensure opportunities for administrators and others in leadership positions who practice in all long-term services and supports settings.

Recommendation 11: Modernize eligibility systems

Delays in financial eligibility determinations remain an area of concern for nursing facility administrators and the Administration. The Subcommittee recommends and the Administration is open to consider near-term remedies for these delays, but the ultimate goal is to simplify and automate eligibility determination in a way that allows county agencies to have more time to spend on the difficult cases, including nursing facility patient liability cases.

Recommendation 12: Consider additional regulatory relief

The Subcommittee recommends that the Administration constantly seek opportunities for regulatory relief so long as it does not diminish the quality of long term services and supports or consumer access to those services. Throughout the Subcommittee process, individual organizations brought forward recommendations with merit. The Administration is keeping a running list of these additional reforms, much as it did during consideration of HB 153, which in that case led to the enactment of 16 significant items of common sense regulatory relief. A similar process should be followed in the state's next budget.

In addition, the Subcommittee reached consensus on the following recommendations except that The Academy of Senior Health Sciences, Inc., withheld its support for Recommendation 13 (strengthen the survey process) and Recommendation 14 (update license requirements).

Recommendation 13: Strengthen the survey process through plans of correction

The Subcommittee recommends clarifying existing requirements for plans of correction to ensure alignment with current federal requirements and emphasize the need to focus on the reason for the failure to provide quality services. The Subcommittee believes that plans of correction for all deficiencies that resulted in harm to individuals or immediate jeopardy should be detailed and focus on an examination of the underlying cause(s) of the poor quality care. The Ohio Department of Health, which oversees plans of correction, proposes to consult within existing time frames with the Ohio Department of Aging, the State of Ohio Long-term Care Ombudsman, and Ohio Medicaid when it reviews plans of correction for deficiencies where harm to residents occurred or an immediate jeopardy resulted. These agencies would coordinate existing resources to improve quality once deficiencies have been identified, shifting the focus of the survey process toward more responsive regulation that encompasses both deterrence and compliance.

Recommendation 14: Update nursing facility licensure requirements

Currently, there are no requirements within state nursing facility licensure to improve quality. The Subcommittee recommends requiring nursing facilities to demonstrate they are engaged in at least one quality improvement project during licensure inspections. Also, as most nursing facilities meet specific accountability measures (e.g., the measures relating to advance care planning and overhead paging), the Administration proposes to move those measures out of the quality payment system and to develop and implement licensure requirements on those issues effective in state fiscal year 2016.

E. Forward Recommendations

The Nursing Facility Reimbursement Subcommittee drafted legislative language (attached) that includes specific accountability measures to be used in awarding points for quality incentive payments and the methodology for calculating quality incentive payments. Otherwise, the Subcommittee's recommendations are contained in this report.

As general recommendations, this report represents the consensus of the membership of the Nursing Facility Reimbursement Subcommittee; however, each member of the group reserves the right to refine its position and possibly oppose a recommendation if subsequent implementation details are not what they had in mind when consensus was achieved. Each member also reserves the right to advance other proposals in the budget process.

This report was submitted to the Ohio General Assembly on December 21, 2012 and, upon submission, all Subcommittee activities concluded.

Calculating a Nursing Facility Rate

Nursing Facility Reimbursement Work
Group

August 14, 2012

5 Rate Components

- Direct Care
- Ancillary and Support
- Capital
- Quality Incentive Payment
- Taxes

Pricing System Concepts

- Direct Care, Ancillary and Support and Capital are reimbursed using peer group prices established using base year cost reports
- Currently the base year cost report is calendar year 2003.
- Rebasing is required at least once every 10 years – FY2017 is the latest fiscal year for rebasing

Peer Groups

- 3 Direct Care Peer Groups based on similar direct care cost experience
- Further Subdivided into Large and Small groups for the Ancillary and Support cost center and the Capital cost center

Direct Care Costs

- Nursing Staff Costs
- Purchased Nursing
- Medical Supplies
- Oxygen
- Wheelchairs
- Resident Transportation
- Therapies
- Nurse Aide Training

Determining The Direct Care Price

- Calculate the “cost per case mix unit” (CPCMU) by dividing the facility’s base year direct care cost per diem by the facility’s base year annual case mix score for all residents, regardless of payer.

The cost per case mix unit represents the cost of a unit of care.

Determining The Direct Care Price, cont.

- The base price is the CPCMU of the provider at the 25th percentile plus 2%.
- Increase the base price by \$1.88 to reflect the consolidated services not included in direct care on the 2003 cost report.
- Apply price growth (currently 5.08%) authorized by the General Assembly.

Calculating The Direct Care Rate

- Multiply the peer group's direct care price by the facility's Medicaid case mix score from the two calendar quarters preceding the rate period.
- Case mix adjustments are made effective July 1 (using the quarters ended December and March) and January 1 (using the quarters ended June and September)

Ancillary and Support Costs

- Dietary Costs
- Medical Records
- Activities, Habilitation and Supplies
- Utilities
- Administrative and General Services
- Maintenance
- Minor Equipment

Determining The Ancillary and Support Price

- Determine the ancillary and support per diem for each facility in the peer group using the base year cost report. The per diem is calculated using the greater of inpatient days or 95% of bed days available.
- The ancillary and support price is the ancillary and support per diem of the provider in the peer group at the 25th per diem.
- Apply price growth (currently 5.08%) authorized by the General Assembly.

Calculating The Ancillary and Support Rate

- Each provider's Ancillary and Support Rate is equal to the Ancillary and Support Price for the provider's peer group.

Capital Costs

- Depreciation
- Lease Expense
- Interest

Determining The Capital Price

- Determine the capital per diem for each facility in the peer group using the base year cost report. The per diem is calculated using bed days available.
- The capital price is the capital per diem of the provider in the peer group at the 25th per diem.
- Apply price growth (currently 5.08%) authorized by the General Assembly.

Calculating The Capital Rate

- Each provider's Capital Rate is equal to the Capital Price for the provider's peer group.

Calculating The Quality Incentive Payment

- 20 possible measures – set at baseline in first year
- Measures from satisfaction survey, ODH survey, cost report, Advancing Excellence and Medicaid quality survey tool
- Each measure is worth \$3.29 per Medicaid day
- Maximum payment of \$16.44

Calculating The Tax Rate Component

- Each provider has a tax rate component based on tax expense reported on base year cost report.
- Includes property tax, corporate franchise tax and income tax
- Apply price growth (currently 5.08%) authorized by the General Assembly.

Critical Access Nursing Facility Rate Add On

- Qualifying facilities are:
 - ✓ In a federally designated empowerment zone as defined on December 31, 2011
 - ✓ Occupancy rate of at least 85%
 - ✓ Medicaid utilization rate of 65%
- Qualifying facilities receive 5% rate add-on.

Quality Bonus Payment

- If all facilities do not receive maximum quality incentive payment in their rate, a bonus pool is created
- Bonus pool is distributed to providers after the end of the fiscal year based on number of points greater than 5 earned by the facility and number of Medicaid days

PA1 and PA2 Reimbursement

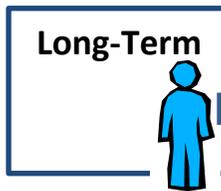
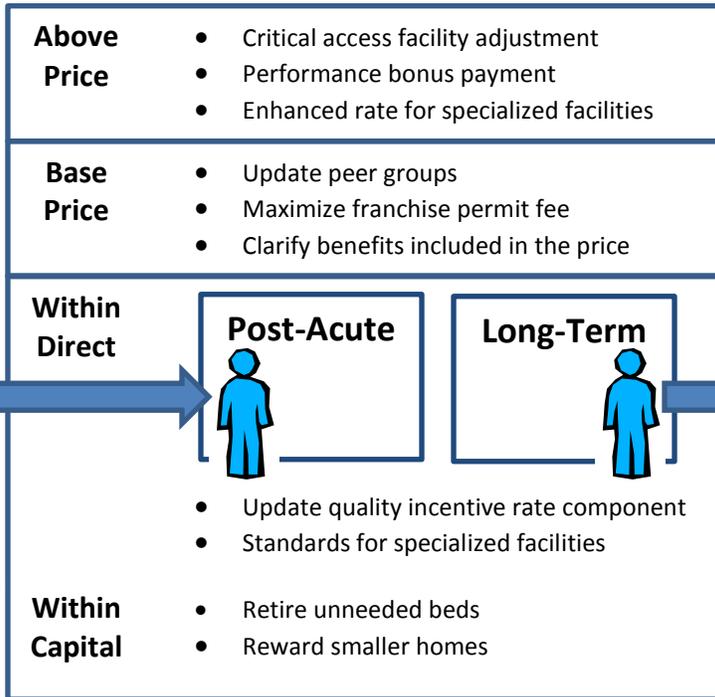
- Residents in two lowest acuity groups are reimbursed at a flat rate of \$130 per Medicaid day

Appendix B

Framework for Considering Medicaid Nursing Facility Payment Innovations

Nursing Facility FFS Reimbursement System

- Simplify the “Front Door”
- Improve care coordination
- Regulatory Reform



- Prioritize post-acute rehabilitation at home or in nursing facilities, not hospitals

- Enhance community mental health benefits as an alternative to nursing homes
- Convert veterans to federal VA benefits

Appendix C: Proposed Quality Measures

December 14, 2012

#	Definition of Measure	Method to Calculate	Sources	Discussion
<i>Framework</i>				
1	To receive a point, a facility must achieve an overall satisfaction score of at least 87.5 on Ohio’s Resident Satisfaction Survey (for rates paid in odd fiscal years) or an overall satisfaction score of at least 88 (update number to be median when current survey results are available) on Ohio’s Family Satisfaction Survey (for rates paid in even fiscal years).	<p>The point will be awarded on the basis of the facility specific results on the Satisfaction Survey initiated in the calendar year preceding the fiscal year for which the rate will be paid.</p> <p>The Resident Satisfaction Survey is used for rates paid for odd fiscal years and the Family Satisfaction Survey is used for rates paid for even fiscal years.</p> <p>If a facility does not have statistically valid survey results, no point will be awarded.</p>	Scores reported by the Ohio Department of Aging	This measure has been updated to reflect the statewide median.
2	To receive a point, a facility will enroll in the “Advancing Excellence in America’s Nursing Homes” campaign and select at least 3 goals. One goal must be clinical and one goal must be organizational.	The point will be awarded if the facility satisfied the requirements for participation in the “Advancing Excellence in America’s Nursing Homes” campaign during the calendar year preceding the fiscal year for which the rate will be paid.	Pull data from Advancing Excellence website	Participation will be defined by “Advancing Excellence in America’s Nursing Homes” at the time the measure is applied.
3	To receive a point, a facility will have no certification deficiencies with a scope and severity rating greater than “F” on the standard survey and any complaint surveys and have no citations for substandard quality of care during the calendar year preceding the fiscal year for which the rate will be paid.	<p>If no survey of a facility is conducted during the calendar year preceding the fiscal year, the most recent survey conducted will be used.</p> <p>F-tags indicating a substandard quality of care are F221-F226,</p>	ODH survey results	<p>Facilities that fail to improve should not be rewarded for quality.</p> <p>Not Improved: Nursing homes that have failed to show significant improvement despite having</p>

Appendix C: Proposed Quality Measures

December 14, 2012

	Homes designated by CMS as Special Focus Facilities with no improvement in 18 months are not eligible for this measure.	F240-F258, and F309 through F334.		had the opportunity to show improvement in at least one survey after being named as a SFF nursing home.
<i>Choice</i>				
4	To receive a point, at least 50% of residents must be offered at least one of the following dining choices for at least two meals each day: a) restaurant style where staff take resident orders, b) buffet style where residents help themselves or tell staff what they want, c) family style where food is served in bowls on dining tables or staff assist them, d) open dining where meal is available for at least a 2 hour period where residents can come when they choose, or e) 24 hour dining where residents can order meals from the facility 24 hours a day.	The point will be awarded to providers who indicate on a data collection tool that at least 50% of their residents are offered choice of meals (as defined). The facility must maintain a written policy regarding choice of meals. The policy must specify the ways in which choice of meals is offered. The policy must be communicated to staff and residents.	Web based data collection tool	Measure was strengthened to ensure continuous quality improvement and resident choice.
5	To receive a point, at least 50% of residents in the facility must be able to get a bath/shower when they choose.	The point will be awarded to providers who indicate on a data collection tool that at least 50% of their residents are able to take a bath or shower when they choose. The facility must maintain a written policy stating that residents are able to take a bath or shower when they choose. The policy must be communicated to staff and residents.	Web based data collection tool	Measure was strengthened to ensure continuous quality improvement and resident choice.

Appendix C: Proposed Quality Measures

December 14, 2012

6	<p>To receive a point, a facility must achieve a score of at least 89 for the question “Can you go to bed when you like” and a score of at least 76 for the question “Can you decide when to get up in the morning?” on the resident satisfaction survey. (for rates paid for odd fiscal years)</p> <p>To receive a point a facility must achieve a score of at least 88 for the question “Can the resident go to bed when he/she likes?” on the family satisfaction survey and a score of at least 75 for a question regarding the resident’s ability to get up when they choose on the family satisfaction survey. (for rates paid for even fiscal years)</p>	<p>In order to achieve the point, the facility must meet or exceed the threshold for both bedtime and waking time.</p> <p>The point will be awarded on the basis of the facility specific results on the Satisfaction Survey initiated in the calendar year preceding the fiscal year for which the rate will be paid.</p> <p>If a facility does not have statistically valid survey results, no point will be awarded.</p>	Resident/Family Satisfaction Survey	This measure has not been changed.
7	<p>To receive the point, the facility must demonstrate that at least 75% of residents will have the opportunity to discuss their goals for care including their preferences for advance care planning with an appropriate member of the healthcare team following admission and prior to completing or updating the plan of care quarterly, and that those preferences are recorded in their medical record and used in the development of their plan of care.</p>	<p>The point will be awarded to facilities that indicate on a data collection tool that at least 75% of residents have an opportunity to participate in advance care planning.</p> <p>The facility must maintain a policy encouraging advance care planning, the policy must be communicated to staff and residents, and resident records must include documentation of advance care planning activities.</p>	Web based data collection tool	This measure has not been changed.
<i>Clinical</i>				
8	<p>To receive a point, not more than the median (13.35%) of the facility's long-stay residents may</p>	Use NQF measure 677	MDS data	This measure has not been changed.

Appendix C: Proposed Quality Measures

December 14, 2012

	report severe to moderate pain during the MDS assessment process.			
9	To receive a point no more than 5.16% of the facility's long stay, high risk residents have been assessed as having one or more stage 2-4 pressure ulcers on their MDS.	Use NQF measure 679	MDS data	Standard was strengthened to ensure continuous quality improvement.
10	To receive a point, no more than 1.52% of long stay residents in a facility were physically restrained as reported on MDS assessments.	Use NQF measure 677	MDS data	This measure has not been changed.
11	To receive a point, the facility must have fewer than 7% of long stay residents with a urinary tract infection reported on the MDS assessments.	Use NQF measure 684	MDS data	Measure was strengthened to ensure continuous quality improvement.
12	To receive a point, the facility must document resident hospital admissions on a monthly level for all residents.	The facility does all of the following: <ul style="list-style-type: none"> • uses a tool for tracking residents' admissions to hospitals • identifies the tools used to track hospital admissions • reports hospital admission data for all residents served for each month of the calendar year to the office of medical assistance. 	Web based data collection tool and will be collected annually on a monthly level.	Increased data collection will provide data on hospitalizations that will allow for benchmarks and standards to be established.
13	To receive a point, at least 95% of long stay residents must be assessed and appropriately given pneumococcal vaccine and at least 93% of long stay residents are assessed and appropriately given the seasonal flu vaccine.	pneumococcal vaccine: NQF measure 681 (long stay) seasonal flu vaccine: NQF 683 (long stay)	MDS data	Connects to high cost avoidable hospitalizations.
<i>Environment</i>				
14	To receive a point, at least 50% on average, of Medicaid certified beds were in private or semi-	Using facility reported data, calculate the number of	Web based data collection tool	A semi-private room with innovations in privacy is a

Appendix C: Proposed Quality Measures

December 14, 2012

	private rooms with innovations in privacy.	Medicaid certified beds in private or semi-private rooms with innovations in privacy on the first day of each month of the calendar year preceding the fiscal year for which the rate will be paid and on the last day of the fiscal year for which the rate will be paid. Average the percentages for the calendar year.		<p>semi private room where each resident has his own distinct territory and window separated from the living space of his roommate by a substantial wall and does not have to cross his roommates living space to reach his own space. A curtain or other screen can be drawn for complete visual privacy.</p> <p>A substantial wall is a permanent structure reaching from floor to ceiling.</p>
15	To receive a point, a facility must turn off any overhead paging systems or limit use of such systems to emergencies.	The facility must maintain a written policy that eliminates overhead paging or limits the use of overhead paging to emergencies. If the policy limits the use of overhead paging to emergencies, the policy must clearly define an emergency. If overhead paging is turned off, the alternative must be defined in the policy. The policy must be communicated to staff and residents.	Web based data collection tool	This measure has not been changed.
16	To receive a point, the facility must achieve a 95% compliance rate with the requirements for requesting resident reviews for individuals admitted through the hospital exemption who	The facility must annually report the data demonstrating compliance.	Web based data collection tool	Ensure individuals are receiving care in the most appropriate setting.

Appendix C: Proposed Quality Measures

December 14, 2012

	remain in the facility upon expiration of the hospital exemption and annually report data demonstrating compliance to the office of medical assistance.			
<i>Staffing</i>				
17	To receive a point, the facility must maintain a written policy requiring consistent assignment of STNAs and communicate this policy with staff, residents and the families of residents. The policy must be communicated to residents, families and staff and must specify a goal limiting the number of STNAs that provide care to a long term resident to no more than 12 STNAs over a 30 day period.	To receive a point, the facility must maintain a written policy requiring consistent assignment of STNAs and communicate this policy with staff, residents and the families of residents. The policy must be communicated to residents, families and staff and must specify a goal limiting the number of STNAs that provide care to a long term resident to no more than 12 STNAs over a 30 day period.	Web based data collection tool	This measure was adjusted to make it more achievable.
18	To receive a point, the facility must demonstrate an employee retention rate of 75% or greater in the calendar year preceding the fiscal year for which the rate will be paid.	Employee retention reflects the percentage of individuals employed by the nursing facility on the last day of the previous calendar year who are still employed by the nursing facility on the last day of the calendar year preceding the fiscal year for which the rate will be paid. The employee retention rate is calculated across all employees in a facility.	Continue current cost report schedule and methodology	This measure has not been changed.

Appendix C: Proposed Quality Measures

December 14, 2012

19	To receive a point, the facility must document an STNA turnover rate at or below 60%.	Utilize Advancing Excellence methodology to calculate turnover rate.	Web based data collection tool	Measure was strengthened to ensure continuous quality improvement.
20	To receive a point, the facility must document that an STNA who is a primary caregiver for the resident attends and participates in a minimum of 50% of resident care conferences in the facility.	Collect the total number of care conferences and the number of care conferences where an STNA who is a primary caregiver for the resident participates. STNA attendance at and participation in the care conference must be documented in resident's record.	Web based data collection tool	This measure has not been changed.

Revised Quality Measures

(A) As used in this section:

~~(1)~~ "Applicable percentage" means, for the accountability measures identified in divisions ~~(C)(10)~~ to ~~(13)~~ of this section, the following:

~~(a)~~ For fiscal year 2013, whichever of the following applies:

~~(i)~~ The percentage that the department of job and family services specifies for an accountability measure pursuant to division ~~(E)(1)(b)~~ or ~~(E)(2)(a)(ii)~~ of this section;

~~(ii)~~ The percentage specified for an accountability measure in division ~~(E)(2)(b)~~, ~~(ii)~~, ~~(iii)~~, ~~(iv)~~, or ~~(v)~~ of this section.

~~(b)~~ For fiscal year 2014, whichever of the following applies:

~~(i)~~ The percentage used pursuant to division ~~(F)(2)~~ of this section;

~~(ii)~~ The percentage that the department specifies for an accountability measure pursuant to division ~~(F)(3)(a)~~ of this section.

~~(c)~~ For fiscal year 2015 and thereafter, whichever of the following applies:

~~(i)~~ The percentage used pursuant to division ~~(F)(2)~~ of this section;

~~(ii)~~ The percentage used pursuant to division ~~(F)(3)(b)~~ of this section.

~~(2)~~ "Complaint surveys" has the same meaning as in 42 C.F.R. 488.30.

~~(3)(2)~~ "Customer satisfaction survey" means the annual survey of long-term care facilities required by section 173.47 of the Revised Code.

~~(4)(3)~~ "Deficiency" has the same meaning as in 42 C.F.R. 488.301.

~~(5)(4)~~ "Family satisfaction survey" means a customer satisfaction survey, or part of a customer satisfaction survey, that contains the results of information obtained from the families of a nursing facility's residents.

~~(6)(5)~~ "Minimum data set" means the standardized, uniform comprehensive assessment of nursing facility residents that is used to identify potential problems, strengths, and preferences of residents and is part of the resident assessment instrument required by section 1919(e)(5) of the "Social Security Act," 101 Stat. 1330-197 (1987), 42 U.S.C. 1396r(e)(5), as amended.

~~(7)(6)~~ "National voluntary consensus standards for nursing homes" means measures used to determine the quality of care provided by nursing facilities as endorsed by the national quality forum.

~~(8)(7)~~ "Nurse aide" has the same meaning as in section 3721.21 of the Revised Code.

~~(9)~~(8) "Resident satisfaction survey" means a customer satisfaction survey, or part of a customer satisfaction survey, that contains the results of information obtained from a nursing facility's residents.

~~(10)~~(9) "Room mirror" means a mirror that is located in either of the following rooms:

~~(a) A resident bathroom if the sink used by a resident after the resident uses the resident bathroom is in the resident bathroom;~~

~~(b) A resident's room if the sink used by a resident after the resident uses the resident bathroom is in the resident's room.~~

~~(11) "Room sink" means a sink that is located in either of the following rooms:~~

~~(a) A resident bathroom if the sink used by a resident after the resident uses the resident bathroom is in the resident bathroom;~~

~~(b) A resident's room if the sink used by a resident after the resident uses the resident bathroom is in the resident's room.~~

~~(12) "Standard survey" has the same meaning as in 42 C.F.R. 488.301.~~

(10) A "substantial wall" is a permanent structure reaching from floor to ceiling which divides a semi-private room into two distinct living spaces, each with its own window.

(B) (1) Each fiscal year, the department of job and family services office of medical assistance shall pay a quality incentive payment to the provider of each nursing facility that is awarded one or more points for meeting accountability measures under division(C) of this section. Subject to division (B)(2) of this section, the per medicaid day amount of a quality incentive payment paid to a provider shall be the product of the following:

(a) The number of points the provider's nursing facility is awarded for meeting accountability measures under division(C) of this section;

(b) Three dollars and twenty-nine cents.

(2) For state fiscal year 2014, the The maximum quality incentive payment that may be paid to the provider of a nursing facility for a fiscal year shall be sixteen dollars and forty-four cents per medicaid day.

(3) For state fiscal year 2015 and thereafter, the maximum quality incentive payment that may be paid to the provider of a nursing facility shall be determined as follows:

(a) If the provider of a nursing facility is awarded at least one point for meeting accountability measures under divisions (E)(9), (10), (11), (12), (13), or (14) of this section, sixteen dollars and forty-four cents.

(b) If the provider of a nursing facility is not awarded a point for meeting accountability measures under divisions (E)(9), (10), (11), (12), (13), or (14) of this section, thirteen dollars and sixteen cents.

(C) ~~For state fiscal year 2014, subject~~ Subject to ~~divisions (D), (E), and~~ division (F)-of this section, the department office shall award each nursing facility participating in the medicaid program one point for each of the following accountability measures the facility meets:

- (1) The facility's overall score on its resident satisfaction survey is at least eighty-six.
- (2) The facility's overall score on its family satisfaction survey is at least eighty-eight.
- (3) The facility satisfies the requirements for participation in the advancing excellence in America's nursing homes campaign.
- (4) The facility had neither of the following on the facility's most recent standard survey conducted not later than the last day of the calendar year preceding the fiscal year for which the point is to be awarded or any complaint surveys conducted in the calendar year preceding the fiscal year for which the point is to be awarded:
 - (a) A health deficiency with a scope and severity level greater than F;
 - (b) A deficiency that constitutes a substandard quality of care.
- (5) The facility offers at least fifty per cent of its residents at least one of the following dining choices for at least one meal each day:
 - (a) Restaurant-style dining in which food is brought from the food preparation area to residents per the residents' orders;
 - (b) Buffet-style dining in which residents obtain their own food, or have the facility's staff bring food to them per the residents' directions, from the buffet;
 - (c) Family-style dining in which food is customarily served on a serving dish and shared by residents;
 - (d) Open dining in which residents have at least a two-hour period to choose when to have a meal;
 - (e) Twenty-four-hour dining in which residents may order meals from the facility any time of the day.
- (6) At least fifty per cent of the facility's residents are able to take a bath or shower as often as they choose.
- (7) The facility has at least both of the following scores on its resident satisfaction survey:
 - (a) With regard to the question in the survey regarding residents' ability to choose when to go to bed in the evening, at least eighty-nine;
 - (b) With regard to the question in the survey regarding residents' ability to choose when to get out of bed in the morning, at least seventy-six.
- (8) The facility has at least both of the following scores on its family satisfaction survey:

(a) With regard to the question in the survey regarding residents' ability to choose when to go to bed in the evening, at least eighty-eight;

(b) With regard to the question in the survey regarding residents' ability to choose when to get out of bed in the morning, at least seventy-five.

(9) All of the following apply to the facility:

(a) At least seventy-five per cent of the facility's residents have the opportunity, following admission to the facility and before completing or quarterly updating their individual plans of care, to discuss their goals for the care they are to receive at the facility, including their preferences for advance care planning, with a member of the residents' healthcare teams that the facility, residents, and residents' sponsors consider appropriate.

(b) The facility records the residents' care goals, including the residents' advance care planning preferences, in their medical records.

(c) The facility uses the residents' care goals, including the residents' advance care planning preferences, in the development of the residents' individual plans of care.

(10) Not more than ~~the applicable percentage~~ thirteen and thirty-five hundredths per cent of the facility's long-stay residents report severe to moderate pain during the minimum data set assessment process.

(11) Not more than ~~the applicable percentage~~ five and seventy-three hundredths per cent of the facility's long-stay, high-risk residents have been assessed as having one or more stage two, three, or four pressure ulcers during the minimum data set assessment process.

(12) Not more than ~~the applicable percentage~~ one and fifty-two hundredths per cent of the facility's long-stay residents were physically restrained as reported during the minimum data set assessment process.

(13) Less than ~~the applicable percentage~~ seven and seventy-eight hundredths per cent of the facility's long-stay residents had a urinary tract infection as reported during the minimum data set assessment process.

(14) The facility uses a tool for tracking residents' admissions to hospitals.

(15) An average of at least fifty per cent of the facility's medicaid-certified beds are in private rooms.

(16) The facility has accessible resident bathrooms, all of which meet at least two of the following standards and at least some of which meet all of the following standards:

(a) There are room mirrors that are accessible to residents in wheelchairs, can be adjusted so as to be visible to residents who are seated or standing, or both.

(b) There are room sinks that are accessible to residents in wheelchairs and have clearance for wheelchairs.

(c) There are room sinks that have faucets with adaptive or easy-to-use lever or paddle handles.

(17) The facility does both of the following:

(a) Maintains a written policy that prohibits the use of overhead paging systems or limits the use of overhead paging systems to emergencies, as defined in the policy;

(b) Communicates the policy to its staff, residents, and families of residents.

(18) The facility has a score of at least ninety on its resident satisfaction survey with regard to the question in the survey regarding residents' ability to personalize their rooms with personal belongings.

(19) The facility has a score of at least ninety-five on its family satisfaction survey with regard to the question in the survey regarding residents' ability to personalize their rooms with personal belongings.

(20) The facility does both of the following:

(a) Maintains a written policy that requires consistent assignment of nurse aides and specifies the goal of having a resident receive nurse aide care from not more than eight different nurse aides during a thirty-day period;

(b) Communicates the policy to its staff, residents, and families of residents.

(21) The facility's staff retention rate is at least seventy-five per cent.

(22) The facility's turnover rate for nurse aides is not higher than sixty-five per cent.

(23) For at least fifty per cent of the resident care conferences in the facility, a nurse aide who is a primary caregiver for the resident attends and participate.s in the conference.

(D) For state fiscal year 2015, subject to division (E) of this section, the office shall award each nursing facility participating in the medicaid program one point for each of the following accountability measures the facility meets.

(1) All of the following apply to the facility:

(a) At least seventy-five per cent of the facility's residents have the opportunity, following admission to the facility and before completing or quarterly updating their individual plans of care, to discuss their goals for the care they are to receive at the facility, including their preferences for advance care planning, with a member of the residents' healthcare teams that the facility, residents, and residents' sponsors consider appropriate.

(b) The facility records the residents' care goals, including the residents' advance care planning preferences, in their medical records.

(c) The facility uses the residents' care goals, including the residents' advance care planning preferences, in the development of the residents' individual plans of care.

(d) The facility maintains a written policy encouraging advance care planning and communicates that policy to staff, residents and resident families.

(2) The facility does both of the following:

(a) Maintains a written policy that prohibits the use of overhead paging systems or limits the use of overhead paging systems to emergencies, as defined in the policy;

(b) Communicates the policy to its staff, residents, and families of residents.

(E) For state fiscal year 2015 and thereafter, subject to division (F) of this section, the department office shall award each nursing facility participating in the medicaid program one point for each of the following accountability measures the facility meets:

(1) The facility's overall score on its resident satisfaction survey is at least ~~eighty-six~~ eighty-seven and five tenths.

(2) The facility's overall score on its family satisfaction survey is at least **eighty-eight** (update number to be median when current survey results are available).

(3) The facility satisfies the requirements for participation in the advancing excellence in America's nursing homes campaign.

(4) The facility is not on the list of special focus facilities, Table B: Facilities Have Not Improved, published by the centers for medicare and medicaid services for eighteen consecutive months and had neither of the following on the facility's most recent standard survey conducted not later than the last day of the calendar year preceding the fiscal year for which the point is to be awarded or any complaint surveys conducted in the calendar year preceding the fiscal year for which the point is to be awarded:

(a) A health deficiency with a scope and severity level greater than F;

(b) A deficiency that constitutes a substandard quality of care.

(5) The facility maintains a written policy specifying the way in which choice of meals is offered, communicates that policy to staff, residents and resident families, and offers at least fifty per cent of its residents at least one of the following dining choices for at least two meals each day:

(a) Restaurant-style dining in which food is brought from the food preparation area to residents per the residents' orders;

(b) Buffet-style dining in which residents obtain their own food, or have the facility's staff bring food to them per the residents' directions, from the buffet;

(c) Family-style dining in which food is customarily served on a serving dish and shared by residents;

(d) Open dining in which residents have at least a two-hour period to choose when to have a meal;

(e) Twenty-four-hour dining in which residents may order meals from the facility any time of the day.

(6) At least fifty per cent of the facility's residents are able to take a bath or shower when they choose and the choice in bathing policy is maintained in writing by the facility and communicated to staff, residents and resident families.

(7) The facility has at least both of the following scores on its resident satisfaction survey:

(a) With regard to the question in the survey regarding residents' ability to choose when to go to bed in the evening, at least eighty-nine;

(b) With regard to the question in the survey regarding residents' ability to choose when to get out of bed in the morning, at least seventy-six.

(8) The facility has at least both of the following scores on its family satisfaction survey:

(a) With regard to the question in the survey regarding residents' ability to choose when to go to bed in the evening, at least eighty-eight;

(b) With regard to the question in the survey regarding residents' ability to choose when to get out of bed in the morning, at least seventy-five.

(9) Not more than ~~the applicable percentage~~ thirteen and thirty-five hundredths per cent of the facility's long-stay residents report severe to moderate pain during the minimum data set assessment process.

(10) Not more than ~~the applicable percentage~~ five and sixteen hundredths per cent of the facility's long-stay, high-risk residents have been assessed as having one or more stage two, three, or four pressure ulcers during the minimum data set assessment process.

(11) Not more than ~~the applicable percentage~~ one and fifty-two hundredths per cent of the facility's long-stay residents were physically restrained as reported during the minimum data set assessment process.

(12) Less than ~~the applicable percentage~~ seven per cent of the facility's long-stay residents had a urinary tract infection as reported during the minimum data set assessment process.

(13) The facility uses a tool for tracking residents' admissions to hospitals. The facility shall annually report hospital admission data for all residents served for each month of the calendar year to the office of medical assistance and specify the tool used to track hospital admissions.

(14) At least 95% of long stay residents must be assessed and appropriately given the pneumococcal vaccine and at least 93% of long stay residents are assessed and appropriately given the seasonal flu vaccine.

(15) An average of at least fifty per cent of the facility's medicaid-certified beds are in private rooms or in semi-private rooms in which each resident has both his own distinct territory and window separated by a substantial wall from the window and territory of his roommate and does not have to cross into his roommate's space to reach his own space. A curtain or other screen can be drawn for complete visual privacy.

(16) The facility shall achieve a 95% compliance rate with the requirements for requesting resident reviews for individuals admitted through the hospital exemption who remain in the facility upon expiration of the hospital exemption and annually report data demonstrating compliance to the office of medical assistance.

(17) The facility does both of the following:

(a) Maintains a written policy that requires consistent assignment of nurse aides and specifies the goal of having a resident receive nurse aide care from not more than eight twelve different nurse aides during a thirty-day period;

(b) Communicates the policy to its staff, residents, and families of residents.

(18) The facility's staff retention rate is at least seventy-five per cent.

(19) The facility's turnover rate for nurse aides is not higher than sixty per cent.

(20) For at least fifty per cent of the resident care conferences in the facility, a nurse aide who is a primary caregiver for the resident attends and participates in the conference.

(F)(1) To be awarded a point for meeting an accountability measure under division(C) or division (D) of this section other than the accountability measure identified in ~~division divisions~~ (C)(4) and (D)(4) of this section, a nursing facility must meet the accountability measure in the calendar year preceding the fiscal year for which the point is to be awarded. However, a nursing facility must meet the accountability measures specified in divisions(C)(3), (5), (6), (9), (14) to (17), (20), (22), and (23) of this section in the period beginning January 1, 2012, and ending March 31, 2012, to be awarded points for those accountability measures for fiscal year 2013.

(2) The ~~department~~ office shall award points pursuant to division(C)(1), (7), or (18) and pursuant to ~~division (D)(1) or (7)~~ of this section to a nursing facility only if a resident satisfaction survey was initiated under section 173.47 of the Revised Code for the nursing facility in the calendar year preceding the fiscal year for which the points are to be awarded.

(3) The ~~department~~ office shall award points pursuant to division(C)(2), (8), or (19) and ~~division (D)(2) or (8)~~ of this section to a nursing facility only if a family satisfaction survey was initiated under section 173.47 of the Revised Code for the nursing facility in the calendar year preceding the fiscal year for which the points are to be awarded.

(4) Not later than July 1, 2013, the ~~department~~ office shall adjust the score used for the purpose of division(C)(8)(b) of this section in a manner that causes at least fifty per cent of nursing facilities to meet division(C)(8)(b) of this section.

~~(E) For the purposes of awarding points under divisions(C)(10) to (13) of this section for fiscal year 2013, the following apply:~~

~~(1) If, by July 1, 2012, the United States centers for medicare and medicaid services makes calculations using the 3.0 version of the minimum data set that indicate whether nursing facilities meet those accountability measures, the department shall do both of the following:~~

~~(a) Rely on those calculations;~~

~~(b) Specify the percentages to be used for the purposes of those accountability measures and, in specifying the percentages, provide for at least fifty per cent of nursing facilities to earn points for meeting those accountability measures.~~

~~(2) If, by July 1, 2012, the United States centers for medicare and medicaid services does not make calculations using the 3.0 version of the minimum data set that indicate whether nursing facilities meet those accountability measures, the department shall do either of the following:~~

~~(a) Do both of the following:~~

~~(i) Make the calculations using the 3.0 version of the minimum data set in accordance with the national voluntary consensus standards for nursing homes;~~

~~(ii) Specify the percentages to be used for the purposes of those accountability measures and, in specifying the percentages, provide for at least fifty per cent of nursing facilities to earn points for meeting those accountability measures.~~

~~(b) Do all of the following:~~

~~(i) Rely on the most recent calculations the United States centers for medicare and medicaid services made using the 2.0 version of the minimum data set that indicate whether nursing facilities meet those accountability measures;~~

~~(ii) Use four per cent as the applicable percentage for the accountability measure identified in division (10) of this section;~~

~~(iii) Use nine per cent as the applicable percentage for the accountability measure identified in division (11) of this section;~~

~~(iv) Use two per cent as the applicable percentage for the accountability measure identified in division (12) of this section;~~

~~(v) Use ten per cent as the applicable percentage for the accountability measure identified in division (13) of this section.~~

~~(F) For the purposes of awarding points under divisions (10) to (13) of this section for fiscal year 2014 and thereafter, the department shall do the following:~~

~~(1) Rely on calculations the United States centers for medicare and medicaid services makes using the 3.0 version of the minimum data set that indicate whether nursing facilities meet those accountability measures;~~

~~(2) If the department takes action pursuant to division (E)(1) of this section for fiscal year 2013, continue to use the percentages the department specifies pursuant to division (E)(1)(b) of this section for the purposes of those accountability measures;~~

~~(3) If the department takes action pursuant to division (E)(2) of this section for fiscal year 2013, do the following:~~

~~(a) For fiscal year 2014, specify the percentages to be used for the purposes of those accountability measures and, in specifying the percentages, provide for at least fifty per cent of nursing facilities to earn points for meeting those accountability measures;~~

~~(b) For fiscal year 2015 and thereafter, continue to use the percentages the department specifies pursuant to division (F)(3)(a) of this section for the purposes of those accountability measures.~~

~~(G) The director of job and family services the office of medical assistance shall may adopt rules under section 5111.02 of the Revised Code as necessary to implement this section.~~