Medicaid State Plan - Nursing Facilities

	State Plan Section	OAC	Description	TN #	State Plan Attachment	Vol.
1	3111.30.26.000		Fiscal Year 2010 Medicaid Reimbursement System for Nursing Facilities	09-013	4.19D	26
2	3111.30.25.000		Fiscal Year 2011 Medicaid Reimbursement System for Nursing Facilities	09-013	4.19D	26
3	3111.02.000		Rule making authority	06-010	4.19D	24
4	3111.02.001	5101:3-3-19	Relationship of Other Covered Medicaid Services	09-013	4.19D	26
5	3111.02.002	5101:3-3-22	Rate Recalculations, Interest on Overpayments, Penalties, etc	06-010	4.19D	24
6	[redacted]	5101:3-3-18.3	Private rooms for Medicaid residents in NFs	08-007	3 tA	25
7	3111.20.000		Definitions	09-013	4.19D	26
8	3111.20.001	5101:3-3-01	Definitions	06-010	4.19D	24
9	3111.20.002	5101:3-3-64.1	Nursing Facility (NF) Payment for Cost-Sharing Other than Medicare Part A	09-013	4.19D	26
10	3111.21.000		Requirements for Medicaid Payments under Provider Agreement with ODJFS	06-010	4.19D	24
11	3111.21.001	5101:3-3-17.3	Outlers: Out of State TBI	06-010	4.19D	24
12	3111.22.000		Provider Agreement with ODJFS	06-010	4.19D	24
13	[redacted]	5101:3-3-02	Provider Agreements: NFs and ICFs-MR	03-013	4.13B	22
14	3111.22.001	5101:3-3-02.2	Termination and Denial of Provider Agreement: NFs and ICFs-MR	06-010	4.19D	24
15	[redacted]	5101:3-3-02.3	Eligible providers and provider types	05-029	4.13B	23
16	[redacted]	5101:3-3-04	Pmt during ODJFS Adm appeals for denial/termination of provider agreement	08-005	4.28A	25
17	[redacted]	5101:3-3-04.1	Pmt during survey agency adm. appeals for denial/termination of provider agreement	08-005	4.28A	25
18	3111.221.000		Timely Vendor Payments	06-010	4.19D	24
19	3111.222.000		Total Facility Rate	06-016	4.19D	25
20	3111.222.001	5101:3-3-41	Nursing Facilities (NFs) Placement into Peer Groups	06-010	4.19D	24
21	3111.231.000		NF Direct Care	09-013	4.19D	26
22	3111.231.001	5101:3-3-43.3	Calc. of Qtrly., Semi-Annual, and Annual NF Avg. Case Mix Scores	06-010	4.19D	24
23	3111.232.000		Medicaid Only Case-Mix	06-010	4.19D	24
24	3111.232.001	5101:3-3-43.1	NF Case-Mix Instrument: MDS Version 2.0	06-010	4.19D	24
25	3111.232.002	5101:3-3-43.2	RUGs III: NF Case-Mix Payment System	06-010	4.19D	24
26	3111.24.000		NF Ancillary and Support	09-013	4.19D	26
27	3111.242.000		NF Property Taxes	06-010	4.19D	24
28	3111.242.001	5101:3-3-57	Tax Cost Add-On for NFs	06-010	4.19D	24
29	3111.243.000		NF Franchise Fee Payment	06-010	4.19D	24
30	3111.244.000		Quality Add-On	06-010	4.19D	24
31	3111.244.001	5101:3-3-58	Quality Incentive Payment for NFs	06-010	4.19D	24
32	3111.25.000		NF Capital	09-013	4.19D	26
33	3111.25.001	5101:3-3-42.3	Capital Asset and Depreciation Guidelines - NFs	06-010	4.19D	24
34	3111.254.000		NF New Facility	09-013	4.19D	26
35	3111.254.001	5101:3-3-65	Rates for Providers with an Initial Date of Certification on or after 07/01/06	06-010	4.19D	24
36	3111.257.000		NF Bed Additions	06-010	4.19D	24
37	3111.258.000		Outliers - Special Populations	06-010	4.19D	24
38	3111.258.001	5101:3-3-17	Payment Methodology for the Provision of Outlier Services in NFs	06-010	4.19D	24
39	3111.258.002	5101:3-3-54.1	Outlier Care in Nursing Facilities for Individuals with TBI (NF - TBI Services)	06-010	4.19D	24
40	3111.258.003	5101:3-3-54.5	Pediatric Outlier Care in Nursing Facilities (NF - PED Services)	06-010	4.19D	24
41	3111.26.000		Annual Cost Report	06-010	4.19D	24
42	3111.26.001	5101:3-3-20	Medicaid Cost Report Filing, Record Retention, and Disclosure Requirement	08-019	4.19D	26
43	3111.26.002	5101:3-3-42	NFs Chart of Accounts	06-010	4.19D	24
44	3111.26.003	5101:3-3-42.1	NFs Annual Cost Report	06-010	4.19D	24
45	3111.26.004	5101:3-3-42.2	NFs Leased Employees	06-010	4.19D	24
46	3111.26.005	5101:3-3-42.4	NFs: Non-Reimbursable Costs	06-010	4.19D	24
48	3111.264.000		Related Party	06-010	4.19D	24
49	3111.265.000		CHOPs/Operating Rights	06-010	4.19D	24
50	3111.266.000		NF Franchise Fee Reporting	06-010	4.19D	24
51	3111.27.000		Desk Reviews	06-010	4.19D	24
52	3111.27.001	5101:3-3-21	Audits of NFs	06-010	4.19D	24
53	3111.27.002	5101:3-3-43.4	Exception Review Process for NFs	07-004	4.19D	25
54	3111.28.000		Amended Cost Reports	06-010	4.19D	24
56	3111.29.000		Rate Reconsiderations	06-010	4.19D	24
58	3111.29.001	5101:3-3-24	Prospective Rate Reconsideration for NFs for Prospective Rate Calc. Errors	06-010	4.19D	24
57	[redacted]	5101:3-3-16.4	Coverage of bed-hold days for medically necessary absences	07-010A	4.19C	25
58	3111.676.000		Adjustments to Medicaid Reimbursement for NFs and ICFs-MR that Change Operator	06-010	4.19D	24
59	3111.676.001	5101:3-3-65.1	Rates for Providers that Change Provider Agreements	06-015	4.19D	25

[redacted] Rules used solely for state plan purposes

[redacted] State plan sections contained in "non-institutional" state plan attachments processed through the Regional CMS Office in Chicago

* As referenced on the CMS-179 form. CMS approved the move of 5111.33.001 (5101:3-3-16.4) to Attachment 4.19C on 04/10/08

** Consider both locations when updating state plan

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Medicaid State Plan - Nursing Facilities
Attachment 4.19D - NF Supplement 1

	State Plan Section	OAC	Description	TN #	State Plan Attachment	Vol.
1	309.30.20.000		Fiscal Year 2010 Medicaid Reimbursement System for Nursing Facilities	09-013	4.19D	26
2	309.30.25.000		Fiscal Year 2011 Medicaid Reimbursement System for Nursing Facilities	09-013	4.19D	26
3	5111.02.000		Rule making authority	06-010	4.19D	24
4	5111.02.001	5101:3-3-19	Relationship of Other Covered Medicaid Services	09-013	4.19D	26
5	5111.02.002	5101:3-3-22	Rate Recalculations, Interest on Overpayments, Penalties, etc	06-010	4.19D	24
6	5111.20.000		Definitions	09-013	4.19D	26
7	5111.20.001	5101:3-3-01	Definitions	06-010	4.19D	24
8	5111.20.002	5101:3-3-64.1	Nursing Facility (NF) Payment for Cost-Sharing Other than Medicare Part A	09-013	4.19D	26
9	5111.21.000		Requirements for Medicaid Payments under Provider Agreement with ODJFS	06-010	4.19D	24
10	5111.21.001	5101:3-3-17.3	Outliers: Out of State TBI	06-010	4.19D	24
11	5111.22.000		Provider Agreement with ODJFS	06-010	4.19D	24
12	5111.22.001	5101:3-3-02.2	Termination and Denial of Provider Agreement: NFs and ICFs-MR	06-010	4.19D	24
13	5111.221.000		Timely Vendor Payments	06-010	4.19D	24
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18	5111.232.000		Medicaid Only Case-Mix	06-010	4.19D	26
19	5111.232.001	5101:3-3-43.1	NF Case-Mix Instrument: MDS Version 2.0	06-010	4.19D	26
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21	5111.24.000		NF Ancillary and Support	09-013	4.19D	26
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23	5111.242.001	5101:3-3-57	Tax Cost Add-On for NFs	06-010	4.19D	24
24	5111.243.000		NF Franchise Fee Payment	06-010	4.19D	24
25	5111.244.000		Quality Add-On	06-010	4.19D	24
26	5111.244.001	5101:3-3-58	Quality Incentive Payment for NFs	06-010	4.19D	24
27	5111.25.000		NF Capital	09-013	4.19D	26
28	5111.25.001	5101:3-3-42.3	Capital Asset and Depreciation Guidelines - NFs	06-010	4.19D	24
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37	5111.26.001	5101:3-3-20	Medicaid Cost Report Filing, Record Retention, and Disclosure Requirement	08-019	4.19D	26
38	5111.26.002	5101:3-3-42	NFs Chart of Accounts	06-010	4.19D	24
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40	5111.26.004	5101:3-3-42.2	NFs Leased Employees	06-010	4.19D	24
41	5111.26.005	5101:3-3-42.4	NFs Non-Reimbursable Costs	06-010	4.19D	24
43	5111.264.000		Related Party	06-010	4.19D	24
44	5111.265.000		CHOPs/Operating Rights	06-010	4.19D	24
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47	5111.27.001	5101:3-3-21	Audits of NFs	06-010	4.19D	24
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50	5111.29.000		Rate Reconsiderations	06-010	4.19D	24
51	5111.29.001	5101:3-3-24	Prospective Rate Reconsideration for NFs for Prospective Rate Calc. Errors	06-010	4.19D	24
52	5111.676.000		Adjustments to Medicaid Reimbursement for NFs and ICFs-MR that Change Operator	06-010	4.19D	24
53	5111.676.001	5101:3-3-65.1	Rates for Providers that Change Provider Agreements	06-015	4.19D	25

[ ] Rates used solely for state plan purposes

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SECTION 309.30.20. FISCAL YEAR ~~2008~~2010 MEDICAID REIMBURSEMENT SYSTEM FOR NURSING FACILITIES

(A) ~~"Applicable calendar year" refers to the calendar year 2003.~~Except as provided in division ~~(B)(1)(e)~~(A)(1)(d) of this section, the provider of a nursing facility that has a valid Medicaid provider agreement shall be paid the rate determined as follows:

(1) For nursing facility services the nursing facility provides during fiscal year ~~2008;~~2010, determine the rate for the nursing facility under sections 5111.20 to 5111.33 of the Revised Code with the following adjustments:

(a) ~~Determine the rate for the nursing facility under sections 5111.20 to 5111.33 of the Revised Code;~~ The cost per case mix-unit calculated under section 5111.231 of the Revised Code, the rate for ancillary and support costs calculated under section 5111.24 of the Revised Code, the rate for tax costs calculated under section 5111.242 of the Revised Code, and the rate for capital costs calculated under section 5111.25 of the Revised Code shall each be adjusted as follows:

~~(b)~~ (i) Increase the rate determined under division ~~(B)(1)(a)~~(A)(1)(a) of this section by two per cent;

~~(c)~~ (ii) Increase the rate determined under division ~~(B)(1)(b)~~(A)(1)(a)(i) of this section by two per cent;

~~(d)~~ (iii) Increase the rate determined under division ~~(B)(1)(c)~~(A)(1)(a)(ii) of this section by one per cent;

(iv) Increase the rate determined under division (A)(1)(a)(iii) of this section by the quality incentive payment calculated under section 5111.244 of the Revised Code. The quality incentive payment shall be established for each provider so that the mean payment is equal to three dollars and three cents;

(v) Increase the rate determined under division (A)(1)(a)(iv) of this section by seventy-three hundredths per cent;

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(b) If the rate determined for a nursing facility under division (A) of this section for nursing facility services provided during fiscal year 2010 is more than one hundred one and seventy-five hundredths per cent of the rate the provider is paid for nursing facility services the nursing facility provides on June 30, 2009, the Department of Job and Family Services shall reduce the nursing facility's rate determined under division (A) of this section for fiscal year 2010 so that the rate is not more than one hundred one and seventy-five hundredths per cent of the nursing facility's rate for June 30, 2009. If the rate determined for a nursing facility under division (A) of this section for nursing facility services provided during fiscal year 2010 is less than ninety-nine per cent of the rate the provider is paid for nursing facility services the nursing facility provides on June 30, 2009, the Department shall increase the nursing facility's rate determined under division (A) of this section for fiscal year 2010 so that the rate is not less than ninety-nine per cent of the nursing facility's rate for June 30, 2009.

(c) After the adjustments under division (A) of this section are made to a nursing facility's fiscal year 2010 rate, the Department of Job and Family Services shall increase the nursing facility's fiscal year 2010 rate by five dollars and seventy cents per Medicaid day. This increase shall be known as the workforce development incentive payment. The total amount of workforce development incentive payments paid to providers of nursing facilities shall be used to improve nursing facilities' employee retention and direct care staffing levels, including by increasing wages paid to nursing facilities' direct care staff. Not later than September 30, 2011, the Department shall submit a report to the Governor and, in accordance with section 101.68 of the Revised Code, the General Assembly detailing the impact that the workforce development incentive payments have on nursing facilities' employee retention, direct care staffing levels, and direct care staff wages.

(d) After the adjustment under division (A)(1)(c) of this section is made to a nursing facility's fiscal year 2010 rate, the Department of Job and Family Services shall increase the nursing facility's fiscal year 2010 rate by the consolidated services rate per Medicaid day. The consolidated services rate shall be three dollars and ninety-seven cents. Reimbursement for transportation, oxygen, therapy, wheelchairs, and over the counter pharmacy services that have been added to the nursing facility (NF) per diem and that are provided to NF residents during the period July 1, 2009, through July 31, 2009, will be provided only per the NF per

diem rate setting methodology as outlined in Attachment 4.19-D. For dates of service August 18, 2009, through September 30, 2009, the Ohio Department of Job and Family Services (ODJFS) will omit from per diem payments made by ODJFS to NFs that portion of the per diem payment attributable to resident transportation that would otherwise be payable to NFs per the NF per diem. Reimbursement for services attributable to resident transportation for dates of service August 18, 2009, through September 30, 2009, will be provided according to methodology outlined in Attachment 4.19-B.

(e) If the fiscal year 2010 rate for a nursing facility as initially determined under division (A) of this section is not subject to an adjustment under division (A)(1)(b) of this section, the nursing facility's rate shall not be subject to an adjustment under that division for the remainder of fiscal year 2010 regardless of any other adjustment made to the nursing facility's fiscal year 2010 rate under sections 5111.20 to 5111.33 of the Revised Code.

~~(e) If the rate determined for a nursing facility under division (B)(1)(d) of this section for nursing facility services provided during fiscal year 2008 is more than one hundred two and seventy-five hundredths per cent of the rate the provider is paid for nursing facility services the nursing facility provides on June 30, 2007, the Department of Job and Family Services shall reduce the nursing facility's fiscal year 2008 rate so that the rate is no more than one hundred two and seventy-five hundredths per cent of the nursing facility's rate for June 30, 2007. If the rate determined for a nursing facility under sections 5111.20 to 5111.33 of the Revised Code for nursing facility services provided during fiscal year 2008 is less than the rate the provider was paid for nursing facility services the nursing facility provides on June 30, 2007, the Department shall increase the nursing facility's fiscal year 2008 rate so that the rate is no less than the nursing facility's rate for June 30, 2007.~~

~~(2) For services provided after June 30, 2008, nursing facilities shall continue to be paid the nursing facility's rate for June 30, 2008. If a participating nursing facility does not have a rate paid on June 30, 2008, the nursing facility shall be paid pursuant to Sections 5111.254.000, 5111.254.001, 5111.676.000, and 5111.676.001.~~

(B) The Department of Job and Family Services shall follow this section in determining the rate to be paid to the provider of a nursing facility that has a valid Medicaid provider agreement on ~~June 30,~~

~~2007~~June 30, 2009, and a valid Medicaid provider agreement for fiscal year ~~2008~~2010 notwithstanding anything to the contrary in sections 5111.20 to 5111.33 of the Revised Code.

SECTION 309.30.25. FISCAL YEAR 2011 MEDICAID REIMBURSEMENT SYSTEM FOR NURSING FACILITIES

(A) As used in this section, "fiscal year 2010 partial rate" means the total rate a provider of a nursing facility is paid for nursing facility services the nursing facility provides on June 30, 2010, less the portion of that total rate that equals the sum of the workforce development incentive payment and consolidated services rate included in the total rate. Except as provided in division (A)(1)(e) of this section, the provider of a nursing facility that has a valid Medicaid provider agreement shall be paid the rate determined as follows:

(1) For nursing facility services the nursing facility provides during fiscal year 2011, determine the rate for the nursing facility under sections 5111.20 to 5111.33 of the Revised Code with the following adjustments:

(a) The cost per case mix-unit calculated under section 5111.231 of the Revised Code, the rate for ancillary and support costs calculated under section 5111.24 of the Revised Code, the rate for tax costs calculated under section 5111.242 of the Revised Code, and the rate for capital costs calculated under section 5111.25 of the Revised Code shall each be adjusted as follows:

(i) Increase the rate determined under division (A)(1)(a) of this section by two per cent;

(ii) Increase the rate determined under division (A)(1)(a)(i) of this section by two per cent;

(iii) Increase the rate determined under division (A)(1)(a)(ii) of this section by one per cent;

(iv) Increase the rate determined under division (A)(1)(a)(iii) of this section by the quality incentive payment calculated under section 5111.244 of the Revised Code. The quality incentive payment shall be established for each provider so that the mean payment is equal to three dollars and three cents.

(v) Increase the rate determined under division (A)(1)(a)(iv) of this section by seventy-three hundredths per cent;

(b) Except as provided in division (A)(1)(e) of this section, if the rate determined for a nursing facility under division (A) of this section for nursing facility services provided during fiscal year 2011 is more than one hundred two and twenty-five hundredths per cent of the nursing facility's fiscal year 2010 partial rate, the Department of Job and Family Services shall reduce the nursing facility's rate determined under division (A) of this section for fiscal year 2011 so that the rate is not more than one hundred two and twenty-five hundredths per cent of the nursing facility's fiscal year 2010 partial rate. Except as provided in division (A)(1)(e) of this section, if the rate determined for a nursing facility under division (A) of this section for nursing facility services provided during fiscal year 2011 is less than ninety-nine per cent of the nursing facility's fiscal year 2010 partial rate, the Department shall increase the nursing facility's rate determined under division (A) of this section for fiscal year 2011 so that the rate is not less than ninety-nine per cent of the nursing facility's fiscal year 2010 partial rate.

(c) After the adjustments under division (A) of this section are made to a nursing facility's fiscal year 2011 rate, the Department of Job and Family Services shall increase the nursing facility's fiscal year 2011 rate by five dollars and seventy cents per Medicaid day. This increase shall be known as the workforce development incentive payment. The total amount of workforce development incentive payments paid to providers of nursing facilities shall be used to improve nursing facilities' employee retention and direct care staffing levels, including by increasing wages paid to nursing facilities' direct care staff. Not later than September 30, 2012, the Department shall submit a report to the Governor and, in accordance with section 101.68 of the Revised Code, the General Assembly detailing the impact that the workforce development incentive payments have on nursing facilities' employee retention, direct care staffing levels, and direct care staff wages.

(d) After the adjustment under division (A)(1)(c) of this section is made to a nursing facility's fiscal year 2011 rate, the Department of Job and

Family Services shall increase the nursing facility's fiscal year 2011 rate by the consolidated services rate per Medicaid day. The consolidated services rate shall equal three dollars and ninety-one cents.

(e) If the fiscal year 2010 rate for a nursing facility as initially determined under section 309.30.20.000 is not subject to an adjustment under division (A)(1)(b) of that section, the nursing facility's fiscal year 2011 rate as initially determined under division (A) of this section shall not be subject to an adjustment under division (A)(1)(b) of this section regardless of whether the nursing facility's fiscal year 2011 rate as initially determined under division (A) of this section would, if not for this division, be subject to the adjustment. If the fiscal year 2011 rate for a nursing facility as initially determined under division (A) of this section is not subject to an adjustment under division (A)(1)(b) of this section, the nursing facility's rate shall not be subject to an adjustment under that division for the remainder of fiscal year 2011 regardless of any other adjustment made to the nursing facility's fiscal year 2011 rate under sections 5111.20 to 5111.33 of the Revised Code.

(2) For services provided after June 30, 2011, nursing facilities shall continue to be paid the nursing facility's rate for June 30, 2011. If a participating nursing facility does not have a rate paid on June 30, 2011, the nursing facility shall be paid pursuant to Sections 5111.254.000, 5111.254.001, 5111.676.000, and 5111.676.001.

(B) The Department of Job and Family Services shall follow this section in determining the rate to be paid to the provider of a nursing facility that has a valid Medicaid provider agreement on June 30, 2010, and a valid Medicaid provider agreement for fiscal year 2011 notwithstanding anything to the contrary in sections 5111.20 to 5111.33 of the Revised Code.

5101:3-3-19 **Relationship of other covered medicaid services to nursing ~~facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)~~facility (NF) services.**

This rule identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by a NF~~ or an ICF-MR~~. Whenever reference is made to reimbursement of services through the "facility cost report mechanism," the rules governing such reimbursement are set forth in sections 5111.25.001, 5111.26.001, 5111.26.002, 5111.26.003, 5111.26.004, and 5111.26.005 of ~~NF Supplement 1,~~ Attachment 4.19D. ~~Chapter 5101:3-3- of the Administrative Code. All references to "ICFs-MR" set forth in paragraphs (A) to (K)(1) of this rule do not include state-operated ICFs-MR for which reimbursement is made in accordance with rule 5101:3-3-99 of the Administrative Code.~~

(A) Dental services.

All covered dental services provided by licensed dentists are reimbursed directly to the provider of the dental services in accordance with Attachment 4.19B. Personal hygiene services provided by facility staff or contracted personnel are reimbursed through the facility cost report mechanism.

(B) Laboratory and x-ray services.

Costs incurred for the purchase and administration of tuberculin tests, and for drawing specimens and forwarding specimens to a laboratory, are reimbursable through the facility's cost report. All laboratory and x-ray procedures covered under the medicaid program are reimbursed directly to the laboratory or x-ray provider in accordance with Attachment 4.19B.

(C) Medical supplier services.

Certain medical supplier services are reimbursable through the facility's cost report mechanism and others directly to the medical supply provider as follows:

(1) Items that must be reimbursed through the facility's cost report include:

(a) Costs incurred for "needed medical and program supplies" defined as those items that have a very limited life expectancy, such as, atomizers, nebulizers, bed pans, catheters, electric pads, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits.

(b) Costs incurred for "needed medical equipment" (and repair of such equipment), defined as items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for the use in the facility. Such medical equipment items include hospital beds, wheelchairs, including custom wheelchairs and all wheelchair parts, options and accessories, and intermittent positive-pressure breathing machines, except as noted in paragraph (C)(2) of this rule.

(c) Contents of oxygen cylinders or tanks, including liquid oxygen. Oxygen producing machines (concentrators) for specific use by an individual recipient. Costs of equipment associated with oxygen administration, such as, carts, regulators/humidifiers, cannulas, masks, and demurrage.

(2) Services that are reimbursed directly to the medical supplier provider, in accordance with Attachment 4.19B, include:

(a) Certain durable medical equipment items, specifically, ventilators~~, and custom-made wheelchairs that have parts which are actually molded to fit the recipient~~.

(b) "Prostheses," defined as devices that replace all or part of a body organ to prevent or correct physical deformity or malfunction, such as, artificial arms or legs, electro-larynxes, and breast prostheses.

(c) "Orthoses," defined as devices that assist in correcting or strengthening a distorted part, such as, arm braces, hearing aids and batteries, abdominal binders, and corsets.

~~(d) Contents of oxygen cylinders or tanks, including liquid oxygen, except that emergency stand-by oxygen which is reimbursed through the facility cost report mechanism.~~

~~(e) Oxygen producing machines (concentrators) for specific use by an individual recipient.~~

(D) Pharmaceuticals.

(1) Over-the-counter drugs ~~not listed in appendix A of rule 5101:3-9-12 of the Administrative Code, for which prior authorization was requested and denied,~~ including selected over-the-counter drugs set forth in paragraph (B) of rule 5101:3-9-03 of the Administrative Code and nutritional supplements are reimbursable ~~only~~ through the facility cost-report mechanism.

(2) Pharmaceuticals reimbursable directly to the pharmacy provider are subject to the limitations found in Attachment 4.19B, the limitations established by the Ohio state board of pharmacy, and the following conditions:

(a) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient.

(b) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years. A receipt for drugs delivered to a NF ~~or an ICF-MR~~ must be signed by the facility representative at the time of delivery and a copy retained by pharmacy.

(E) Physical therapy, occupational therapy, speech therapy, audiology services, psychologist services, and respiratory therapy services.

~~(1)~~ For NFs, the costs incurred for physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants are reimbursed ~~directly to the NF as specified in Attachment 4.19B~~through the facility cost report mechanism. ~~The costs incurred for these services provided by nursing staff of the NF are reimbursable through the facility cost report mechanism as specified in rule 5101:3-3-465101:3-3-46.1 of the Administrative Code.~~ Costs incurred for the services of a licensed psychologist are reimbursable through the facility cost report mechanism. No reimbursement for psychologist services shall be made to a provider other than the NF, ~~ICF-MR,~~ or a community mental health center certified by the Ohio department of mental health. Services provided by an employee of the community mental health center must be billed directly to medicaid by the community mental health center. Costs incurred for physician ordered administration of aerosol therapy that is rendered by a licensed respiratory care professional are reimbursable through the facility cost report mechanism. No reimbursement for respiratory therapy services shall be made to a provider other than the NF ~~or ICF-MR~~through the facility cost report mechanism.

~~(2) For ICFs-MR, the costs incurred for physical therapy, occupational therapy, speech therapy, audiology services, psychology services and respiratory therapy services provided by licensed therapists or therapy assistants or provided by licensed psychologists or psychology assistants and that are covered for ICF-MR residents either by medicare or medicaid, are reimbursable through the facility cost report mechanism. Reasonable costs for rehabilitative, restorative, or maintenance therapy services rendered to facility residents by contracted staff or facility staff and the overhead costs to support the provision of such services are~~

~~reimbursable through the rate determined in accordance with rule 5101:3-3-78 of the Administrative Code sections 5111.20 to 5111.33 of the Revised Code. Costs incurred for the services of a licensed psychologist are reimbursable through the facility cost report mechanism. No reimbursement for psychologist services shall be made to a provider other than the NF, ICF-MR, or a community mental health center certified by the Ohio department of mental health. Services provided by an employee of the community mental health center must be billed directly to medicaid by the community mental health center. Costs incurred for physician ordered administration of aerosol therapy that is rendered by a licensed respiratory care professional are reimbursable through the facility cost report mechanism. No reimbursement for respiratory therapy services shall be made to a provider other than the NF or ICF-MR.~~

~~(3) Psychologist services are covered for both NFs and ICFs-MR pursuant to paragraph (G) of this rule. Respiratory therapy services for NFs and ICFs-MR are covered pursuant to paragraph (H) of this rule.~~

(F) Physician services.

(1) A physician may be directly reimbursed for the following services provided to a resident of a NF ~~or ICF-MR:~~ by a physician:

(a) All covered diagnostic and treatment services in accordance with Attachment 4.19B.

(b) All medically necessary physician visits in accordance with Attachment 4.19B.

(c) All required physician visits as described in ~~paragraphs (F)(1)(c)(i) to (F)(1)(c)(iv) of~~ this rule when the services are billed in accordance with Attachment 4.19B.

(i) Physician visits must be provided to a resident of a NF ~~or ICF-MR~~ and must conform to the following schedule:

(a) For nursing facilities, the resident must be seen by a physician at least once every thirty days for the first ninety days after admission, and at least once every ninety days, thereafter.

(b) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(ii) For reimbursement of the required physician visits, the physician must:

(a) Review the resident's total program of care including medications and treatments, at each visit required by paragraph (F)(1)(c)(i) of this rule;

(b) Write, sign, and date progress notes at each visit;

(c) Sign all orders; and

(d) Personally visit (see) the patient except as provided in paragraph (F)(1)(c)(iii) of this rule.

(iii) At the option of the physician, required visits after the initial visit may be delegated in accordance with paragraph (F)(1)(c)(iv) of this rule and alternate between physician and visits by physician assistant or certified nurse practitioner.

(iv) Physician delegation of tasks.

(a) A physician may delegate tasks to a physician assistant or certified nurse practitioner as defined by Attachment 4.19B ~~Chapter 4730. of the Revised Code and Chapter 4730-1 of the Administrative Code~~ for physician assistants~~,~~ and ~~Chapter 4723. of the Revised Code and Chapter 4723-4 of the Administrative Code~~ for certified nurse practitioners who are in compliance with the following criteria:

(i) Are acting within the scope of practice as defined by state law; and

(ii) Are under supervision and employment of the billing physician.

(b) A physician may not delegate a task when regulations specify that the physician must perform it personally, or when delegation is prohibited by state law or the facility's own policies.

(2) Services directly reimbursable to the physician must:

(a) Be based on medical necessity, as defined in Attachment 4.19B ~~of the Administrative Code~~, and requested by the NF ~~or ICF-MR~~ resident with the exception of the required visits defined in paragraph (F)(1)(c) of this rule; and

(b) Be documented by entries in the resident's medical records along with any symptoms and findings. Every entry must be signed and dated by the physician.

(3) Services provided in the capacity of overall medical direction are reimbursable only to a NF ~~or ICF-MR~~ and may not be directly reimbursed to a physician.

(G) Podiatry services.

Covered services provided by licensed podiatrists are reimbursed directly to the authorized podiatric provider in accordance with Attachment 4.19B. Payment by ODJFS is limited to one visit per month for residents in a NF ~~or ICF-MR~~ setting.

(H) Transportation services.

Costs incurred by the facility for transporting residents by ~~means other than covered~~ ambulance ~~or~~, ambulette, or other means of transportation ~~services~~ are reimbursable through the facility cost report mechanism. ~~Payment is made directly to authorized providers for covered ambulance and ambulette services as set forth in Attachment 4.19B.~~

(I) Vision care services.

All covered vision care services, including examinations, dispensing, and the fitting of eyeglasses, are reimbursed directly to authorized vision care providers in accordance with Attachment 4.19B.

Sec. 5111.20 ~~Definitions~~

As used in sections 5111.20 to 5111.34 of the Revised Code:

(A) "Allowable costs" are those costs determined by the department of job and family services to be reasonable and do not include fines paid under sections 5111.35 to 5111.61 and section 5111.99 of the Revised Code.

(B) "Ancillary and support costs" means all reasonable costs incurred by a nursing facility other than direct care costs or capital costs. "Ancillary and support costs" includes, but is not limited to, costs of activities, social services, pharmacy consultants, habilitation supervisors, qualified mental retardation professionals, program directors, medical and habilitation records, program supplies, incontinence supplies, food, enterals, dietary supplies and personnel, laundry, housekeeping, security, administration, medical equipment, utilities, liability insurance, bookkeeping, purchasing department, human resources, communications, travel, dues, license fees, subscriptions, home office costs not otherwise allocated, legal services, accounting services, minor equipment, wheelchairs, resident transportation, maintenance and repairs, help-wanted advertising, informational advertising, start-up costs, organizational expenses, other interest, property insurance, employee training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted by the director of job and family services under section 5111.02 of the Revised Code, for personnel listed in this division. "Ancillary and support costs" also means the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992.

(C) "Capital costs" means costs of ownership and, in the case of an intermediate care facility for the mentally retarded, costs of nonextensive renovation.

(1) "Cost of ownership" means the actual expense incurred for all of the following:

(a) Depreciation and interest on any capital assets that cost five hundred dollars or more per item, including the following:

(i) Buildings;

(ii) Building improvements that are not approved as nonextensive renovations under section 5111.251 of the Revised Code;

(iii) Except as provided in division (B) of this section, equipment;

(iv) In the case of an intermediate care facility for the mentally retarded, extensive

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(C) "Capital costs" means costs of ownership and, in the case of an intermediate care facility for the mentally retarded, costs of nonextensive renovation.

(1) "Cost of ownership" means the actual expense incurred for all of the following:

(a) Depreciation and interest on any capital assets that cost five hundred dollars or more per item, including the following:

(i) Buildings;

(ii) Building improvements that are not approved as nonextensive renovations under section 5111.251 of the Revised Code;

(iii) Except as provided in division (B) of this section, equipment;

(iv) In the case of an intermediate care facility for the mentally retarded, extensive

renovations;

(v) Transportation equipment.

(b) Amortization and interest on land improvements and leasehold improvements;

(c) Amortization of financing costs;

(d) Except as provided in division (K) of this section, lease and rent of land, building, and equipment.

The costs of capital assets of less than five hundred dollars per item may be considered capital costs in accordance with a provider's practice.

(2) "Costs of nonextensive renovation" means the actual expense incurred by an intermediate care facility for the mentally retarded for depreciation or amortization and interest on renovations that are not extensive renovations.

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

(E) "Case-mix score" means the measure determined under section 5111.232 of the Revised Code of the relative direct-care resources needed to provide care and habilitation to a resident of a nursing facility or intermediate care facility for the mentally retarded.

(F) (1) "Date of licensure," for a facility originally licensed as a nursing home under Chapter 3721. of the Revised Code, means the date specific beds were originally licensed as nursing home beds under that chapter, regardless of whether they were subsequently licensed as residential facility beds under section 5123.19 of the Revised Code. For a facility originally licensed as a residential facility under section 5123.19 of the Revised Code, "date of licensure" means the date specific beds were originally licensed as residential facility beds under that section.

~~(1)~~ If nursing home beds licensed under Chapter 3721. of the Revised Code or residential facility beds licensed under section 5123.19 of the Revised Code were not required by law to be licensed when they were originally used to provide nursing home or residential facility services, "date of licensure" means the date the beds first were used to provide nursing home or residential facility services, regardless of the date the present provider obtained licensure.

~~(2)~~ If a facility adds nursing home beds or residential facility beds or extensively renovates all or part of the facility after its original date of licensure, it will have a different date of licensure for the additional beds or extensively renovated portion of the

facility, unless the beds are added in a space that was constructed at the same time as the previously licensed beds but was not licensed under Chapter 3721. or section 5123.19 of the Revised Code at that time.

(2) The definition of "date of licensure" in this section applies in determinations of the medicaid reimbursement rate for a nursing facility or intermediate care facility for the mentally retarded but does not apply in determinations of the franchise permit fee for a nursing facility or intermediate care facility for the mentally retarded.

(G) "Desk-reviewed" means that costs as reported on a cost report submitted under section 5111.26 of the Revised Code have been subjected to a desk review under division (A) of section 5111.27 of the Revised Code and preliminarily determined to be allowable costs.

(H) "Direct care costs" means all of the following:

(1)(a) Costs for registered nurses, licensed practical nurses, and nurse aides employed by the facility;

(b) Costs for direct care staff, administrative nursing staff, medical directors, respiratory therapists, and except as provided in division (H)(2) of this section, other persons holding degrees qualifying them to provide therapy;

(c) Costs of purchased nursing services;

(d) Costs of quality assurance;

(e) Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted by the director of job and family services in accordance with Chapter 119. of the Revised Code, for personnel listed in divisions (H)(1)(a), (b), and (d) of this section;

(f) Costs of consulting and management fees related to direct care;

(g) Allocated direct care home office costs.

(2) In addition to the costs specified in division (H)(1) of this section, for nursing facilities only, direct care costs include costs of habilitation staff (other than habilitation supervisors), medical supplies, ~~emergency~~ oxygen, over-the-counter pharmacy products, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, audiologists, habilitation supplies, and universal precautions supplies.

(3) In addition to the costs specified in division (H)(1) of this section, for intermediate carefacilities for the mentally retarded only, direct care costs include both of the following:

(a) Costs for physical therapists and physical therapy assistants, occupational therapists and occupational therapy assistants, speech therapists, audiologists, habilitation staff (including habilitation supervisors), qualified mental retardation professionals, program directors, social services staff, activities staff, off-site day programming, psychologists and psychology assistants, and social workers and counselors;

(b) Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted under section 5111.02 of the Revised Code, for personnel listed in division (H)(3)(a) of this section.

(4) Costs of other direct-care resources that are specified as direct care costs in rules adopted under section 5111.02 of the Revised Code.

(I) "Fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.

(J) "Franchise permit fee" means the ~~fee imposed by sections 3721.50 to 3721.58 of the Revised Code~~ following:

(1) In the context of nursing facilities, the fee imposed by sections 3721.50 to 3721.58 of the Revised Code;

(2) In the context of intermediate care facilities for the mentally retarded, the fee imposed by sections 5112.30 to 5112.39 of the Revised Code.

(K) "Indirect care costs" means all reasonable costs incurred by an intermediate care facility for the mentally retarded other than direct care costs, other protected costs, or capital costs. "Indirect care costs" includes but is not limited to costs of habilitation supplies, pharmacy consultants, medical and habilitation records, program supplies, incontinence supplies, food, enterals, dietary supplies and personnel, laundry, housekeeping, security, administration, liability insurance, bookkeeping, purchasing department, human resources, communications, travel, dues, license fees, subscriptions, home office costs not otherwise allocated, legal services, accounting services, minor equipment, maintenance and repairs, help-wanted advertising, informational advertising, start-up costs, organizational expenses, other interest, property insurance, employee training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified

in rules adopted under section 5111.02 of the Revised Code, for personnel listed in this division. Notwithstanding division (C)(1) of this section, "indirect care costs" also means the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992.

(L) "Inpatient days" means all days during which a resident, regardless of payment source, occupies a bed in a nursing facility or intermediate care facility for the mentally retarded that is included in the facility's certified capacity under Title XIX. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days.

(M) "Intermediate care facility for the mentally retarded" means an intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the medicaid program by the director of health in accordance with Title XIX.

(N) "Maintenance and repair expenses" means, except as provided in division (BB)(2) of this section, expenditures that are necessary and proper to maintain an asset in a normally efficient working condition and that do not extend the useful life of the asset two years or more. "Maintenance and repair expenses" includes but is not limited to the cost of ordinary repairs such as painting and wallpapering.

(O) "Medicaid days" means all days during which a resident who is a Medicaid recipient eligible for nursing facility services occupies a bed in a nursing facility that is included in the nursing facility's certified capacity under Title XIX. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered Medicaid days proportionate to the percentage of the nursing facility's per resident per day rate paid for those days.

(P) "Nursing facility" means a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX and is not an intermediate care facility for the mentally retarded. "Nursing facility" includes a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX and is certified as a skilled nursing facility by the director in accordance with Title XVIII.

(Q) "Operator" means the person or government entity responsible for the daily operating and management decisions for a nursing facility or intermediate care facility for the mentally retarded.

(R) "Other protected costs" means costs incurred by an intermediate care facility for the

mentally retarded for medical supplies; real estate, franchise, and property taxes; natural gas, fuel oil, water, electricity, sewage, and refuse and hazardous medical waste collection; allocated other protected home office costs; and any additional costs defined as other protected costs in rules adopted under section 5111.02 of the Revised Code.

(S)(1) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in any of the following regarding a nursing facility or intermediate care facility for the mentally retarded:

(a) The land on which the facility is located;

(b) The structure in which the facility is located;

(c) Any mortgage, contract for deed, or other obligation secured in whole or in part by the land or structure on or in which the facility is located;

(d) Any lease or sublease of the land or structure on or in which the facility is located.

(2) "Owner" does not mean a holder of a debenture or bond related to the nursing facility or intermediate care facility for the mentally retarded and purchased at public issue or a regulated lender that has made a loan related to the facility unless the holder or lender operates the facility directly or through a subsidiary.

(T) "Patient" includes "resident."

(U) Except as provided in divisions (U)(1) and (2) of this section, "per diem" means a nursing facility's or intermediate care facility for the mentally retarded's actual, allowable costs in a given cost center in a cost reporting period, divided by the facility's inpatient days for that cost reporting period.

(1) When calculating indirect care costs for the purpose of establishing rates under section 5111.241 of the Revised Code, "per diem" means an intermediate care facility for the mentally retarded's actual, allowable indirect care costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been eighty-five per cent.

(2) When calculating capital costs for the purpose of establishing rates under section 5111.251 of the Revised Code, "per diem" means a facility's actual, allowable capital costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

(V) "Provider" means an operator with a provider agreement.

(W) "Provider agreement" means a contract between the department of job and family services and the operator of a nursing facility or intermediate care facility for the mentally retarded for the provision of nursing facility services or intermediate care facility services for the mentally retarded under the medicaid program.

(X) "Purchased nursing services" means services that are provided in a nursing facility by registered nurses, licensed practical nurses, or nurse aides who are not employees of the facility.

(Y) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider.

(Z) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider.

(1) An individual who is a relative of an owner is a related party.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in both the provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.

(3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

(4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all of the following conditions are met:

(a) The supplier is a separate bona fide organization.

(b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the provider and there is an open, competitive

market for the types of goods or services the supplier furnishes.

(c) The types of goods or services are commonly obtained by other nursing facilities or intermediate care facilities for the mentally retarded from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities.

(d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.

(AA) "Relative of owner" means an individual who is related to an owner of a nursing facility or intermediate care facility for the mentally retarded by one of the following relationships:

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted parent, child, or sibling;

(4) Stepparent, stepchild, stepbrother, or stepsister;

(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;

(6) Grandparent or grandchild;

(7) Foster caregiver, foster child, foster brother, or foster sister.

(BB) "Renovation" and "extensive renovation" mean:

(1) Any betterment, improvement, or restoration of an intermediate care facility for the mentally retarded started before July 1, 1993, that meets the definition of a renovation or extensive renovation established in rules adopted by the director of job and family services in effect on December 22, 1992.

(2) In the case of betterments, improvements, and restorations of intermediate care facilities for the mentally retarded started on or after July 1, 1993:

(a) "Renovation" means the betterment, improvement, or restoration of an intermediate care facility for the mentally retarded beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. A renovation may

include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A renovation may include costs that otherwise would be considered maintenance and repair expenses if they are an integral part of the structural change that makes up the renovation project. "Renovation" does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity.

(b) "Extensive renovation" means a renovation that costs more than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years. For the purposes of division (BB)(2) of this section, the cost of constructing a new bed shall be considered to be forty thousand dollars, adjusted for the estimated rate of inflation from January 1, 1993, to the end of the calendar year during which the renovation is completed, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics. The department of job and family services may treat a renovation that costs more than eighty-five per cent of the cost of constructing new beds as an extensive renovation if the department determines that the renovation is more prudent than construction of new beds.

(CC) "Title XIX" means Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended.

(DD) "Title XVIII" means Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.

5101:3-3-64.1 **Nursing facility (NF) payment for cost-sharing other than medicare part A.**

(A) The NF per diem rate includes medicaid payments for medicare or other third-party insurance cost-sharing, including coinsurance or deductible payments, associated with services that are included in the NF per diem.

(B) Neither the NF resident nor the Ohio department of job and family services (ODJFS) is responsible for any medicare or other third-party insurance cost-sharing, including coinsurance or deductibles, associated with services that are included in the NF per diem.

Sec. 5111.231. Determination of Cost Per Case Mix Unit for Each Peer Group

(A) ~~For the purpose of the department of job and family services' determination under division (D) of this section of each peer group's cost per case- mix unit, "applicable calendar year" is defined in Section 206.66.23.000.~~As used in this section, "applicable calendar year" means the following:

(1) For the purpose of the department of job and family services' initial determination under division (D) of this section of each peer group's cost per case-mix unit, calendar year 2003;

(2) For the purpose of the department's subsequent determinations under division (D) of this section of each peer group's cost per case-mix unit, the calendar year the department selects.

(B) The department of job and family services shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for direct care costs determined semiannually by multiplying the cost per case-mix unit determined under division (D) of this section for the facility's peer group by the facility's semiannual case-mix score determined under section 5111.232 of the Revised Code.

(C) For the purpose of determining nursing facilities' rate for direct care costs, the department shall establish three peer groups. Each nursing facility located in any of the following counties shall be placed in peer group one: Brown, Butler, Clermont, Clinton, Hamilton, and Warren. Each nursing facility located in any of the following counties shall be placed in peer group two: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood. Each nursing facility located in any of the following counties shall be placed in peer group three: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot.

(D) (1) The department shall determine a cost per case-mix unit for each peer group established under division (C) of this section. A cost per case-mix unit determined under this division for a peer group shall be used for subsequent years until the department redetermines it. To determine a peer group's cost per case-mix unit, the department shall do all of the following:

(a) Determine the cost per case-mix unit for each nursing facility in the peer group for the applicable calendar year by dividing each facility's desk-reviewed, actual, allowable, per diem direct care costs for the applicable calendar year by the facility's annual average case mix score determined under section 5111.232 of the Revised Code for the applicable calendar year.

(b) Subject to division (D)(2) of this section, identify which nursing facility in the peer group is at the twenty-fifth percentile of the cost per case-mix units determined under division (D)(1)(a) of this section.

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

(d) Multiply the amount calculated under division (D)(1)(c) of this section by the rate of inflation for the eighteen-month period beginning on the first day of July of the applicable calendar year and ending the last day of December of the calendar year immediately following the applicable calendar year using the ~~employment cost index for total compensation, health services component, published by the United States bureau of labor statistics.~~ following:

(i) In the case of the initial calculation made under division (D)(1)(d) of this section, the employment cost index for total compensation, health services component, published by the United States bureau of labor statistics, as the index existed on July 1, 2005;

(ii) In the case of subsequent calculations made under division D)(1)(d) of this section and except as provided in division (D)(1)(d)(iii) of this section, the employment cost index for total compensation, nursing and residential care facilities occupational group, published by the United States bureau of labor statistics;

(iii) If the United States bureau of labor statistics ceases to publish the index specified in division (D)(1)(d)(ii) of this section, the index the bureau subsequently publishes that covers nursing facilities' staff costs.

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

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

(b) Nursing facilities whose cost per case-mix unit is more than one standard deviation from the mean cost per case-mix unit for all nursing facilities in the nursing facility's peer group for the applicable calendar year.

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

Sec. 5111.24. Per Resident Per Day Rate Ancillary and Support Costs; Determination of Rate for Each Peer Group

(A) ~~For the purpose of the department of job and family services' determination under division (D) of this section of each peer group's rate for ancillary and support costs, "applicable calendar year" is defined in Section 206.66.23.000.~~As used in section 5111.231.000, "applicable calendar year" means the following:

(1) For the purpose of the department of job and family services' initial determination determinations under division (D) of each peer group's rate for ancillary and support costs, calendar year 2003;

(2) For the purpose of the department's subsequent determinations under division (D) of this section of each peer group's rate for ancillary and support costs, the calendar year the department selects.

(B) The department of job and family services shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for ancillary and support costs determined for the nursing facility's peer group under division (D) of this section.

(C) For the purpose of determining nursing facilities' rate for ancillary and support costs, the department shall establish six peer groups. Each nursing facility located in any of the following counties shall be placed in peer group one or two: Brown, Butler, Clermont, Clinton, Hamilton, and Warren. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group one. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group two. Each nursing facility located in any of the following counties shall be placed in peer group three or four: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group three. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group four. Each nursing facility located in any of the following counties shall be placed in peer group five or six: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group five.

Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group six.

(D) (1) The department shall determine the rate for ancillary and support costs for each peer group established under division (C) of this section. The rate for ancillary and support costs determined under this division for a peer group shall be used for subsequent years until the department redetermines it. To determine a peer group's rate for ancillary and support costs, the department shall do all of the following:

(a) Determine the rate for ancillary and support costs for each nursing facility in the peer group for the applicable calendar year by using the greater of the nursing facility's actual inpatient days for the applicable calendar year or the inpatient days the nursing facility would have had for the applicable calendar year if its occupancy rate had been ninety per cent. For the purpose of determining a nursing facility's occupancy rate under division (D)(1)(a) of this section, the department shall include any beds that the nursing facility removes from its medicaid-certified capacity unless the nursing facility also removes the beds from its licensed bed capacity.

(b) Subject to division (D)(2) of this section, identify which nursing facility in the peer group is at the twenty-fifth percentile of the rate for ancillary and support costs for the applicable calendar year determined under division (D)(1)(a) of this section.

(c) Calculate the amount that is three per cent above the rate for ancillary and support costs determined under division (D)(1)(a) of this section for the nursing facility identified under division (D)(1)(b) of this section.

(d) Multiply the amount calculated under division (D)(1)(c) of this section by the rate of inflation for the eighteen-month period beginning on the first day of July of the applicable calendar year and ending the last day of December of the calendar year immediately following the applicable calendar year using the ~~consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics.~~ following:

(i) In the case of the initial calculation made under division (D)(1)(d) of this section, the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics, as that index existed on July 1, 2005;

(ii) In the case of subsequent calculations made under division (D)(1)(d) of this section and except as provided in division (D)(1)(d)(iii) of this section, the consumer price index for all items for all urban consumers for the midwest region, published by the United States bureau of labor statistics;

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

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

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

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

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

Sec. 5111.25. Per Resident Per Day Rate for Capital Costs of Nursing Facility.

(A) ~~For the purpose of the department of job and family services' determination under division (D) of this section of each peer group's median rate for capital costs, "applicable calendar year" is defined in Section 206.66.23.000.~~As used in section 5111.231.000, "applicable calendar year" means the following:

(1) For the purpose of the department of job and family services' initial determination under division (D) of this section of each peer group's median rate for capital costs, calendar year 2003;

(2) For the purpose of the department's subsequent determinations under division (D) of this section of each peer group's median rate for capital costs, the calendar year the department selects.

(B) The department of job and family services shall pay a provider for each of the provider's eligible nursing facilities a per resident per day rate for capital costs. A nursing facility's rate for capital costs shall be the median rate for capital costs for the nursing facilities in the nursing facility's peer group as determined under division (D) of this section.

(C) For the purpose of determining nursing facilities' rate for capital costs, the department shall establish six peer groups. Each nursing facility located in any of the following counties shall be placed in peer group one or two: Brown, Butler, Clermont, Clinton, Hamilton, and Warren. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group one. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group two. Each nursing facility located in any of the following counties shall be placed in peer group three or four: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group three. Each nursing facility located in any of those counties that has one hundred or more beds shall be placed in peer group four. Each nursing facility located in any of the following counties shall be placed in peer group five or six: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot. Each nursing facility located in any of those counties that has fewer than one hundred beds shall be placed in peer group five. Each nursing facility

located in any of those counties that has one hundred or more beds shall be placed in peer group six.

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

(a) Subject to division (D)(2) of this section, use the greater of each nursing facility's actual inpatient days for the applicable calendar year or the inpatient days the nursing facility would have had for the applicable calendar year if its occupancy rate had been one hundred per cent.

(b) Exclude both of the following:

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

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

(2) For the purpose of determining a nursing facility's occupancy rate under division (D)(1)(a) of this section, the department shall include any beds that the nursing facility removes from its medicaid-certified capacity after June 30, 2005, unless the nursing facility also removes the beds from its licensed bed capacity.

(E) Buildings shall be depreciated using the straight line method over forty years or over a different period approved by the department. Components and equipment shall be depreciated using the straight-line method over a period designated in rules adopted under section 5111.02 of the Revised Code, consistent with the guidelines of the American hospital association, or over a different period approved by the department. Any rules authorized by this division that specify useful lives of buildings, components, or equipment apply only to assets acquired on or after July 1, 1993. Depreciation for costs paid or reimbursed by any government agency shall not be included in capital costs unless that part of the payment under sections 5111.20 to 5111.33 of the Revised Code is used to reimburse the government agency.

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

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

(2) For facilities with dates of licensure after June 30, 1993, the capital cost basis shall be determined in accordance with the principles of the medicare program established under Title XVIII, except as otherwise provided in sections 5111.20 to 5111.33 of the Revised Code.

(3) Except as provided in division (F)(4) of this section, if a provider transfers an interest in a facility to another provider after June 30, 1993, there shall be no increase in the capital cost basis of the asset if the providers are related parties or the provider to which the interest is transferred authorizes the provider that transferred the interest to continue to operate the facility under a lease, management agreement, or other arrangement. If the previous sentence does not prohibit the adjustment of the capital cost basis under this division, the basis of the asset shall be adjusted by the lesser of the following:

(a) One-half of the change in construction costs during the time that the transferor held the asset, as calculated by the department of job and family services using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time that the transferor held the asset.

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

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

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

(c) The department of job and family services determines that the transfer is an arm's length transaction pursuant to rules adopted under section 5111.02 of the Revised Code. The rules shall provide that a transfer is an arm's length transaction if all of the following apply:

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

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

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

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

(G) As used in this division: "Imputed interest" means the lesser of the prime rate plus two per cent or ten per cent. "Lease expense" means lease payments in the case of an operating lease and depreciation expense and interest expense in the case of a capital lease. "New lease" means a lease, to a different lessee, of a nursing facility that previously was operated under a lease.

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

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

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

(2) Subject to division (B) of this section, for a lease of a facility that was in existence but not operated under a lease on May 27, 1992, actual, allowable capital costs shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the

lessor's entire historical capital asset cost basis, adjusted by the lesser of the following amounts:

(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease.

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

(a) The annual depreciation expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis;

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

(4) Subject to division (B) of this section, for a lease of a facility with a date of licensure on or after May 27, 1992, that was not initially operated under a lease and has been in existence for ten years, actual, allowable capital costs shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the entire historical capital asset cost basis of the lessor, adjusted by the lesser of the following:

(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease.

(5) Subject to division (B) of this section, for a new lease of a facility that was operated under a lease on May 27, 1992, actual, allowable capital costs shall include the lesser of the annual new lease expense or the annual old lease payment. If the old lease was in effect for ten years or longer, the old lease payment from the beginning of the old lease shall be adjusted by the lesser of the following:

(a) One-half of the change in construction costs from the beginning of the old lease to the beginning of the new lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease.

(6) Subject to division (B) of this section, for a new lease of a facility that was not in existence or that was in existence but not operated under a lease on May 27, 1992, actual, allowable capital costs shall include the lesser of annual new lease expense or the annual amount calculated for the old lease under division (G)(2), (3), (4), or (6) of this section, as applicable. If the old le ase was in effect for ten years or longer, the lessor's historical capital asset cost basis shall be adjusted by the lesser of the following for purposes of calculating the annual amount under division (G)(2), (3), (4), or (6) of this section:

(a) One-half of the change in construction costs from the beginning of the old lease to the beginning of the new lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease. In the case of a lease under division (G)(3) of this section of a facility for which a substantial commitment of money was made after December 22, 1992, and before July 1, 1993, the old lease payment shall be adjusted for the purpose of determining the annual amount.

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

(8) Except as provided in division (G)(9) of this section, if a provider leases an interest in a facility to another provider who is a related party or previously operated the

facility, the related party's or previous operator's actual, allowable capital costs shall include the lesser of the annual lease expense or the reasonable cost to the lessor.

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

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

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

(c) The department of job and family services determines that the lease is an arm's length transaction pursuant to rules adopted under section 5111.02 of the Revised Code. The rules shall provide that a lease is an arm's length transaction if all of the following apply:

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

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

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

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

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

~~(H) After the date on which a transaction of sale is closed, the provider shall refund to the department the amount of excess depreciation paid to the provider for the facility by the department for each year the provider has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the~~

~~provider has received payment for the facility. The provider of a facility that is sold or that voluntarily terminates participation in the medicaid program also shall refund any other amount that the department properly finds to be due after the audit conducted under this division. For the purposes of this division, "depreciation paid to the provider for the facility" means the amount paid to the provider for the nursing facility for capital costs pursuant to this section less any amount paid for interest costs, amortization of financing costs, and lease expenses. For the purposes of this division, "excess depreciation" is the nursing facility's depreciated basis, which is the provider's cost less accumulated depreciation, subtracted from the purchase price net of selling costs but not exceeding the amount of depreciation paid to the provider for the facility.~~

Sec. 5111.254 Initial Rates for New or Replacement Facility or Newly Certified Facility

(A) The department of job and family services shall establish initial rates for a nursing facility with a first date of licensure that is on or after July 1, 2006, including a facility that replaces one or more existing facilities, or for a nursing facility with a first date of licensure before that date that was initially certified for the Medicaid program on or after that date, in the following manner:

(1) The rate for direct care costs shall be the product of the cost per case-mix unit determined under division (D) of section 5111.231 of the Revised Code for the facility's peer group and the nursing facility's case-mix score. For the purpose of division (A)(1) of this section, the nursing facility's case-mix score shall be the following:

(a) Unless the nursing facility replaces an existing nursing facility that participated in the medicaid program immediately before the replacement nursing facility begins participating in the medicaid program, the median annual average case-mix score for the nursing facility's peer group;

(b) If the nursing facility replaces an existing nursing facility that participated in the medicaid program immediately before the replacement nursing facility begins participating in the medicaid program, the semiannual case-mix score most recently determined under section 5111.232 of the Revised Code for the replaced nursing facility as adjusted, if necessary, to reflect any difference in the number of beds in the replaced and replacement nursing facilities.

(2) The rate for ancillary and support costs shall be the rate for the facility's peer group determined under division (D) of section 5111.24 of the Revised Code.

(3) The rate for capital costs shall be the median rate for the facility's peer group determined under division (D) of section 5111.25 of the Revised Code.

(4) The rate for tax costs as defined in section 5111.242 of the Revised Code shall be the median rate for tax costs for the facility's peer group in which the facility is placed under division (C) of section 5111.24 of the Revised Code.

~~(5) The quality incentive payment shall be the mean payment specified in division (B) of section 5111.244 of the Revised Code.~~

(B) The department shall increase rates established under division (A) of this section by two per cent.

(C) The department shall increase rates established under division (B) of this section by two per cent;

(D) The department shall increase rates established under division (C) of this section by one per cent;

(E) The department shall increase rates established under division (D) of this section by the quality incentive payment, which shall be the mean payment specified in division (B) of section 5111.244 of the Revised Code;

(F) The department shall increase rates established under division (E) of this section by seventy-three hundredths per cent.

(G) The department shall increase rates established under these sections by five dollars and seventy cents per Medicaid day. This increase shall be known as the workforce development incentive payment. The department shall further increase rates established under this section by the consolidated services rate, which shall be:

(1) Three dollars and eighty-four cents per Medicaid day for fiscal year 2010.

(2) Three dollars and ninety-one cents per Medicaid day for fiscal year 2011.

~~(B)~~(H) Subject to division ~~(C)~~(I) of this section, the department shall adjust the rates established under divisions (A) through (G) of this section effective the first day of July, to reflect new rate calculations for all nursing facilities under sections 5111.20 to 5111.33 of the Revised Code.

~~(C)~~(I) If a rate for direct care costs is determined under this section for a nursing facility using the median annual average case-mix score for the nursing facility's peer group, the rate shall be redetermined to reflect the replacement nursing facility's actual semiannual case-mix score determined under section 5111.232 of the Revised Code after the nursing facility submits its first two quarterly assessment data that qualify for use in calculating a case-mix score in accordance with rules authorized by division (E) of section 5111.232 of the Revised Code. If the nursing facility's quarterly submissions do not qualify for use in calculating a case-mix score, the department shall continue to use the median annual average case-mix score for the nursing facility's peer group in lieu of the nursing facility's semiannual case-mix score until the nursing facility submits two consecutive quarterly assessment data that qualify for use in calculating a case-mix score.

OS Notification

State/Title/Plan Number: Ohio 09-013

Type of Action: SPA Approval

Required Date for State Notification: September 28, 2011

Fiscal Impact:

FY 2009	$ 26,693,460
FY 2010	$ 81,331,290

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail:

Effective July 1, 2009, Ohio proposes to reimburse for transportation services; over-the-counter drugs; and physical therapy, occupational therapy, and speech language pathology and audiology services by including the rates for these services in the institutional NF per diem rate. In turn, NFs ensure that residents have access to these services and reimburse the providers of these services. Under this new NF per diem rate methodology the transportation, over-the-counter drugs, and selected therapy services for these NF residents are no longer reimbursable by the State on a fee-for-service basis.

The State submitted four SPAs to propose these changes to the reimbursement methodology for: 1) institutional NF services (TN 09-013), 2) transportation services (TN 09-010), 3) over-the-counter drugs (TN 09-018), and 4) therapy services (TN 09-016). The effective date for TN 09-013 is July 1, 2009. Due to concerns by the Ohio Legislature, the effective date for TNs 09-010, 09-016, and 09-018 is August 1, 2009. At CMS's request, the State inserted language in the reimbursement methodology that clarified that the revised NF per diem rate (TN 09-013) would be effective July 1, 2009.

The State anticipates an aggregate budget savings of approximately $4.5 million based on, according to the State, "assumptions about the purchasing strategies used by the NF providers purchasing these services directly" and "not due to a rate reduction". The State assumed that, "individual service utilization and access to the impacted services would remain the same for NF residents." The State provided an acceptable NF services UPL demonstration. The State provided satisfactory responses to the funding questions. Funding is provided through State appropriations and provider tax. Ohio does not have any Federally Recognized Tribes, Indian health programs or Urban Indian Organizations; therefore, no consultation is required.

The review of these four SPAs has taken over two years because of the complexity of the review due to their inter-related parts regarding the "bundling" of reimbursement for transportation services, over-the-counter drugs, and therapy services; the multiple effective date issue (see above); and acceptable

demonstration that the State satisfied public notice/process requirements.

Additionally, TN 09-013 alone provides for a .73% increase in the SFY 2010 NF reimbursement rate; changes the "stop loss-stop gain" limitations; adds a workforce development rate; clarifies the data used for calculating the cost per case mix unit; clarifies the data used for calculating the ancillary and support cost rate; clarifies the data used for calculating the capital cost rate; revises the methodology for establishing rates for new or replacement facilities or newly certified facilities.

Other Considerations:

CMS received inquiries from several provider associations concerned about the reimbursement changes to the institutional NF per diem rate, specifically the bundling of reimbursement of transportation services, over-the-counter drugs; and selected therapies (physical therapy, occupational therapy, and speech language pathology and audiology services) into the NF per diem rate and its impact on access to care and services. The review team inquired with the State about access concerns and provider participation (pharmacy). The State indicated that it is not aware of any access or provider participation concerns.

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

CMS Contact:

Todd McMillion (608) 441-5344
National Institutional Reimbursement Team