"SUNSHINE/KING ROAD FAMILY CARE HOME is an ICF-MR outlier provider on the Medicaid program. SUNSHINE/KING ROAD FAMILY CARE HOME receives a per diem rate of ~~$470.03~~ $455.34 per resident per day for each Medicaid resident in lieu of the calculated rate set forth under ICF-MR Supplement 2."

~~5101:3-3-19~~ **~~Relationship of other covered medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) 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 5101:3-3-20, 5101:3-3-71, 5101:3-3-71.1, 5101:3-3-71.2, 5101:3-3-71.3, and 5101:3-3-71.4 of ICF-MR Supplement 2, Attachment 4.19D. All references to "ICFs-MR" in paragraphs (A) to (I) 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, and intermittent positive pressure breathing machines, except as noted in paragraph (C)(2) of this rule.~~

~~(c) 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 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, 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. 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 5101:3-3-46.1 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.~~

~~(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 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.~~

~~(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 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 rule 5101:3-1-01 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 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.~~

5101:3-3-19.1 **Relationship of other covered medicaid services to intermediate care facility for the mentally retarded (ICF-MR) services.**

This rule identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism," the provisions governing such reimbursement are set forth in sections 5101:3-3-20, 5101:3-3-71, 5101:3-3-71.1, 5101:3-3-71.2, 5101:3-3-71.3, and 5101:3-3-71.4 of ICF-MR Supplement 2, Attachment 4.19D of the state plan. All references to "ICFs-MR" in paragraphs (A) to (I) of this rule do not include state-operated ICFs-MR for which reimbursement is made in accordance with section 5101:3-3-99 of Attachment 4.19D of the state plan.

(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 of the state plan. 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 of the state plan.

(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, and intermittent positive-pressure breathing machines, except as noted in paragraph (C)(2) of this rule.

(c) 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 of the state plan, 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 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, 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 of the state plan, 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 an ICF-MR must be signed by the facility representative at the time of delivery and a copy retained by the pharmacy.

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

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 Attachment 4.19D of the state plan. 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 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 ICF-MR.

(F) Physician services.

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

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

(b) All medically necessary physician visits in accordance with Attachment 4.19B of the state plan.

(c) All required physician visits as described in this rule when the services are billed in accordance with Attachment 4.19B of the state plan.

(i) Physician visits must be provided to a resident of an ICF-MR and are considered timely if they occur 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 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 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 rule 5101:3-1-01 of the Administrative Code, and requested by the 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 an 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 of the state plan. Payment by ODJFS is limited to one visit per month for residents in an ICF-MR setting.

(H) Transportation services.

Costs incurred by the facility for transporting residents by means other than covered ambulance or ambulette 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 of the state plan.

(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 of the state plan.

5101:3-3-78 **Intermediate care facilities for the mentally retarded (ICFs-MR): method for establishing the total prospective rate.**

(A) The method for establishing the total prospective rate for ICFs-MR is the combination of allowable per diems established for direct care, other protected care, indirect care and capital costs as set forth in rules 5101:3-3-79, 5101:3-3-82, 5101:3-3-83 and 5101:3-3-84.2 of the Administrative Code. The Ohio department of job and family services (ODJFS) shall not reduce the rates calculated pursuant to these rules on the basis that the facility charges a lower rate to any resident who is not eligible for medicaid.

(B) After ODJFS receives the cost reports for a cost reporting period, ODJFS shall perform a desk review of each cost report. Based on the desk review, ODJFS shall make a preliminary determination whether the costs are allowable. No later than July first of each year, ODJFS shall notify each ICF-MR if any of its costs are preliminarily determined not to be allowable. ODJFS shall allow the ICF-MR to verify the cost they submitted and, if necessary, submit additional information.

5101:3-3-82.1 **—Method for establishing reimbursement to intermediate care facilities for the mentally retarded (ICFs-MR) for the franchise permit fee-.**

(A) For each ICF-MR subject to the franchise fee assessment as specified in ~~rules 5101:3-3-30 to 5101:3-3-30.4 of the Administrative Code~~ sections 5112.30 to 5112.39 of the Revised Code, the Ohio department of job and family services (ODJFS) shall include a franchise permit fee rate ~~add-on~~ in ~~its~~ the prospective per diem rate. The ICF-MR will not receive reimbursement for the franchise permit fee ~~as a rate add-on~~ if there is no assessment. Notwithstanding the methodology of reimbursement for other protected care costs, as set forth under rules 5101:3-3-01, 5101:3-3-82, and 5101:3-3-71 of the Administrative Code, the reimbursement methodology for franchise permit fee is set forth below.

~~(A)~~(B) ~~A franchise permit fee will be assessed as specified in rule 5101:3-3-30.1 of the Administrative Code.~~ The department of job and family services shall pay a provider for each of the provider's eligible ICFs-MR a per resident per day rate for the franchise permit fee for the ICFs-MR Medicaid residents. The franchise permit fee rate ~~add-on~~ is not subject to the inflation factor that is allowed for costs reported in the other protected care cost center as referenced in rule 5101:3-3-82 of the Administrative Code.

~~(B) For ICFs MR which are new to the medical assistance program, the per diem rate shall be determined as set forth below.~~

~~(1) A franchise permit fee will be assessed as specified in rule 5101:3-3-30.1 of the Administrative Code. The department of job and family services shall pay a provider for each of the provider's eligible ICFs MR a per resident per day rate for the franchise permit fee for the ICFs MR Medicaid residents. The franchise permit fee rate add-on is not subject to the inflation factor that is allowed for costs reported in the other protected care cost center as referenced in rule 5101:3-3-82 of the Administrative Code.~~

5101:3-3-86

5101:3-3-86 **Intermediate Care Facilities for the Mentally Retarded (ICFs-MR): Rates for Providers New to the Medicaid Program.**

(A) The Ohio department of job and family services (ODJFS) shall determine the initial rate for the fiscal year in which the ICF-MR begins participation in the medicaid program for an ICF-MR with a first date of licensure and subsequent certification on or after July 1, 2007, including an ICF-MR that replaces one or more existing facilities, or an ICF-MR with a first date of licensure before that date that was certified for the medicaid program on or after that date under section 5111.255 of the Revised Code as follows:

(1) For the fiscal year in which the ICF-MR begins participation in the medicaid program, the initial rate shall be set as follows:

(a) The rate for direct care costs shall be determined as follows:

(i) The initial rate shall be the cost per case-mix unit (CPCMU) which reflects the median medicaid day of the ICF-MR bed-size group multiplied by the median annual average case-mix score of the ICF-MR bed-size group multiplied by the eighteen-month inflation rate determined for the fiscal year under rule 5101:3-3-79 of the Administrative Code. Both the CPCMU which reflects the median medicaid day of the ICF-MR bed-size group and the median annual average case-mix score of the ICF-MR bed-size group are determined from the calendar year preceding the fiscal year in which the rate will be paid. ODJFS shall assign the ICF-MR to the applicable bed-size group based upon the number of medicaid certified beds of the ICF-MR as determined under rule 5101:3-3-79 of the Administrative Code.

~~(ii) After the ICF-MR submits quarterly assessment information for its first reporting quarter under rule 5101:3-3-73.1 of the Administrative Code, its rate for the following payment quarter shall be calculated using its actual case mix score from the reporting quarter as determined under rule 5101:3-3-73.3 of the Administrative Code instead of the median case mix score prescribed by paragraph (A)(1)(a)(i) of this rule. If either of the ICF-MR's first two quarterly submissions do not contain assessment information that qualifies for use in calculating a case mix score under rule 5101:3-3-73.3 of the Administrative Code, ODJFS shall continue to calculate the rate using the median annual case mix score for the ICF-MR bed-size group and shall not assign a quarterly case mix score as provided in that rule.~~

~~(iii)~~(ii) If the ICF-MR is a replacement facility and the facility or facilities that are being replaced are in operation immediately before the replacement ICF-MR opens, the direct care rate shall be the same as the direct care rate for the replaced facility or facilities, weighted by the number of beds from each replaced facility. If one or more of the replaced facilities is not in operation immediately before the replacement ICF-MR opens, its proportion of the direct care rate shall be determined under paragraph (A)(1)(a)(i) of this rule.

(b) The rate for other protected costs shall be determined as follows:

(i) The initial rate shall be one hundred fifteen percent of the median rate for all ICFs-MR as calculated at the beginning of the fiscal year in which the rate will be paid under rule 5101:3-3-82 of the Administrative Code. The median rate will not include the franchise permit fee. Facilities billed this fee in their initial rate year, will be assigned an amount as provided in paragraph (A) of rule 5101:3-3-82.1 of the Administrative Code.

(c) The rate for indirect care costs shall be determined as follows:

(i) The initial rate shall be the applicable maximum rate for the ICF-MR bed-size group as calculated for the fiscal year in which the rate will be paid under rule 5101:3-3-83 of the Administrative Code. ODJFS shall assign the ICF-MR to the applicable bed-size group based upon the number of medicaid certified beds of the ICF-MR as determined under rule 5101:3-3-83 of the Administrative Code.

(d) The rate for capital costs shall be determined as follows:

(i) The ICF-MR shall be assigned the median capital rate of all ICFs-MR as calculated at the beginning of the fiscal year in which the rate will be paid under rule 5101:3-3-84 of the Administrative Code.

(B) For the following fiscal year the new provider's rate shall be calculated as follows:

(1) For a new ICF-MR provider beginning July first through October first, ODJFS shall set the rate pursuant to sections 5111.20 to 5111.33 of the Ohio Revised Code for the following fiscal year using the year end cost report filed under rule 5101:3-3-20 of the Administrative Code.

(2) For a new ICF-MR provider beginning October second through December thirty-first, ODJFS shall set the rate pursuant to sections 5111.20 to 5111.33 of the Ohio Revised Code for the following fiscal year using the three month cost report filed under rule 5101:3-3-20 of the Administrative Code.

(3) For a new ICF-MR provider beginning January first through June thirtieth, ODJFS shall set the rate pursuant to sections 5111.20 to 5111.33 of the Ohio Revised Code for the following fiscal year in accordance with paragraph (A)(1) of this rule.

5101:3-3-90 **Intermediate care facilities for the mentally retarded (ICFs-MR) expenditure limitation.**

(A) Notwithstanding rules 5101:3-3-71 to 5101:3-3-96 of the Administrative Code, "total per diem rate" includes the payments to ICFs-MR, excluding state-operated ICFs-MR, under the medicaid program subject to the following limitations:

(1) For state fiscal year ~~2008~~ 2010, the mean total per diem rate for all ICFs-MR in the state, weighted by ~~May 2007~~ May 2009 medicaid days and calculated as of ~~July 1, 2007~~ August 1, 2009, shall not exceed two hundred ~~sixty-six dollars and fourteen cents.~~ seventy-eight dollars and fifteen cents.

(2) For ~~Fiscal year 2009~~ subsequent fiscal years, the mean total per diem rate for all ICFs-MR in the state, weighted by May ~~2008~~ medicaid days from the previous state fiscal year and calculated as of ~~July 1, 2008~~ July 1, shall not exceed two hundred ~~seventy-four dollars and ninety-eight cents.~~ seventy-eight dollars and fifteen cents.

(3) If the mean total per diem rate for all ~~intermediate care facilities for the mentally retarded~~ ICFs-MR in the state for fiscal year ~~2008 or 2009~~ 2010, weighted by medicaid days as specified in paragraph (A)(1) ~~or (A)(2)~~ of this rule, as appropriate, and calculated as of the first day of ~~July~~ August of the calendar year in which the fiscal year begins, exceeds the amount specified in paragraph (A)(1) ~~or (A)(2)~~ of this rule, as applicable, the Ohio department of job and family services (ODJFS) shall reduce the total per diem rate for each ~~intermediate care facility for the mentally retarded~~ ICF-MR in the state by a percentage that is equal to the percentage by which the mean total per diem rate exceeds the amount specified in paragraph (A)(1) ~~or (A)(2)~~ of this rule for that fiscal year.

(4) If the mean total per diem rate for all ICFs-MR in the state for subsequent fiscal years, weighted by medicaid days as specified in paragraph (A)(2) of this rule, as appropriate, and calculated as of the first day of July of the calendar year in which the fiscal year begins, exceeds the amount specified in paragraph (A)(2) of this rule, as applicable, the Ohio department of job and family services (ODJFS) shall reduce the total per diem rate for each ICF-MR in the state by a percentage that is equal to the percentage by which the mean total per diem rate exceeds the amount specified in paragraph (A)(2) of this rule for that fiscal year.

(B) The rate of an ICF-MR adjusted pursuant to this section shall not be subject to any further adjustments authorized by sections 5111.20 to 5111.33 of the Revised Code, or any rule authorized by those sections, during the remainder of the fiscal year.

OS Notification

State/Title/Plan Number: Ohio 09-014

Type of Action: SPA Approval

Required Date for State Notification: June 21, 2011

Fiscal Impact:

FY 2009	$ 952,477
FY 2010	$ 4,353,098

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 for services on or after August 1, 2009, this amendment increases the intermediate care facility for the mentally retarded (ICF/MR) per diem limitation to $278.15 and reduces the per diem rate for Sunshine/King Road Family Care Home, an ICF/MR outlier provider, to $455.34. The State estimates an increase to the Federal budget even though there is both an increase to the normal ICF/MR per diem and a decrease to the outlier provider per diem. Access to care questions were not asked of the State regarding the per diem reduction for Sunshine/King Family Care Home because this facility is considered an outlier provider and even though the per diem is being reduced it's still well above the normal per diem rate for ICFs/MR. Additionally this amendment adds plan language that clarifies how certain other covered Medicaid services performed in an ICF/MR are reimbursed, whether directly to the provider on a FFS basis or as part of the ICF/MR per diem rate; adds language that provides that the State shall not reduce an ICF/MR's per diem rate if that ICF/MR charges a lower rate to a non-Medicaid eligible resident; makes technical changes to the plan language provisions for including the Medicaid portion of the franchise permit fee to ICF/MRs in the prospective per diem rate; clarifies methodology for determining rates for new ICF/MR providers. There are no issues with the UPL, funding comes from State appropriations and provider tax (franchise permit fee).

Other Considerations:

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

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:

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