

## **Table of Contents**

**State/Territory Name: OH**

**State Plan Amendment (SPA) #: 13-020**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



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**NOV 18 2015**

John McCarthy, Medicaid Director  
Office of Ohio Health Plans  
Ohio Department of Medicaid  
P.O. Box 182709  
50 West Town Street, Suite 400  
Columbus, Ohio 43218

RE: Ohio State Plan Amendment (SPA) 13-020

Dear Mr. McCarthy:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 13-020. Effective July 1, 2013, this SPA proposes to implement changes to the intermediate care facilities program as established in Amended Substitute House Bill 59 of the 130111 Ohio General Assembly.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment (TN) 13-020 is approved effective July 1, 2013. We are enclosing the Form CMS-179 and the amended plan pages.



If you have any questions, please call Fred Sebree at (217) 492-4122.

Sincerely,

A black rectangular redaction box covers the signature of Kristin Fan.

Kristin Fan  
Director

Enclosure

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>13-020 (Revised)</b>	2. STATE <b>OHIO</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
<b>FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b> TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2013	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> <b>AMENDMENT</b>			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.150 42 CFR 447 Subpart C		7. FEDERAL BUDGET IMPACT: a. FFY 2013    \$ 381.48 thousands b. FFY 2014    \$ 1,512.48 thousands	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19-D, Supplement 2, Pages <del>1-19 of 19</del> (NEW) <sup>1-20 of 20</sup>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Attachment 4.19-D, Supplement 2, (DELETED; multiple TNs)	
10. SUBJECT OF AMENDMENT: Intermediate care facility services: Payment for services			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The State Medicaid Director is the Governor's designee	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:  Carolyn Brewer Ohio Department of Medicaid P.O. BOX 182709 Columbus, Ohio 43218	
13. TYPED NAME: John B. McCarthy			
14. TITLE: STATE MEDICAID DIRECTOR			
15. DATE SUBMITTED: 9/30/13			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: NOV 18 2013	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2013		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Krysten FAN		22. TITLE: Deputy Director, FMCs	
23. REMARKS:			

Instructions on Back

**Background**

Facility specific rates for Intermediate Care Facility for Individuals with Intellectual Disabilities are established prospectively using facility cost report data from the calendar year proceeding the fiscal year in which rates will be set. The cost report is Ohio-specific, and is submitted electronically within ninety days after the end of the reporting period as specified in rule 5123:2-7-12 of the Ohio Administrative Code. Each cost report contains the following cost centers and the rate is the sum of the following components:

- 1) Direct Care costs
- 2) Indirect Care costs
- 3) Capital costs
- 4) Other Protected costs

Cost reports reflect allowable costs (costs determined by the State to be reasonable and do not include fines paid). Unless otherwise specified, allowable costs are determined in accordance with the following, as currently issued and updated, in the following priority:

- 1) Title 42 Code of Federal Regulations (CFR) Chapter IV
- 2) The provider reimbursement manual (CMS Publication 15-1)
- 3) Generally accepted accounting principles.

A reasonable cost is one that 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 do not exceed what a prudent buyer pays for a given item or services. The costs of goods, services and facilities furnished to a provider by a related party are includable in the allowable costs of the provider at the reasonable cost to the related party.

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**Eligibility for Payment for Intermediate Care Facility for Individuals with Intellectual Disabilities Services**

In order to be eligible for Medicaid payments, the operator of an intermediate care facility for individuals with intellectual disabilities shall enter into a provider agreement with the state, apply for and maintain a valid license to operate and comply with all applicable state and federal laws and rules. The operator of an intermediate care facility for individuals with intellectual disabilities that chooses to be a Medicaid provider must maintain Ohio Medicaid certification for all beds participating in the Medicaid program.

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**Relation to Other Services**

The intermediate care facility for individuals with intellectual disabilities rate is a comprehensive rate including many services otherwise provided through the Medicaid program on a fee for service basis. The majority of costs are covered through the cost report mechanism. However, there are some services that are reimbursed directly to the medical service provider.

Services that are reimbursed directly to the medical service provider include:

- 1) Dental services provided by licensed dentists that are not facility staff or contracted personnel
- 2) Laboratory and x-ray services, excluding tuberculin tests
- 3) Certain durable medical equipment items, including:
  - a. Ventilators
  - b. Custom-made wheelchairs
- 4) Prostheses
- 5) Orthoses
- 6) Contents of oxygen cylinders or tanks (except for emergency stand-by oxygen)
- 7) Oxygen producing machines
- 8) Pharmaceuticals
- 9) Psychologist services provided by a community mental health center
- 10) Physician services
- 11) Podiatry services
- 12) Ambulance services
- 13) Vision care services

Payment methodologies for these services are described in Attachment 4.19-B.

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**Peer Groups**

Peer Groups are used to establish the direct care, indirect care and capital rate components for intermediate care facility for individuals with intellectual disabilities rates. There are two peer groups which are based on the number of certified beds in the intermediate care facility for individuals with intellectual disabilities. Intermediate care facilities for individuals with intellectual disabilities with eight or fewer certified beds are in the small peer group and intermediate care facilities for individuals with intellectual disabilities with nine or more certified beds are in the large peer group.

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**Direct Care**

**Allowable costs for direct care**

Costs included in direct care are reasonable costs incurred for wages, taxes, benefits, staff development and contracting/consulting expenses for the following:

- 1) Registered nurses, licensed practical nurses and nurse aides
- 2) Administrative nursing staff and medical directors
- 3) Psychologist and psychology assistants
- 4) Respiratory therapist, physical therapist, physical therapy assistant, occupational therapist, occupational therapy assistant, speech therapist, audiologist and other persons holding degrees qualifying them to provide therapy
- 5) Qualified Intellectual Disabilities Professionals
- 6) Habilitation staff and supervisor
- 7) Program director, program specialist, activity director and activity staff
- 8) Social work/counseling, social services and pastoral care
- 9) Active treatment off-site day programming
- 10) Quality assurance and other home office costs related to direct care
- 11) Other direct care costs

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**Calculation of Direct Care Per Diem**

A direct care per diem rate is established for each intermediate care facility for individuals with intellectual disabilities using allowable direct care costs as reported by each facility in accordance with the following calculation:

- 1) Calculate the direct care cost per diem for each provider by dividing the allowable direct care costs by the inpatient days reported on the same cost report.
- 2) Calculate the direct care cost per case mix unit for each provider by dividing the provider's direct care costs per diem by the annual average case mix score for the provider. The annual average case mix score is the average of the provider's scores for the March 31, June 30, September 30, and December 31 reporting period end dates for the calendar year corresponding to the calendar year for which costs are reported.
  - a. For state fiscal year 2014 only, the annual average case mix score for the provider is calculated as the average of the provider's score for the December 31, 2012 and March 31, 2013 reporting period end dates and the statewide assessment.
- 3) Determine the maximum cost per case mix unit for each peer group:
  - a. The maximum cost per case mix unit for the large peer group is \$123.05.
  - b. The maximum cost per case mix unit for the small peer group is \$117.22.
- 4) The allowable cost per case mix unit is the lesser of the facility cost per case mix unit or the maximum cost per case mix unit for the peer group.
- 5) Multiply the allowable cost per case mix unit by the annual average case mix score for the provider and then multiply the product by an inflation factor to determine the direct care per diem for the facility. The inflation factor is 1.0140.

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## INDIRECT COSTS

### Allowable costs for indirect care

Costs included in indirect care are reasonable costs incurred for goods or services for the following:

- 1) Dietary costs including:
  - a. Dietitian,
  - b. Dietary staff,
  - c. Dietary supplies and equipment,
  - d. Food,
  - e. Enterals,
  - f. Other Dietary costs
- 2) Medical, Habilitation, Pharmacy and Incontinence supplies
- 3) Administrative & General services including:
  - a. Personnel,
  - b. Supplies,
  - c. Travel,
  - d. Laundry and housekeeping,
  - e. Legal fees,
  - f. Accounting fees,
  - g. Insurance,
  - h. Start-up costs,
  - i. Home office costs/Indirect costs,
  - j. Other administrative & general services
- 4) Maintenance and minor equipment
- 5) Payroll taxes, fringe benefits and staff development for wages included in the indirect care cost category

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**Calculation of Indirect Care Per Diem**

An indirect care per diem rate is established for each intermediate care facility for individuals with intellectual disabilities using allowable indirect care costs as reported by each facility in accordance with the following calculation:

- 1) Divide the allowable indirect care costs by the greater of the inpatient days reported on the same cost report or imputed occupancy.
  - a. Imputed Occupancy is 85% of the total number of bed days available based on the number of certified beds for the facility
- 2) Multiply the result above by an inflation factor to determine the inflated indirect care costs per diem. The inflation factor is 1.0140.
- 3) Determine the maximum inflated indirect care cost per diem for each peer group:
  - a. The maximum inflated indirect care cost per diem for the large peer group is \$68.98.
  - b. The maximum inflated indirect care cost per diem for the small peer group is \$59.60.
- 4) Determine the maximum efficiency incentive for each peer group:
  - a. The maximum efficiency incentive for the large peer group is \$3.69
  - b. The maximum efficiency incentive for the small peer group is \$3.19
- 5) The allowable indirect care per diem rate is:
  - a. If the inflated indirect care cost per diem is higher than the maximum inflated indirect care cost per diem for the peer group, the indirect care per diem rate is equal to the maximum inflated indirect care cost per diem for the peer group
  - b. If the inflated indirect care cost per diem is lower than the maximum inflated indirect care cost per diem for the peer group, the indirect care cost per diem is equal to:
    - i. The inflated indirect care cost per diem plus
      1. An efficiency incentive equal to either the maximum efficiency incentive for the peer group; or
      2. A reduced efficiency incentive if the maximum efficiency incentive would cause the indirect care per diem rate to be above the maximum inflated indirect care cost per diem for the peer group.

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## CAPITAL COSTS

### Allowable costs for Capital

Capital costs are reasonable costs incurred for the depreciation, amortization and interest on any capital assets that cost \$500 or more per item, including the following:

- 1) Buildings and improvements
- 2) Equipment
- 3) Transportation equipment
- 4) Land improvements
- 5) Leasehold improvements
- 6) Financing costs
- 7) Home office costs/capital costs

### Depreciation

All assets are depreciated using the straight-line method of depreciation. Depreciation is calculated using estimated useful lives of capital assets. No depreciation is recognized in the month that an asset is placed into service. A full month's depreciation expense is recognized in the month following the month the asset is placed into service. In the month an asset is disposed and it is not a change in ownership, depreciation equal to the difference between the historical cost and accumulated depreciation is recognized.

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**Calculation of Capital Per Diem**

A capital per diem rate is established for each intermediate care facility for individuals with intellectual disabilities using allowable capital costs as reported by each facility in accordance with the following calculation:

- 1) The capital per diem rate is the sum of the following:
  - a. Cost of Ownership per diem
  - b. Non-Extensive Renovations per diem
  - c. Return on Net Equity per diem
  - d. Cost of Ownership efficiency incentive

The Cost of Ownership per diem is calculated by the following:

- 1) Divide the allowable cost of ownership costs as reported by each facility by the greater of the inpatient days reported on the same cost report or imputed occupancy
  - a. Imputed occupancy is 95% of the total number of bed days available based on the number of certified beds for the facility
- 2) The cost of ownership per diem is the lower of the results of the calculation above or the cost of ownership ceilings which are set in accordance with Section 5124.17 of the Ohio Revised Code (effective July 1, 2013):
  - a. For the large peer group, the ceiling ranges from \$2.58 - \$14.28 (then adjusted for inflation). The precise ceiling for each facility is determined in accordance with the above-reference statute, and is based on the original date of licensure of each bed in the facility and represents a weighted average of all beds in the facility.
  - b. For the small peer group, the ceiling is \$18.32 (then adjusted for inflation).

Cost of ownership ceilings are adjusted for inflation based on amounts set in state statute for July 1, 1993, and inflated to the current year. The inflation factor used to adjust the capital portion of the rate is based on the consumer price index for shelter for all urban consumers for the Midwest region, as published by the United States bureau of labor statistics.

The Non-Extensive Renovations per diem is calculated by the following:

- 1) Divide the allowable non-extensive renovations costs as reported by each facility by the greater of the inpatient days reported on the same cost report or imputed occupancy
  - a. Imputed occupancy is 95% of the total number of certified beds for the facility
- 2) The non-extensive renovations per diem is the lower of the result of the calculation in #1 above or the maximum non-extensive renovations per diem which is \$8.08 (then adjusted for inflation in the same manner as the cost of ownership ceilings) set in accordance with Section 5124.17 of the Ohio Revised Code (effective July 1, 2013).

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The Return on Net Equity per diem is calculated by the following:

- 1) Divide the allowable return on net equity costs as reported by each facility by the greater of the inpatient days reported on the same cost report or imputed occupancy
  - a. Imputed occupancy is 95% of the total number of bed days available based on the number of certified beds for the facility
- 2) The Return on Net Equity per diem is the lower of the amount calculated in #1 above or the maximum return on net equity per diem which is \$1.00

The Cost of Ownership Efficiency Incentive is calculated by the following:

- 1) Twenty-five percent of the difference between the allowable cost of ownership calculation in #1 under Cost of Ownership per diem above and the inflated maximum cost of ownership per diem for the facility calculated in Cost of Ownership #2 above.
  - a. For the small peer group, the maximum cost of ownership efficiency incentive is \$3.00 (then adjusted for inflation in the same manner as the cost of ownership ceilings) set in accordance with Section 5124.17 of the Ohio Revised Code (effective July 1, 2013).

The total capital per diem rate for a facility in the small peer group cannot exceed the sum of the maximum amounts for the Cost of Ownership per diem and the Non-Extensive Renovations per diem as described above.

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**Other Protected Costs**

**Allowable costs for other protected**

Costs included for other protected costs are reasonable costs incurred for the following:

- 1) Medical supplies
- 2) Utility costs
- 3) Property Taxes
- 4) Franchise Permit Fees
- 5) Home office costs/Other protected
- 6) Payroll taxes, fringe benefits and staff development related to protected costs
- 7) Other covered costs

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**Calculation of Other Protected Per Diem**

Another protected per diem rate is established for each intermediate care facility for individuals with intellectual disabilities using allowable other protected costs as reported by each facility in accordance with the following calculation:

- 1) Subtract allowable franchise permit fee costs from the total allowable other protected costs
- 2) Divide the amount in #1 above by the total inpatient days reported on the same cost report for the facility to determine the other protected costs per diem
- 3) Multiply the other protected costs per diem by an inflation factor which is 1.0140
- 4) Add Medicaid's portion of the franchise permit fee per diem rate to determine the other protected costs per diem rate

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**Franchise Permit Fee**

The State assesses all providers of Intermediate care facility services for individuals with intellectual disabilities a franchise permit fee based on the provider's certified bed count. The franchise permit fee is calculated using projected net patient revenue and bed counts for the provider class, in accordance with the Indirect Guarantee Percentage as defined in federal regulations (section 1903(w)(4)(C)(ii) of the "Social Security Act," 120 Stat. 2994 (2006), 42 U.S.C. 1396b(w)(4)(C)(ii), as amended). The amount of the franchise fee is \$18.24 per bed per day.

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**Non-Standard Rates**

**Change of Operator (CHOP)**

For an entering operator that begins participation in the Medicaid program, the operator's initial rate shall be the rate the exiting operator would have received had the exiting operator continued to participate in the Medicaid program. An operator is the entity that enters into a Medicaid provider agreement for the provision of services at an Intermediate Care Facility for Individuals with Intellectual Disabilities.

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**New Facility**

The initial rate for a facility with a first date of licensure or Medicaid certification after June 30, 2006, including a facility that replaces one or more existing facilities shall be calculated as follows:

- 1) The direct care rate component shall be calculated as follows:
  - a. If there is no cost or resident assessment data available, the rate shall be the median cost per case-mix unit calculated for standard rates (as calculated in the direct care section of this Attachment) multiplied by the median annual average case-mix score for the peer group for that period and by the rate of inflation estimated for standard rates.
  - b. If the facility is a replacement facility and the facility or facilities being replaced are in operation immediately before the replacement facility opens, the rate shall be the same as the rate for the replaced facility or facilities, proportionate to the number of beds in each replaced facility.
- 2) The rate for indirect care costs shall be the maximum rate for the facility's peer group as calculated for the standard rates.
- 3) The rate for capital costs shall be the median of all standard capital rates (as calculated in the capital section of this Attachment).
- 4) The rate for other protected costs shall be one hundred fifteen percent of the median rate for intermediate care facilities for individuals with intellectual disabilities calculated for the standard rates (as calculated in the other protected section of this Attachment) and shall include the franchise permit fee rate if the beds were subject to the franchise permit fee during the fiscal year.
- 5) The rates calculated above will be adjusted effective the first date of July, to reflect new rate calculations for standard rates

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**Rate Adjustments**

- 1) If the mean total per diem rate for all ICFs-IID active on July 1, 2013, weighted by May 2013 Medicaid days is other than \$282.84, for fiscal year 2014, the total per diem rate for each ICF-IID is adjusted by a percentage that is equal to the percentage by which the mean total per diem rate is greater or less than \$282.84. The mean total per diem rate for state fiscal year 2014 resulted in a (1.47%) adjustment.
- 2) An intermediate care facility for individuals with intellectual disabilities may request a reconsideration of a rate on the basis of an extreme hardship on the facility as follows:
  1. Upon direct admission of a resident from a state-operated developmental center to the intermediate care facility.

If a rate adjustment is granted, the adjustment shall be implemented the first day of the first month the former resident of the developmental center resides in the intermediate care facility. The rate adjustment shall be time-limited to no longer than twelve consecutive months, but the adjustment shall be rescinded should the admitted resident permanently leave the intermediate care facility for any reason.

The maximum amount available for each admitted former resident of a state-operated developmental center shall be no more than fifty dollars per day prorated for the number of filled beds in the facility.

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**Capacity reductions**

If an ICF-IID permanently reduces the facility's certified capacity by a minimum of either 5 ICF-IID beds or 10% of the total beds of the ICF-IID, the ICF-IID is eligible for a recalculation of the per diem rate.

- 1) The ICF-IID will submit a cost report for the first 3 full months following the permanent reduction of capacity.
- 2) The 3 month cost report will be used to recalculate the facility's total rate including:
  - a. Direct Care (as calculated in the direct care section of this Attachment)
  - b. Indirect Care (as calculated in the indirect care section of this Attachment)
  - c. Capital (as calculated in the capital section of this Attachment)
  - d. Other protected (as calculated in the other protected section of this Attachment)

If a new ICF-IID is the result of an ICF-IID that permanently reduced the facility's certified capacity by a minimum of either 5 beds or 10% of the total beds of the ICF-IID, the new ICF-IID is eligible for a recalculation of the per diem rate.

- 1) The new ICF-IID will submit a cost report for the first 3 full months following the certification.
- 2) The 3 month cost report will be used to recalculate the facility's total rate including:
  - a. Direct Care (as calculated in the direct care section of this Attachment)
  - b. Indirect Care (as calculated in the indirect care section of this Attachment)
  - c. Capital (as calculated in the capital section of this Attachment)
  - d. Other protected (as calculated in the other protected section of this Attachment)

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**Outlier**

An outlier is a facility or unit in a facility serving residents with diagnoses or special care needs that require direct care resources not measured adequately by the Individual Assessment Form or who serve residents with special care needs otherwise qualifying for consideration. An outlier rate is a contracted rate and may differ from standard rates as follows:

- 1) For the Behavioral Redirection and Medical Monitoring (BRMM) outlier, the State will contract with the intermediate care facility to set initial and subsequent rates. Rates are negotiated, comprised of the same rate components as standard rates (direct, indirect, other protected and capital) and are based on provider costs and inpatient days. The basis for the negotiations is the actual cost to the provider of services rendered. The rate has been set for state fiscal year 2014 at \$463.82 per bed per day.

Individuals must receive prior approval for outlier services.

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