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State/Territory Name: OH

State Plan Amendment (SPA) #: 18-019

This file contains the following documents in the order listed:

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

NOV 21 2018

Barbara Sears, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: Ohio State Plan Amendment (SPA) 18-019

Dear Ms. Sears:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 18-019. Effective July 1, 2018, payment for services: Intermediate Care Facilities-Individuals with Intellectual Disabilities (ICF-IID) Payment Methodology Restructure.

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 18-019 is approved effective July 1, 2018. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please contact Fred Sebree at (217) 492-4122 or Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan,
Director

Enclosure

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **18-019**	2. STATE **OHIO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2018**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.150; 447 Subart C; and 483 Subpart I	7. FEDERAL BUDGET IMPACT: a. FFY 2018 $7,960 thousands b. FFY 2019 $23,998 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D Supplement 2** Pages 1-3 Page 4 Page 4a Page 5 Pages 5a, 5b Page 6 Page 6a Page 7 Pages 8, 8a Pages 8b, 8c Page 9 Page 10 Pages 10a-10f Page 11 Page 12 Page 13 Page 13a Page 14 Page 15 Page 16 Page 16a Page 17 Page 17a Page 18 Page 19 Page 19a Page 20 Page 20a Page 21 Page 22 Page 23 Page 24	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D Supplement 2** Pages 1-3 (TN 13-020) Page 4 (TN 14-019) (NEW) Page 5 (TN 15-013) (NEW) Page 6 (TN 17-036) (NEW) Page 7 (TN 13-020) Pages 8, 8a (TN 17-036) (NEW) Page 9 (TN 13-020) Page 10 (TN 16-024) (NEW) Page 11 (TN 16-024) Page 12 (TN 13-020) Page 13 (TN 17-036) (NEW) Page 14 (TN 16-024) Page 15 (TN 13-020) Page 16 (TN 16-024) (NEW) Page 17 (TN 14-019) (NEW) Page 18 (TN 16-024) Page 19 (TN 17-036) (NEW) Page 20 (TN 16-024) (NEW) Page 21 (TN 18-005) Page 22 (TN 16-024) Page 23 (TN 16-024) (NEW)

10. SUBJECT OF AMENDMENT: Payment for Services: ICF-IID Payment Methodology Restructure

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: **BARBARA R. SEARS**	**Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: 9-11-2018	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED:	18. DATE APPROVED: NOV 21 2018
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2018	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG
23. REMARKS:	

Instructions on Back

FORM CMS-179 (07-92)

Applies to New and Retiring Methodologies

Background

Facility-specific rates for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) are established prospectively using facility cost report data from the calendar year preceding the fiscal year in which rates will be set. The cost report is Ohio-specific, and is submitted electronically within 90 days after the end of the reporting period. 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.

Applies to New and Retiring Methodologies

Eligibility for Payment for ICF-IID Services

In order to be eligible for Medicaid payments, the operator of an ICF-IID 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 ICF-IID that chooses to be a Medicaid provider must maintain Ohio Medicaid certification for all beds participating in the Medicaid program.

Applies to New and Retiring Methodologies

Relation to Other Services

The ICF-IID 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.

Retiring Methodology

Peer Groups

Peer groups are used to establish the direct care, indirect care and capital rate components for ICF-IID rates. There are three peer groups. Peer Group 1-B consists of ICFs-IID with a Medicaid certified capacity greater than eight beds. Peer Group 2-B consists of each ICF-IID with a Medicaid certified capacity of eight or fewer beds which is not in Peer Group 3-B. Peer Group 3-B consists of each ICF-IID to which all of the following apply:

1) The ICF-IID is first certified after July 1, 2014;

2) The ICF-IID has a Medicaid certified capacity not exceeding six beds;

3) The ICF-IID has a contract with the Department of Developmental Disabilities (DODD) that is for 15 years and includes a provision for DODD to approve all admissions to and discharges from the facility;

4) The residents are admitted to the ICF-IID directly from a state operated developmental center or have been determined by DODD to be at risk of admission to a developmental center.

New Methodology

Peer Groups

Peer groups are used to establish the direct care, indirect care, and capital rate components for ICFs-IID rates. Under the new methodology, there are five peer groups.

1. Peer Group 1-A includes each ICF-IID with a Medicaid-certified capacity exceeding 16.
2. Peer Group 2-A includes each ICF-IID with a Medicaid-certified capacity exceeding eight but not exceeding 16.
3. Peer Group 3-A includes each ICF-IID with a Medicaid-certified capacity of seven or eight.
4. Peer Group 4-A includes each ICF-IID with a Medicaid-certified capacity not exceeding six, other than ICF-IID that is in Peer Group 5-A.
5. Peer Group 5-A includes each ICF-IID to which all of the following apply:
    a. The ICF-IID is first certified as an ICF-IID after July 1, 2014; and
    b. The ICF-IID has a Medicaid-certified capacity not exceeding six; and
    c. The ICF-IID has a contract with the Department of Developmental Disabilities (DODD) that is for 15 years and includes a provision for DODD to approve all admissions to, and discharges from, the ICF-IID; and
    d. The ICF-IID's residents are admitted to the ICF-IID directly from a developmental center or have been determined by DODD to be at risk of admission to a developmental center.

Direct Care

Retiring Methodology Calculation

Calculation of the provider case mix score

The case mix score is calculated by averaging the weights assigned to each resident based on the Resident Assessment Classification (RAC) system for the facility. The RAC groups are as follows:

1 – Chronic Medical
2 – Overriding Behaviors
3 – Chronic Behaviors and High Adaptive Needs
4 – Non-significant Behaviors and High Adaptive Needs
5 – Chronic Behaviors and Typical Adaptive Needs
6 - Non-significant Behaviors and Typical Adaptive Needs

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

New Methodology

Direct Care: Calculation of the provider case mix score

A. The case mix score is calculated by averaging the weights assigned to each resident based on the Resident Assessment Classification (RAC) system for the facility. The RAC groups are assigned based on the overall needs of the individual as scored under three domains:

1. Medical;
2. Behavioral; and
3. Adaptive skills.

B. The Department of Developmental Disabilities (DODD) shall calculate a resident's assessment score for each of the medical, behavioral, and adaptive skills domains and assign points:

1. If the resident's assessment score for the domain is more than one standard deviation above the mean assessment score for the domain for all ICF-IID residents as of December 31, 2017, one point;
2. If the resident's assessment score for the domain is more than one-half standard deviation above the mean assessment score for the domain for all ICF-IID residents as of December 31, 2017, and not more than one standard deviation above that mean, two points;
3. If the resident's assessment score for the domain is more than the mean assessment score for the domain for all ICF-IID residents as of December 31, 2017, and not more than one-half standard deviation above that mean, three points;
4. If the resident's assessment score for the domain is not more than the mean assessment score for the domain for all ICF-IID residents as of December 31, 2017, and not more than one-half standard deviation below that mean, four points;
5. If the resident's assessment score for the domain is more than one-half standard deviation below the mean assessment score for the domain for all ICF-IID residents as of December 31, 2017, and not more than one standard deviation below that mean, five points; and
6. If the resident's assessment score for the domain is more than one standard deviation below the mean assessment score for the domain for all ICF-IID residents as of December 31, 2017, six points.

C. DODD shall determine the weighted sum of the points assigned in accordance with paragraph (B) above to each of the resident's domain assessment scores and round the weighted sum to the nearest whole number:

1. Points assigned to the resident's assessment score for the medical domain shall be weighted at 35%;
2. Points assigned to the resident's assessment score for the behavioral domain shall be weighted at 30%;

New Methodology, continued

3. Points assigned to the resident's assessment score for the adaptive skills domain shall be weighted at 35%.

D. The department shall place the resident into an acuity group:

1. If the resident's weighted sum of points is five or lower, group one;
2. If the resident's weighted sum of points is at least six and not more than eight, group two;
3. If the resident's weighted sum of points is nine or10, group three;
4. If the resident's weighted sum of points is 11 or12, group four;
5. If the resident's weighted sum of points is at least 13 and not more than 15, group five; and
6. If the resident's weighted sum of points is 16 or higher, group six.

Allowable costs for direct care

A. 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

Retiring Methodology

Calculation of Direct Care Per Diem for Peer Groups 1-B, 2-B, and 3-B

A direct care per diem rate is established for each ICF-IID 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.

3) Determine the maximum cost per case mix unit for each peer group:
   a. The maximum cost per case mix unit for Peer Group 1-B is $110.78.
   b. The maximum cost per case mix unit for Peer Group 2-B is $115.99.
   c. The maximum cost per case mix unit for Peer Group 3-B is equal to the cost per case mix unit of the provider at the 95th percentile of all providers in Peer Group 3-B for the calendar year preceding the fiscal year in which the rate will be paid.

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.
   a. For Peer Groups 1-B and 2-B the inflation factor is 1.0140.
   b. For Peer Group 3-B the inflation factor is 1.0372.

New Methodology

Calculation of Direct Care Per Diem for Peer Groups 1-A, 2-A, 3-A, 4-A, and 5-A

A direct care per diem rate is established for each ICF-IID 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.
3) Determine the maximum cost per case mix unit for each peer group:
    a. The maximum cost per case-mix unit for a peer group for a fiscal year, other than Peer Group 5-A is the following percentage above the peer group's median cost per case-mix unit for that fiscal year.
        i. For Peer Group 1-A use 16%.
        ii. For Peer Group 2-A use 14%.
        iii. For Peer Group 3-A use 18%.
        iv. For Peer Group 4-A use 22%.
    b. The maximum cost per case mix unit for Peer Group 5-A is equal to the cost per case mix unit of the provider at the 95th percentile of all providers in Peer Group 5-A for the calendar year preceding the fiscal year in which the rate will be paid.
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.
    a. For Peer Group 1-A, 2-A, 3-A, 4-A, and 5-A the inflation factor is 1.0372.

Applies to New and Retiring Methodologies

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 and 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 and general services
4) Maintenance and minor equipment
5) Payroll taxes, fringe benefits and staff development for wages included in the indirect care cost category

Retiring Methodology

Calculation of Indirect Care Per Diem for Peer Groups 1-B, 2-B, and 3-B

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.
   a. For Peer Groups 1-B and 2-B the inflation factor is 1.0140.
   b. For Peer Group 3-B the inflation factor is 1.0185.
3) Determine the maximum inflated indirect care cost per diem for each peer group:
   a. The maximum inflated indirect care cost per diem for Peer Group 1-B and Peer Group 2-B shall be calculated as follows:
   (i) Have the amount so determined result in payment of all desk-reviewed, actual, allowable indirect care costs for the same percentage of Medicaid days for ICF's-IID in Peer Group 1-B as for ICF's-IID in Peer Group 2-B as of July 1, 2018, based on May 2018 Medicaid days.
   (ii) Avoid rate adjustments under paragraph 1) of page 19 of Attachment 4.19-D, Supplement 2.
   b. The maximum inflated indirect care cost per diem for Peer Group 3-B shall be the rate that is no less than 10.3% above the median desk-reviewed, actual, allowable, per diem inflated indirect care cost for all providers in Peer Group 3-B (excluding providers whose inflated indirect care costs are more than three standard deviations from the mean desk-reviewed, actual, allowable, per diem inflated indirect care cost for all providers in Peer Group 3-B) for the calendar year immediately preceding the fiscal year in which the rate will be paid.
4) Determine the maximum efficiency incentive for each peer group:
   a. The maximum efficiency incentive for Peer Group 1-B is $3.69.
   b. The maximum efficiency incentive for Peer Group 2-B is $3.19.
   c. The maximum efficiency incentive for Peer Group 3-B is 7% of the maximum inflated indirect care cost per diem.
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) For Peer Group 1-B if the intermediate care facility for individuals with intellectual disabilities has obtained the Department of Developmental Disabilities' (DODD) approval to downsize or convert to home and community-based services at least 10% of their Medicaid certified bed capacity or five beds, whichever is fewer, an efficiency

Retiring Methodology, continued

incentive equal to either the maximum efficiency incentive for the peer group or 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.

2) For Peer Group 1-B if the ICF-IID has not obtained the Department of Developmental Disabilities' (DODD) approval to downsize or convert to home and community based services at least 10% of their Medicaid certified bed capacity or five beds, whichever is fewer, an efficiency incentive equal to either one half of the maximum efficiency incentive for the peer group; or an efficiency incentive equal to one half of the 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.
3) For Peer Groups 2-B and 3-B an efficiency incentive equal to either the maximum efficiency incentive for the peer group or 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.

New Methodology

Calculation of Indirect Care Per Diem for Peer Groups 1-A, 2-A, 3-A, 4-A, and 5-A

An indirect care per diem rate is established for each ICF-IID 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 of 1.0185 to determine the inflated indirect care costs per diem.
3) The maximum rate for an ICF-IID's peer group shall be the following percentage above the peer group's median per diem indirect care costs for the applicable cost report year:
   a. For Peer Group 1-A that percentage is 8%;
   b. For Peer Group 2-A and Peer Group 3-A that percentage is 10%;
   c. For Peer Group 4-A and Peer Group 5-A that percentage is 12%.
4) Determine the maximum efficiency incentive for each peer group:
   a. The maximum efficiency incentive for Peer Group 1-A is 5% of the maximum per diem calculated for the peer group in Item 3 above.
   b. The maximum efficiency incentive for Peer Groups 2-A, 3-A, 4-A, and 5-A is 6% of the maximum per diem calculated for the peer group in Item 3 above.
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) For Peer Group 1-A or 2-A if the intermediate care facility for individuals with intellectual disabilities has obtained the Department of Developmental Disabilities' (DODD) approval to downsize or convert to home and community based services at least 10% of their Medicaid certified bed capacity or five beds, whichever is fewer, an efficiency incentive equal to either the maximum efficiency incentive for the peer group or 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.

New Methodology, continued

2) For Peer Group 1-A or 2-A if the ICF-IID has not obtained DODD's approval to downsize or convert to home and community based services at least 10% of their Medicaid certified bed capacity or five beds, whichever is fewer, an efficiency incentive equal to either the maximum efficiency incentive for the peer group or 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.

3) For Peer Group 1-A or 2-A if the ICF-IID has not obtained DODD's approval to downsize or convert to home and community based services at least 10% of their Medicaid certified bed capacity or five beds, whichever is fewer, an efficiency incentive equal to either one half of the maximum efficiency incentive for the peer group; or an efficiency incentive equal to one half of the 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.

4) For Peer Groups 3-A, 4-A, and 5-A an efficiency incentive equal to either the maximum efficiency incentive for the peer group or 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.

Applies to New and Retiring Methodologies

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.

Retiring Methodology

Calculation of Capital Per Diem for Peer Groups 1-B, 2-B, and 3-B

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. 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 5124.171 of the Ohio Revised Code (effective July 1, 2018):
    a. For Peer Group 1-B, 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-referenced 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 Peer Groups 2-B and 3-B, the ceiling is $18.32 (then adjusted for inflation).
3) 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 Item 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 5124.171 of the Ohio Revised Code (effective July 1, 2018).

New Methodology

Calculation of Capital Per Diem for Peer Groups 1-A, 2-A, 3-A, 4-A, and 5-A

A capital per diem rate is established for each ICF-IID based on the determined fair rental value of the facility, allowable secondary buildings, and equipment costs. The result is compared to the facility's actual allowable reported capital costs and limited if the result is greater than costs. Any non-extensive renovations approved under the Retiring Methodology and not covered in this calculation are grandfathered in. The details are as follows:

Facility Fair Rental Value Calculation

1. Square footage cap
    a. From the cost report, determine the total square footage of the facility and the number of beds.
    b. Divide the total square footage by the number of beds to get the number of square feet per bed.
    c. The minimum limit for square feet per bed is 200.
    d. The maximum limit for square feet per bed is set by peer group as follows:
        i. Peer Group 1-A provider has downsized or partially converted five beds or 10% of the previous capacity, whichever is less: 1000
        ii. Peer Group 1-A provider has not downsized or partially converted the minimum required in (d.i.) above: 550
        iii. Peer Group 2-A provider has downsized or partially converted five beds or 10% of the previous capacity, whichever is less: 1000
        iv. Peer Group 2-A provider has not downsized or partially converted the minimum required in (d.iii.) above: 750
        v. Peer Group 3-A: 850
        vi. Peer Group 4-A: 900
        vii. Peer Group 5-A: 900
    e. For purposes of the fair rental value calculation the facility's allowable square footage shall be adjusted to reflect the minimum or maximum limits described above if the facility's calculated square feet per bed falls outside those limits.
2. Value per square foot
    a. The value per square foot is based on the provider's peer group and county.
    b. Use the following values by peer group (updated annually):
        i. Peer Groups 1-A and 2-A: RS Means Construction Cost Estimating Data for Assisted Living, use $181.51;

New Methodology, continued

ii. Peer Groups 3-A, 4-A, and 5-A: RS Means Construction Cost Estimating Data for Nursing Home, use $206.55.

c. The amount in (2b) is adjusted by a modifier published for each major metropolitan area by RS Means. The modifier applies to the county or counties that contain the metropolitan area. An appropriate proxy is assigned pursuant to Ohio Revised Code Section 5124.17 (effective July 1, 2018) for those counties that do not contain a metropolitan area as published.

3. Effective Age calculation

a. The initial construction year is assumed as the effective age unless renovations and/or additions have been reported.

i. Age is based on the cost report year. For example, a facility built in the cost report year would have the age of zero.

ii. Maximum age of a facility is 40 years.

iii. Minimum age of a facility is zero.

b. Each reported renovation or addition re-ages the facility. The re-aging is calculated as follows:

c. Additions:

i. For each square footage addition (positive value) the provider reports calculate the new bed equivalent.

1. Multiple the square footage of the addition by the value per square foot from Item 2 above.

2. Divide that amount by $70,000 to get the new bed equivalent.

3. Multiply the new bed equivalent by the project age to get the weighted new bed equivalent.

ii. For each bed addition (positive value, ignore reductions) the provider reports calculate the weighted new bed equivalent by multiplying the number of beds added by the age of the addition.

iii. Total the weighted new bed equivalent of all bed and square footage additions for each provider

d. Renovations:

i. Disregard any renovations reported which are 40 or more years old

ii. For each allowable renovation reported take the project cost and divide by $70,000 to get the new bed equivalent.

iii. Multiple the new bed equivalent by the age of the renovation to get the weighted age of the renovation.

New Methodology, continued

iv. Repeat the process and sum the weighted age of renovations for the provider

e. Effective Age:

i. Total the new bed equivalent and weighted new bed equivalent of all additions and renovations for each provider.

ii. Subtract the new bed equivalent from the bed count to get the bed difference.

iii. Calculate the weighted age of the original beds by multiplying the bed difference by the building age.

iv. Add the weighted new bed equivalent of both renovations and additions to the weighted age of the original beds to get the total weighted age adjustment.

v. Divide the weighted age adjustment by the number of beds to get the effective age.

vi. The effective age cannot be less than zero.

4. Fair Rental Value

a. Calculate the current asset value by multiplying the square footage by the value per square foot.

b. Calculate the depreciation by multiplying the current asset value by the product of the effective age times the depreciation rate (set at 1.6%).

c. Subtract from the current asset value to get the depreciated asset value.

d. Calculate the land value as 10% of the current asset value and add to the depreciated asset value to get the total base value.

e. Calculate the fair rental value by multiplying the total base value by the rental rate (equal to 11%).

5. Fair Rental Value per diem

a. Calculate imputed occupancy for capital as 92% of the total bed days available reported. If the cost report covers less than a full year, annualize both the total bed days available and the inpatient days.

b. Divide the fair rental value by the greater of annualized inpatient days or annualized imputed occupancy to get the fair rental value per diem.

Secondary Building Fair Rental Value Calculation

1. Only secondary buildings that serve a function of home office or record storage are allowable.

2. Calculate the allowable square footage by multiplying the building square footage by the specified utilization/allocation percentage as reported on the cost report.

New Methodology, continued

3. The current asset value is equal to the cost per square foot type (set at $112.11 for FY19 for home office/record storage and updated annually) times by the allowable square footage.
4. Calculate the depreciation by multiplying the current asset value by the product of the building age (maximum of 40) times the depreciation rate (set at 1.6%).
5. Subtract from the current asset value to get the depreciated asset value.
6. Calculate the land value as 10% of the current asset value and add to the depreciated asset value to get the total base value
7. Calculate the secondary building fair rental value by multiplying the total base value by the rental rate (equal to 11%).
8. Calculate imputed occupancy for capital as 92% of the total bed days available reported. If the cost report covers less than a full year annualize both the total bed days available and the inpatient days.
9. Divide the secondary building fair rental value by the greater of annualized inpatient days or annualized imputed occupancy to get the secondary building fair rental value per diem.

Equipment Per Diem Calculation

1. Sum the equipment costs reported for the provider on the cost report.
2. Calculate imputed occupancy for equipment costs as 92% of the total bed days available reported.
3. Divide the equipment costs by the greater of inpatient days or imputed occupancy to get the equipment per diem.
4. Compare the equipment costs per diem to the ceiling for the provider's peer group as follows:
    a. Peer Group 1-A: $5.00
    b. Peer Group 2-A: $6.50
    c. Peer Group 3-A: $8.00
    d. Peer Groups 4-A and 5-A: $9.00
5. The allowable equipment cost per diem is equal to the lesser of the provider's equipment cost per diem and the ceiling for the provider's peer group.

Full Capital Rate Per Diem Calculation

1. Calculate the total fair rental value rate as the sum of the facility fair rental value rate, the secondary building fair rental value rate, and the equipment rate.
2. Calculate the capital cost per diem.
    a. Sum the total allowable capital costs as reported on the cost report.

New Methodology, continued

b. Divide by the greater of inpatient days or imputed occupancy to get the capital cost per diem

3. Compare the total fair rental value rate with the capital cost per diem
   a. Calculate the rate difference as the total fair rental value rate minus the capital cost per diem
   b. Determine the allowable dollar increase as follows:
      i. Peer Groups 1-A and 2-A: $3.00
      ii. Peer Groups 3-A, 4-A, and 5-A: $5.00
   c. The provider is able to receive the amount of the allowable dollar increase plus 10% of any additional surplus if it exists beyond the allowable dollar increase.
      i. Calculate the surplus amount as the rate difference minus the allowable dollar increase.
      ii. Calculate the retained surplus as 10% of the surplus amount (only if it's a positive value).
   d. The total capped rate is equal to the total fair rental value rate plus the allowable dollar increase plus the retained surplus.

Non-Extensive Renovations

Non-extensive renovations are project approved by the Department of Developmental Disabilities prior to July 1, 2018 for the betterment, improvement, or restoration of a facility beyond its functional capacity through a structural change that costs at least $500 per bed. Under the new methodology, non-extensive renovations are not reimbursed separately with other capital costs. However, providers whose projects were approved prior to the implementation of the new methodology are held harmless if the new methodology does not fully cover the non-extensive renovations.

Non-Extensive Renovations "Grandfathering" Calculation

1. Calculate the provider's total cost of ownership from the cost report.
2. Calculate the cost of ownership per diem by taking the total cost of ownership costs and dividing by the greater of inpatient days or imputed occupancy.
3. Calculate the rate above cost of ownership capped by subtracting the cost of ownership per diem from the total capped rate (cannot be less than $0).
4. Calculate the non-extensive renovations cost per diem by taking the amount of non-extensive renovations costs reported on the cost report and dividing by the greater of inpatient days or imputed occupancy.
5. If the rate above cost of ownership is greater than the non-extensive renovations cost per diem, the allowable non-extensive renovations cost per diem is equal to $0.

New Methodology, continued

6. If the rate above cost of ownership is less than the non-extensive renovations cost per diem the allowable non-extensive renovations cost per diem is the difference between the non-extensive renovations cost per diem and the rate above cost of ownership.
7. The allowable non-extensive renovations cost per diem is added to the total capped rate to get the provider's final total capital rate.

Retiring Methodology

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

1) For Peer Group 1-B, 25% of the difference between the allowable cost of ownership calculation in Item 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 Item 2 above.
2) For Peer Group 2-B, 25% of the difference between the allowable cost of ownership calculation in Item 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 Item 2 above.
    a. For Peer Group 2-B, 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 5124.171 of the Ohio Revised Code (effective July 1, 2018).
3) For Peer Group 3-B, 50% of the difference between the allowable cost of ownership calculation in Item 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 Item 2 above.
    a. For Peer Group 3-B, 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 5124.171 of the Ohio Revised Code (effective July 1, 2018).

The total capital per diem rate for a facility in Peer Group 2-B or Peer Group 3-B 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.

Applies to New and Retiring Methodologies

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

Retiring Methodology

Calculation of Other Protected Per Diem for Peer Groups 1-B, 2-B, and 3-B

Another protected per diem rate is established for each ICF-IID 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 Item 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) For Peer Groups 1-B and 2-B, multiply the other protected costs per diem by an inflation factor which is 1.0140;
4) For Peer Group 3-B, multiply the other protected costs per diem by an inflation factor which is 1.0137;
5) Add Medicaid's portion of the franchise permit fee per diem rate to determine the other protected costs per diem rate.

New Methodology

Calculation of Other Protected Per Diem for Peer Groups 1-A, 2-A, 3-A, 4-A, and 5-A

Another protected per diem rate is established for each ICF-IID 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 Item 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) For Peer Groups 1-A, 2-A, 3-A, 4-A, and 5-A multiply the other protected costs per diem by an inflation factor which is 1.0137;
4) Add Medicaid's portion of the franchise permit fee per diem rate to determine the other protected costs per diem rate.

Applies to New and Retiring Methodologies

Franchise Permit Fee

The State assesses all providers of ICF-IID services 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 section 1903(w)(4)(C)(ii) of the Social Security Act, 120 Stat. 2994 (2006) and 42 U.S.C. 1396b(w)(4)(C)(ii), as amended. The amount of the franchise fee is $18.02 per bed per day.

Applies to New and Retiring Methodologies

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 ICF-IID.

Retiring Methodology

New Facility in Peer Group 1-B or 2-B

The initial rate for an ICF-IID 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 115% of the median rate for ICFs-IID 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 rate for the direct support personnel payment shall be the median rate value of the direct support personnel payment rates calculated in that section of this Attachment.
6) The rates calculated above will be adjusted effective the first day of July, to reflect new rate calculations for standard rates.

New Methodology

New Facility in Peer Group 1-A, 2-A, 3-A, or 4-A

The initial rate for an ICF-IID 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 under the New Methodology (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 under the New Methodology 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 under the New Methodology 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 calculated under the New Methodology (as calculated in the capital section of this Attachment).
4) The rate for other protected costs shall be 115% of the median rate for ICFs-IID calculated under the New Methodology 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 rate for the direct support personnel payment shall be the median rate value of the direct support personnel payment rates calculated in that section of this Attachment.
6) The rates calculated above will be adjusted effective the first day of July, to reflect new rate calculations for standard rates.

Retiring Methodology

New Facility in Peer Group 3-B

The initial rate for a facility in Peer Group 3-B shall be determined in the following manner:

1) The rate for Direct Care shall be $264.89.

2) The rate for Indirect Care shall be $59.85.

3) The rate for Capital shall be $29.61.

4) The rate for Other Protected shall be $25.99.

New Methodology

New Facility in Peer Group 5-A

The initial rate for a facility in Peer Group 5-A shall be determined in the following manner:

1) The rate for Direct Care shall be $264.89.

2) The rate for Indirect Care shall be $59.85.

3) The rate for Capital shall be $29.61.

4) The rate for Other Protected shall be $25.99.

Applies to New and Retiring Methodologies

Direct Support Personnel Payment

Each ICF-IID shall receive a direct support personnel payment equal to 3.04% of the provider's allowable direct care per diem costs.

Retiring Methodology

Rate Adjustments

1) If the mean total per diem rate for all ICFs-IID in Peer Groups 1-B and 2-B and active on July 1, 2018, weighted by May 2018 Medicaid days is other than $290.10, for fiscal year 2019, 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 $290.10.
2) An ICF-IID 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 ICF-IID.

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 ICF-IID. 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 ICF-IID for any reason.

The maximum amount available for each admitted former resident of a state-operated developmental center shall be no more than $50 per day prorated for the number of filled beds in the facility.

New Methodology

Rate Adjustments

1. An ICF-IID may request a reconsideration of a rate on the basis of an extreme hardship on the facility as follows:
   a. Upon direct admission of a resident from a state-operated developmental center to the ICF-IID.

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 ICF-IID. 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 ICF-IID for any reason.

The maximum amount available for each admitted former resident of a state-operated developmental center shall be no more than $50 per day prorated for the number of filled beds in the facility.

Retiring Methodology

Capacity reductions

If an ICF-IID permanently reduces the facility's certified capacity by a minimum of either five 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 three full months following the permanent reduction of capacity.
2) The three-month cost report will be used to recalculate the facility's total rate including:
   a. Direct Care - as calculated in the Retiring Methodology direct care section of this Attachment except for the following:
      i. In place of the annual average case mix score otherwise used in determining the ICFs-IID per Medicaid day payment rate under the Retiring Methodology for direct care, the ICFs-IID case mix score in effect on the last day of the calendar quarter that ends during the period the cost report covers (or, if more than one calendar quarter ends during that period, the last of those calendar quarters) shall be used to determine the ICFs-IID per Medicaid day payment rate for direct care costs.
   b. Indirect Care - as calculated in the Retiring Methodology indirect care section of this Attachment
   c. Capital - as calculated in the Retiring Methodology capital section of this Attachment except for the following:
      i. The ICF-IID shall not be subject to the limit on the costs of ownership per diem payment rate or non-extensive renovations specified in page 10.
      ii. The ICF-IID shall be subject to the limit on the total payment rate for costs of ownership, capitalized costs of non-extensive renovations, and the efficiency incentive specified in page 11 regardless of whether the ICF-IID is in Peer Group 1-B or Peer Group 2-B.
   d. Other protected - as calculated in the Retiring Methodology 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 five 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 three full months following the certification.
2) The three-month cost report will be used to recalculate the facility's total rate including:
   a. Direct Care - as calculated in the Retiring Methodology direct care section of this Attachment except for the following:
      i. In place of the annual average case mix score otherwise used in determining the ICFs-IID per Medicaid day payment rate under the Retiring Methodology for direct care, the ICFs-IID case mix score in effect on the last day of the calendar quarter that ends during the period the cost report covers (or, if more than one calendar quarter ends during that period, the last of those calendar quarters) shall be used to determine the ICFs-IID per Medicaid day payment rate for direct care costs.
   b. Indirect Care - as calculated in the Retiring Methodology indirect care section of this Attachment
   c. Capital - as calculated in the Retiring Methodology capital section of this Attachment
   d. Other Protected - as calculated in the Retiring Methodology other protected section of this Attachment

New Methodology

Capacity reductions

If an ICF-IID permanently reduces the facility's certified capacity by a minimum of either five 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 three full months following the permanent reduction of capacity.
2) The three month cost report will be used to recalculate the facility's total rate including:
    a. Direct Care - as calculated in the New Methodology direct care section of this Attachment except for the following:
        i. In place of the annual average case mix score otherwise used in determining the ICFs-IID per Medicaid day payment rate under the New Methodology for direct care, the ICFs-IID case mix score in effect on the last day of the calendar quarter that ends during the period the cost report covers (or, if more than one calendar quarter ends during that period, the last of those calendar quarters) shall be used to determine the ICFs-IID per Medicaid day payment rate for direct care costs.
    b. Indirect Care - as calculated in the New Methodology indirect care section of this Attachment.
    c. Capital - as calculated in the New Methodology capital section of this Attachment.
    d. Other Protected - as calculated in the New Methodology 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 five 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 three full months following the certification.
2) The three month cost report will be used to recalculate the facility's total rate including:
    a. Direct Care - as calculated in the New Methodology direct care section of this Attachment except for the following:
        i. In place of the annual average case mix score otherwise used in determining the ICFs-IID per Medicaid day payment rate under the New Methodology for direct care, the ICFs-IID case mix score in effect on the last day of the calendar quarter that ends during the period the cost report covers (or, if more than one calendar quarter ends during that period, the last of those calendar quarters) shall be used to determine the ICFs-IID per Medicaid day payment rate for direct care costs.
    b. Indirect Care - as calculated in the New Methodology indirect care section of this Attachment
    c. Capital - as calculated in the New Methodology capital section of this Attachment
    d. Other Protected - as calculated in the New Methodology other protected section of this Attachment

Applies to New and Retiring Methodologies

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 Ohio Development Disabilities Profile that serves residents with special care needs otherwise qualifying for consideration. An outlier rate is a contracted rate and may differ from standard rates.

1) For the Ventilator Services outlier, the State provides an add-on payment of $300 per day for each individual authorized to receive ventilator services in the facility.

Individuals must receive prior approval from DODD for payment of ventilator outlier services.

Applies to New and Retired Methodologies

Coverage and Payment for Bed Hold Days

ICF-IID providers are eligible for payment to reserve a bed for a resident who is away from the facility for hospital leave, visits with friends and family, therapeutic leave, and trial visits to home and community based settings. Up to 30 days are granted automatically per calendar year per resident. Any requests beyond 30 days require prior approval from the Department of Developmental Disabilities (DODD) except for emergency hospital stays which must be requested within one business day of the start of the leave period. Payment for all allowable bed hold days is equal to 100% of the provider's per diem rate.

Applies to New and Retiring Methodologies

Coverage and Payment for short term respite stays

ICF-IID providers are eligible for payment for an individual on a home and community-based waiver to temporarily reside in the facility for up to 90 days in a calendar year. The ICF-IID provider shall be paid at the per diem rate for any individual residing in a Medicaid certified ICF-IID bed. Payment for the individual shall cease after 90 days in the calendar year unless the individual disenrolls from the home and community-based waiver and becomes a permanent resident of the ICF-IID.

Applies to New and Retiring Methodologies

Final Rate Calculation

During a transition period from July 1, 2018 through June 30, 2021, the rate calculated under the Retiring Methodology is compared with the rate calculated under the New Methodology for each ICF-IID. Each provider's final rate is the greater of the two calculations.