

## **Table of Contents**

**State/Territory Name: OH**

**State Plan Amendment (SPA) #: 22-0030**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data and block 8 addendum)
- 3) Approved SPA Pages

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**Financial Management Group**

December 20, 2022

Maureen Corcoran, Director  
Ohio Department of Medicaid  
50 West Town Street, Suite 400  
Columbus, Ohio 43215

RE: Ohio State Plan Amendment (SPA) 22-0030

Dear Ms. Corcoran:

We have reviewed the proposed amendment to Attachments 4.19-D of your Medicaid State plan submitted under transmittal number 22-0030 titled “Payment for Services: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Changes.”

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2022. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Fredrick Sebree at [Fredrick.sebree@cms.hhs.gov](mailto:Fredrick.sebree@cms.hhs.gov).

Sincerely,



Rory Howe  
Director

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2 2</u> — <u>0 0 3 0</u>	2. STATE <u>OH</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	

TO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
**July 1, 2022**

5. FEDERAL STATUTE/REGULATION CITATION  
**42 CFR 440.150; 447 Subpart C; 483 Subpart I**

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)  
a. FFY 2022 \$ 9,490,500  
b. FFY 2023 \$ 34,333,200

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  
**Attachment 4.19-C Supplement 2, Page 1**  
**Attachment 4.19-D Supplement 2, Page 1-25**  
**Attachment 4.19-D Supplement 2, Pages 26-28 (new)**

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)  
**See CMS-179 Block 8 Addendum**

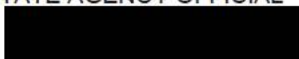
9. SUBJECT OF AMENDMENT

**Payment for Services: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Changes**

10. 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**

11. SIGNATURE OF STATE AGENCY OFFICIAL  


12. TYPED NAME **MAUREEN M. CORCORAN**

13. TITLE **STATE MEDICAID DIRECTOR**

14. DATE SUBMITTED  
**September 30, 2022**

15. RETURN TO  
**Greg Niehoff**  
**Ohio Department of Medicaid**  
**P.O. BOX 182709**  
**Columbus, Ohio 43218**


**FOR CMS USE ONLY**

16. DATE RECEIVED  
**9/30/2022**

17. DATE APPROVED  
**December 20, 2022**

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL  
**12/13/2022**

19. APPROVING OFFICIAL  


20. TYPED NAME OF APPROVING OFFICIAL  
**Rory Howe**

21. TITLE OF APPROVING OFFICIAL  
**Director, FMG**

22. REMARKS  
**12/13/2022 - Administrative update in block 1, changed from 22-030 to 22-0030**

**CMS-179 Block 8 Addendum**  
**SPA TN OH-22-030**

Attachment 4.19-C, Supplement 2 Page 1 (TN 19-020)

Attachment 4.19-D, Supplement 2:

Page 1 (TN 21-028)  
Page 2 (TN 18-019)  
Page 3 (TN 18-019)  
Page 4 (TN 18-019) – REMOVE  
Page 4a (TN 18-019) – renumbered to 4  
Page 5 (TN 18-019) – REMOVE  
Page 5a (TN 18-019) – renumbered to 5  
Page 5b (TN 18-019) – renumbered to 6  
Page 6 (TN 19-020) – REMOVE  
Page 6a (TN 20-019) – renumbered to 7  
Page 7 (TN 18-019) – renumbered to 8  
Page 8 - (TN 20-019) – REMOVE  
Page 8a (TN 19-020) – REMOVE  
Page 8b (TN 20-019) – renumbered to 9  
Page 9 (TN 18-019) – renumbered to 10  
Page 10 (TN 18-019) – REMOVE  
Page 10a (TN 20-019) – renumbered to 11  
Page 10b (TN 20-019) – renumbered to 12  
Page 10c (TN 18-019) – renumbered to 13  
Page 10d (TN 20-019) – renumbered to 14  
Page 10e (TN 19-020) – renumbered to 15  
Page 10f (TN 18-019) – renumbered to 16  
Page 11 (TN 18-019) – REMOVE  
Page 12 (TN 18-019) – renumbered to 17  
Page 13 (TN 19-020) – REMOVE  
Page 13a (TN 20-019) – renumbered to 18  
Page 14 (TN 20-019) – renumbered to 19  
Page 15 (TN 18-019) – renumbered to 20  
Page 16 (TN 19-020) – REMOVE  
Page 16a (TN 18-019) – renumbered to 21  
Page 17 (TN 18-019) – REMOVE  
Page 17a (TN 18-019) – renumbered to 22  
Page 18 (TN 18-019) – renumbered to 23  
Page 19 (TN 20-019) – REMOVE  
Page 19a (TN 18-019) – renumbered to 24  
Page 20 (TN 18-019) – REMOVE  
Page 20a (TN 18-019) – renumbered to 25  
Page 21 (TN 19-020) – renumbered to 26  
Page 22 (TN 19-020) - REMOVE  
Page 23 (TN 18-019) – renumbered to 27  
Page 24 (TN 18-019) – REMOVE  
Page 25 (TN 19-011) – renumbered to 28

**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.

TN: 22-030

Supersedes:

TN: 19-020Approval Date: December 20, 2022Effective Date: 07/01/2022

**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.

**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.

TN: 22-030  
Supersedes:  
TN: 18-019

Approval Date: December 20, 2022  
Effective Date: 07/01/2022

**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.



**Peer Groups**

Peer groups are used to establish the direct care, indirect care, and capital rate components for ICFs-IID rates. 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: 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%;

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 or 10, group three;
  4. If the resident's weighted sum of points is 11 or 12, 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

TN: 22-030  
Supersedes:  
TN: 18-019

Approval Date: December 20, 2022  
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**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 95<sup>th</sup> 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 1.1008.

**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

**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 1.1418 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 the sum of the following:
    - i. The inflated indirect care cost per diem;
    - ii. The efficiency incentive calculated as the difference between the amount of the per diem indirect care costs for the applicable cost report year and the maximum rate established for the ICF/IID peer group under Section 4 above.

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Supersedes:  
TN: 20-019

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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.

TN: 22-030  
Supersedes:  
TN: 18-019

Approval Date: December 20, 2022  
Effective Date: 07/01/2022

**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 \$202.30;



**Facility Fair Rental Value Calculation, continued**

- ii. Peer Groups 3-A, 4-A, and 5-A: RS Means Construction Cost Estimating Data for Nursing Home, use \$228.20.
  - 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. Multiply the new bed equivalent by the age of the renovation to get the weighted age of the renovation.

**Facility Fair Rental Value Calculation, continued**

- i. Repeat the process and sum the weighted age of renovations for the provider
  - b. 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.
2. 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%).
3. 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.

TN: 22-030  
Supersedes:  
TN: 18-019

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**Secondary Building Fair Rental Value Calculation, continued**

1. The current asset value is equal to the cost per square foot type (set at \$112.11 for FY23 for home office/record storage and updated annually) times the allowable square footage.
2. 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%).
3. Subtract from the current asset value to get the depreciated asset value.
4. Calculate the land value as 10% of the current asset value and add to the depreciated asset value to get the total base value
5. Calculate the secondary building fair rental value by multiplying the total base value by the rental rate (equal to 11%).
6. 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.
7. 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.

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**Full Capital Rate Per Diem Calculation, 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 projects 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.

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**Non-Extensive Renovations “Grandfathering” Calculation, continued**

6. 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.
7. 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.
8. The allowable non-extensive renovations cost per diem is added to the total capped rate to get the provider’s final total capital rate.

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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 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 1.1192;
- 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 ICF-IID services a franchise permit fee based on the provider's monthly reported inpatient days. If inpatient days are not reported timely, days for that month are calculated based on the ICF-IID'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 \$24.89 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 ICF-IID.

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**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 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 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.

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**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.

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**Direct Support Personnel Payment**

Each ICF-IID shall receive a direct support personnel payment equal to 2.04% of the provider's allowable direct care per diem costs.

**Quality Incentive Payment**

1. Calculate the relative weight point value for the fiscal year
  - a. Multiply the number of inpatient days the ICF/IID had for the applicable cost report year by the number of quality points the ICF/IID was awarded
  - b. Determine the sum of all ICF/IID products calculated under section a
  - c. Determine the amount equal to one percent of the total desk-reviewed, actual, allowable direct care costs of all ICF/IID for the applicable cost report year
  - d. Divide the amount determined under section c by the sum determined under section b
2. Calculate the number of points the ICF/IID was awarded
3. Multiply the relative weight point value by the points awarded to the ICF/IID

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**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.

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**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 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 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 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 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 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 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 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

**Outliers**

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 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.
- 2) For the Intensive Behavior Support outlier, the State provides an add-on payment of \$300 per day for each individual authorized to receive intensive behavioral health support services in the facility.

Individuals must receive prior approval from DODD for payment of ventilator and/or intensive behavioral outlier services.

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**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 consecutive 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 consecutive 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.

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**Private Room Payment in ICFs-IID**

An ICF-IID shall accept payment by the State Medicaid agency as payment in full for items and services, that are covered by the Medicaid program. Private rooms in ICFs-IID, including when therapeutically required for infection control or similar reasons, do not receive an additional, supplemental, or differing rate than that already calculated for the ICF-IID, as described in Attachment 4.19-D Supplement 2.

A private room in an ICF-IID may be charged to a resident's personal needs allowance account when a private room is not medically necessary.