
DEPARTMENT OF DEVELOPMENTAL DISABILITIES

Employment First

- Modifies the state's Employment First Policy for individuals with developmental disabilities.
- Authorizes the Ohio Department of Developmental Disabilities (ODODD) Director to establish an employment first task force consisting of certain state departments and enter into interagency agreements with those departments.
- Requires each county board of developmental disabilities (county DD board) to implement an employment first policy that clearly identifies community employment as the desired outcome for every individual of working age who receives services from the board.

Regional council and county DD board cost report

- Requires each regional council and county DD board to file with ODODD a cost report on its expenditures and income and for each report to be audited.
- Permits ODODD to withhold regional council or board subsidy payments if a cost report is not timely filed or determined not auditable.

County DD board vacancy

- Creates an exception to the limitation of no more than three consecutive member terms, if a county DD board experiences extenuating circumstances, as determined by the ODODD Director, and the appointing authority requests a waiver.

Intermediate care facilities for the mentally retarded

- Relocates and reorganizes the law governing Medicaid coverage of intermediate care facility for the mentally retarded (ICF/MR) services as part of the process of ODODD assuming many duties of the Ohio Department of Medicaid (ODM) regarding those services.
- Modifies, effective July 1, 2014, Medicaid payments for capital costs of ICFs/MR by (1) halving the efficiency incentive payments to ICFs/MR with more than eight beds, (2) eliminating nonextensive renovation payments to ICFs/MR with more than eight beds, and (3) eliminating return on equity payments to all ICFs/MR.

- Reduces, beginning with fiscal year 2015, the efficiency incentive that is part of the Medicaid payment rate for the indirect care costs of ICFs/MR with more than eight beds.
- Permits ODODD, subject to ODM's approval, to pay a qualifying ICF/MR a Medicaid rate add-on for outlier ICF/MR services provided on or after July 1, 2014, to a resident who is a Medicaid recipient, is under 22 years of age, is dependent on a ventilator, and meets other requirements established in rules.
- Provides for the ODODD Director to establish in rules a flat Medicaid payment rate for ICF/MR services provided on or after July 1, 2014, to low resource utilization residents.
- For fiscal year 2014, requires ODODD to determine modified rates and capped rates for existing ICFs/MR and provides for an existing ICF/MR to be paid a Medicaid rate that is the average of its modified and capped rates, unless the mean of such rates for all existing ICFs/MR is other than \$282.84, in which case the ICF/MR's rate is to be adjusted by a percentage that equals the percentage by which the mean rate is greater or less than \$282.84.
- For fiscal year 2015, requires ODODD to determine modified rates and capped rates for existing ICFs/MR and provides for an existing ICF/MR to be paid a rate that is the average of its modified and capped rates, unless the mean of such rates for all existing ICFs/MR is other than \$282.77, in which case the ICF/MR's rate is to be adjusted by a percentage that equals the percentage by which the mean rate is greater or less than \$282.77.
- Permits an ICF/MR that downsizes or partially converts to providing home and community-based services to file a Medicaid cost report if the ICF/MR has, on the day it downsizes or partially converts, a Medicaid-certified capacity that is at least 10% lower than its Medicaid-certified capacity on the day before and at least five fewer ICF/MR beds than it has on the day before.
- Provides for the cost report to cover the period that begins with the day the ICF/MR downsizes or partially converts and ends on the first day of the month immediately following the first three full months of operation as a downsized ICF/MR or partially converted ICF/MR.
- Provides for the cost report to be used to determine the ICF/MR's Medicaid payment rate for the period:

- (1) Beginning on the day it downsizes or partially converts if that day is the first day of a month or, if not, beginning on the first day of the month following the month the ICF/MR downsizes or partially converts; and
 - (2) Ending on the first day of the fiscal year for which it begins to be paid a rate determined using a cost report filed in accordance with regular filing procedures.
- Requires ODODD and a workgroup to evaluate revisions to the formula used to determine Medicaid payment rates for ICF/MR services.
 - Requires the ODODD Director to pay the nonfederal share of a claim for ICF/MR services using subsidies otherwise allocated to county DD boards if:
 - (1) Medicaid covers the services;
 - (2) The services are provided to a Medicaid recipient who is eligible for the services and does not occupy a bed in the ICF/MR that used to be included in the Medicaid-certified capacity of another ICF/MR certified before June 1, 2003;
 - (3) The services are provided by an ICF/MR whose Medicaid certification was initiated or supported by a county DD board; and
 - (4) The provider has a valid Medicaid provider agreement for the time the services are provided.
 - Sets the rate for the franchise permit fee charged ICFs/MR at \$18.24 for fiscal year 2014 and \$18.17 for fiscal year 2015 and thereafter.

Home and community-based services

- Provides for an Individual Options waiver provider to continue to receive for fiscal years 2014 and 2015 at least the higher Medicaid payment rate for routine homemaker/personal care services that the provider received for up to a year during fiscal years 2012 and 2013.
- Provides for ODODD to retain all of the fees that county DD boards pay regarding Medicaid-paid claims for home and community-based services provided to individuals eligible for services from the county DD boards.
- Requires the ODODD Director to establish a methodology to be used in fiscal years 2014 and 2015 to estimate the quarterly amount each county DD board is to pay of

the nonfederal share of the Medicaid expenditures for which the board is responsible.

- Permits a developmental center to provide services to persons with mental retardation and developmental disabilities living in the community or to providers of services to these persons.

Innovative pilot projects

- Permits the ODODD Director to authorize, in fiscal years 2014 and 2015, innovative pilot projects that are likely to assist in promoting the objectives of state law governing ODODD and county DD boards.

"Employment First" for individuals with developmental disabilities

(R.C. 5123.022, 5123.023, 5126.05, 5126.051, and 5226.01; Sections 259.90 and 259.100)

Employment First policy

The bill adds to current law expressing the state's policy concerning individuals with developmental disabilities the statement that every individual with a developmental disability is presumed capable of community employment unless proven otherwise through an individualized assessment process. It defines "community employment" for this purpose as competitive employment that takes place in an integrated setting. "Competitive employment" is defined as full-time or part-time work in the competitive labor market in which payment is at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons who are not disabled. An "integrated setting" is a setting typically found in the community where individuals with developmental disabilities interact with individuals who do not have disabilities to the same extent that individuals in comparable positions who are not disabled interact with other individuals, including in employment settings in which employees interact with the community through technology.

Task force

The bill authorizes the Ohio Department of Developmental Disabilities (ODODD) Director to establish an employment first task force consisting of ODODD, Ohio Department of Education, Ohio Department of Medicaid (ODM), Ohio Department of Job and Family Services (ODJFS), Ohio Department of Mental Health and Addiction Services, and Opportunities for Ohioans with Disabilities Agency. If

established, the purpose of the task force would be to improve the coordination of the state's efforts to address the needs of individuals with developmental disabilities who seek community employment.

ODODD would have authority to enter into interagency agreements with any of the government entities on the task force. The interagency agreements could specify either or both of the following:

(1) The roles and responsibilities of the government entities that are members of the task force, including any money to be contributed by those entities;

(2) The projects and activities of the task force.

The bill creates in the state treasury the Employment First Task Force Fund. Any money received by the task force from its members is to be credited to the fund and used by ODODD to support the work of the task force.

A task force created under the bill would cease to exist on January 1, 2020. Any money, assets, or employees of ODODD that on that date were dedicated to the work of the task force would have to be reallocated by ODODD for employment services for individuals with developmental disabilities.

County boards of developmental disabilities (county DD board)

Each county board of developmental disabilities (county DD board) is required by the bill to do all of the following:

(1) Implement an employment first policy that clearly identifies community employment as the desired outcome for every individual of working age who receives services from the board;

(2) Set benchmarks for improving community employment outcomes;

(3) Establish a list of services, from least to most integrated, that improve community employment outcomes.

The bill modifies current law on services for adults with developmental disabilities by requiring each county DD board, to the extent that resources are available, to provide or arrange for the provision of adult services, including job training, vocational evaluation, and community employment services. Current law provides that those services are optional and are in addition to sheltered employment and work activities.

Regional council and county DD board annual cost report

(R.C. 5126.131)

Each regional council established for the purpose of performing the duties of a county DD board and each county DD board is required by the bill to file with ODODD an annual cost report detailing the council's or board's income and expenditures.¹⁸ ODODD is authorized to withhold subsidy payments from a regional council or board if the report is not filed timely or is not auditable. ODODD must provide annual cost report training to regional council and board employees.

Unless ODODD establishes a later date, regional council reports must be filed with ODODD no later than the last day of April and board reports must be filed no later than the last day of May. At the written request of a regional council or board, ODODD is permitted to grant a 14-day filing extension.

Each report filed by a regional council or board must be audited by ODODD or an entity designated by ODODD. A regional council or board is permitted to submit changes to the cost report until the date the audit begins. ODODD or the designated entity is required to notify the regional council or board of the date the audit begins.

If ODODD or the entity determines that the cost report is not auditable, it must provide written notification to the regional council or board and grant the council or board 60 days to submit additional documentation. After 60 days, ODODD or the entity must determine whether the cost report is auditable with the additional documentation and notify the regional council or board of its determination. The determination of ODODD or the entity is final.

A completed cost report audit must be certified by ODODD or the entity and filed in the office of the clerk of the governing body, executive officer of the governing body, and chief fiscal officer of the audited regional council or board. No changes are permitted to a certified cost report audit that is filed by ODODD or the entity. A cost report is not a public record until copies of the cost report are filed by ODODD or the entity. Cost reports must be retained by regional councils and boards for seven years.

¹⁸ The report is in addition to the cost and operating report the regional council or board is required to provide ODODD under R.C. 5126.12 or 5126.13.



County DD board vacancy

(R.C. 5126.026 and 5126.021, not in the bill)

Under the bill, if a county DD board experiences extenuating circumstances that would severely restrict it from being able to fill a pending vacancy of a board member who will become ineligible for service on the board after serving three consecutive terms, the appointing authority can request a waiver from the ODODD Director to allow that member to serve an additional four-year term subsequent to serving three consecutive four-year terms. The bill requires the ODODD Director to determine if the extenuating circumstances associated with the board warrant the granting of such a waiver.

Under general continuing law, a county DD board consists of seven members with five members being appointed by the board of county commissioners of the county and two members being appointed by the senior probate judge of the county. A county DD board member can be reappointed if the appointing authority ascertains, through written communication with the board, that the member being considered for reappointment meets the requirements for board members. However, a member who has served during each of three consecutive terms must not be reappointed for a subsequent term until two years after ceasing to be a member of the board, except that a member who has served for ten years or less within three consecutive terms can be reappointed for a subsequent term before becoming ineligible for reappointment for two years.

Intermediate care facilities for the mentally retarded (ICFs/MR)

(R.C. 5124.01 (primary), 1337.11, 2133.01, 2317.02, 3317.02, 3701.74, 3702.62, 3721.10, 3795.01, 4723.17, 5103.02, 5123.171, 5123.19, 5123.192, 5123.198, 5123.38, 5126.054, 5126.055, 5162.01, 5162.21, 5163.01, 5163.31, 5163.33, 5164.01, 5164.35, 5164.37, 5164.38, 5164.46, 5164.70, 5166.01, 5166.02, 5166.04, 5166.20, 5168.60, 5168.61, 5168.62, 5168.63, 5168.64, 5168.65, 5168.66, 5168.67, 5168.68, and 5168.70; Chapter 5124.)

Federal law permits a state's Medicaid program to cover services provided by intermediate care facilities for the mentally retarded (ICFs/MR). Ohio's Medicaid program covers ICF/MR services. State law includes many provisions regarding Medicaid's coverage of ICF/MR services but does not expressly include ICF/MR services as part of Medicaid. The bill expressly requires Medicaid to cover ICF/MR services when all of the following apply:

- (1) The services are provided to a Medicaid recipient eligible for the services.



(2) The services are provided by provider that has a valid provider agreement to provide the services.

(3) Federal financial participation is available for the services.

Administration of Medicaid coverage of ICF/MR services

(R.C. 5124.02 (primary), 5111.211 (repealed), and 5123.198; Chapters 5124. and 5165.; Sections 259.260 and 259.270)

H.B. 153 of the 129th General Assembly requires that ODM (ODJFS at the time H.B. 153 was enacted) enter into an interagency agreement with ODODD that provides for ODODD to assume powers and duties of ODM regarding the Medicaid program's coverage of ICF/MR services. The bill relocates and reorganizes the law governing Medicaid coverage of ICF/MR services as part of the process of ODODD assuming many of ODM's duties regarding ICF/MR services. It provides that the ODODD Director is not required to amend any rule for the sole purpose of updating the citation in the Ohio Administrative Code to the Revised Code section that authorizes the rule to reflect that the bill renumbers or otherwise relocates the authorizing statute. The citations are to be updated as the Director amends the rules for other purposes.

Not all of ODM's responsibilities regarding Medicaid's coverage of ICF/MR services are transferred to ODODD. Federal law does not permit ODM to transfer all of its responsibilities. For example, ODM continues to be responsible for entering into Medicaid provider agreements with ICFs/MR.¹⁹ And, the bill specifies that the ODODD Director is to adopt rules governing Medicaid's coverage to the extent authorized by rules adopted by the ODM Director.²⁰

As part of the process of ODODD assuming this responsibility, the bill eliminates certain laws that cease to be applicable.

First, the bill repeals a law that makes ODODD responsible for the nonfederal share of only certain ICF/MR Medicaid claims. Under that law, ODODD is responsible for the nonfederal share of Medicaid claims submitted for ICF/MR services if (1) the services are provided on or after July 1, 2003, (2) the ICF/MR receives initial certification by the Ohio Department of Health (ODH) Director as an ICF/MR on or after June 1, 2003, (3) the ICF/MR, or a portion of the ICF/MR, is licensed by the ODODD Director as a residential facility, and (4) there is a valid Medicaid provider agreement for the ICF/MR. ODODD is not responsible for Medicaid claims submitted for an ICF/MR if a

¹⁹ 42 C.F.R. 431.107(b).

²⁰ 42 C.F.R. 431.10(e)(1)(ii).

residential facility license was obtained or modified for the ICF/MR without obtaining approval of a plan for the proposed residential facility. This law provides, however, that the provisions discussed above apply only to the extent, if any, provided in the contract between ODODD and ODM regarding the transfer of the powers and duties regarding ICF/MR services.

The second law that is eliminated permits ODODD to notify ODM of a reduction in the licensed capacity of a residential facility that is an ICF/MR. The reduction occurs under continuing law that requires, with certain exceptions, ODODD to reduce a residential facility's licensed capacity when a resident of the residential facility is involuntarily committed to a state-operated ICF/MR. On receiving the notice about the reduction, ODM is permitted by the law being eliminated to transfer to ODODD the savings in the nonfederal share of Medicaid expenditures for each fiscal year after the year of the commitment to be used for costs of the resident's care in the state-operated ICF/MR.

ICFs/MR's Medicaid rates for capital costs

(R.C. 5124.17, 5124.21, and 5124.28; Section 812.60)

Capital costs are part of an ICF/MR's costs that are used in determining the ICF/MR's total Medicaid payment rate. Under current law, there are four components to an ICF/MR's Medicaid payment rate for capital costs: (1) its cost of ownership, (2) an efficiency incentive, (3) amounts for nonextensive renovations, and (4) amounts for return on equity. The bill modifies, effective July 1, 2014, the Medicaid payments for the capital costs of ICFs/MR by (1) halving the efficiency incentive payments to ICFs/MR with more than eight beds, (2) eliminating nonextensive renovation payments to ICFs/MR with more than eight beds, and (3) eliminating return on equity payments to all ICFs/MR.

Efficiency incentive

Current law provides that an ICF/MR's efficiency incentive is to equal 50% of the difference between its costs of ownership and a limit on costs of ownership payments. The efficiency incentive for an ICF/MR with eight or fewer beds may not exceed a particular cap which is adjusted for inflation annually. The bill provides that, beginning July 1, 2014, the efficiency incentive for an ICF/MR with more than eight beds is not to exceed 25% of the difference between its costs of ownership and the limit on costs of ownership payments.



Nonextensive renovations

Current law uses inconsistent terminology regarding the part of an ICF/MR's Medicaid payment for renovations. Continuing law defines "capital costs" as costs of ownership and costs of nonextensive renovation. However, the provision of current law that governs the amount of an ICF/MR's Medicaid payment for nonextensive renovations uses the terms "renovation" and "nonextensive renovations." This may cause confusion as to whether the provision applies to both renovations and nonextensive renovations or only nonextensive renovations. To avoid that confusion, the bill uses only the term "nonextensive renovation."

Current law establishes two conditions for an ICF/MR to qualify for a Medicaid payment for nonextensive renovations. First, at least five years must have elapsed since the ICF/MR's date of licensure or date of an extensive renovation of the portion of the ICF/MR that is proposed to be nonextensively renovated, unless the nonextensive renovation is necessary to meet the requirements of federal, state, or local statutes, ordinances, rules, or policies. Second, the ICF/MR must obtain ODODD's prior approval by submitting a plan that describes in detail the changes in capital assets to be accomplished by means of the nonextensive renovation and the timetable for completing the project, which cannot be more than 18 months after the nonextensive renovation begins. The bill adds a third condition for an ICF/MR to qualify for a Medicaid payment for nonextensive renovations: it must have eight or fewer beds. This means that, beginning July 1, 2014 ICFs/MR with eight or more beds will no longer qualify for Medicaid payments for nonextensive renovations.

ICFs/MR's efficiency incentives for indirect care costs

(R.C. 5124.21)

Indirect care costs are part of an ICF/MR's costs that are used in determining the ICF/MR's total Medicaid payment rate. A Medicaid payment rate for indirect care costs is determined for each ICF/MR individually and a maximum payment rate for indirect care costs is determined for each peer group of ICFs/MR. An ICF/MR's Medicaid rate for its indirect care costs is the lesser of the rate determined for it individually and the maximum rate determined for its peer group. The bill reduces, beginning with fiscal year 2015, the efficiency incentive that is included in determining the individual Medicaid payment rate for the indirect care costs of an ICF/MR with more than eight beds.

Under current law, the efficiency incentive for an ICF/MR with more than eight beds is, for a fiscal year ending in an even-numbered calendar year, 7.1% of the maximum rate established for the ICF/MR's peer group. Its efficiency incentive for a



fiscal year ending in an odd-numbered calendar year is the amount calculated for the preceding fiscal year. For fiscal years 2015-2016 and each fiscal year thereafter ending in an even-numbered calendar year, the bill provides for the efficiency incentive for an ICF/MR with more than eight beds, to be 3.55% of the maximum rate established for the ICF/MR's peer group. The efficiency incentive for fiscal year 2017 and each fiscal year thereafter that ends in an odd-numbered calendar year continues to be the amount calculated for the immediately preceding fiscal year.

Return on equity payments

Current law requires ODODD to pay ICFs/MR a return on their net equity as part of their Medicaid payments for capital costs. A return on net equity payment is to be computed at the rate of 1.5 times the average of interest rates on special issues of public debt obligations issued to the federal Hospital Insurance Trust Fund for the cost reporting period. No ICF/MR's return on net equity may exceed one dollar per patient day. In calculating an ICF/MR's rate for return on net equity, ODODD must use the greater of the ICF/MR's inpatient days during the applicable cost reporting period or the number of inpatient days it would have had during that period if its occupancy rate had been 95%.

The bill eliminates, effective July 1, 2014, the requirement that ODODD pay ICFs/MR a return on their net equity.

Medicaid rate add-on for outlier ICF/MR services

(R.C. 5124.25 (primary) and 5124.15)

The bill permits ODODD, subject to ODM's approval, to pay a Medicaid rate add-on to an ICF/MR for outlier ICF/MR services the ICF/MR provides to qualifying ventilator-dependent residents on or after July 1, 2014, if the ICF/MR applies to ODODD to receive the rate add-on and ODODD approves the application. ODODD may approve an ICF/MR's application if all of the following apply:

(1) The ICF/MR submits to ODODD a best practices protocol for providing outlier ICF/MR services and ODODD determines that the protocol is acceptable;

(2) The ICF/MR executes with ODM an addendum to its Medicaid provider agreement regarding the outlier ICF/MR services;

(3) The ICF/MR meets all other eligibility requirements for the rate add-on established in rules the ODODD Director is to adopt.

An ICF/MR that is approved to provide outlier ICF/MR services must provide the services in accordance with (1) the best practices protocol ODODD determines is acceptable and (2) requirements regarding the services established in rules the ODODD Director is to adopt.

To qualify to receive outlier ICF/MR services from an ICF/MR, a resident of the ICF/MR must be a Medicaid recipient, be under 22 years of age, be dependent on a ventilator, and meet all other eligibility requirements established in rules the ODODD Director is to adopt.

ODODD is to negotiate the amount of the Medicaid payment rate add-on, if any, to be paid, or the method by which that amount is to be determined, with ODM. ODODD is prohibited from paying the rate add-on unless ODM approves the amount of the rate add-on or method by which the amount is to be determined.

Medicaid rates for low resource utilization residents

(R.C. 5124.152 (primary) and 5124.01)

The bill provides for the Medicaid payment rate for ICF/MR services provided on or after July 1, 2014, to low resource utilization residents to be a flat rate rather than the regular Medicaid payment rate for ICF/MR services. The ODODD Director is to set the flat rate in rules. "Low resource utilization resident" is defined as a Medicaid recipient residing in an ICF/MR who is placed in the typical adaptive needs and nonsignificant behaviors classification pursuant to the resident assessment instrument and grouper methodology that is used as part of the process of determining ICF/MR's Medicaid rates for direct care costs.

Fiscal year 2014 Medicaid rates for ICF/MR services

(Section 259.200)

The bill provides for an existing ICF/MR's Medicaid reimbursement rate for fiscal year 2014 to be the average of its modified and capped rates unless the mean of such rates for all existing ICFs/MR is other than \$282.84, in which case the ICF/MR's rate is to be adjusted by a percentage that equals the percentage by which the mean rate is greater or less than \$282.84. An ICF/MR is considered to be an existing ICF/MR if (1) the provider of the ICF/MR has a valid Medicaid provider agreement for the ICF/MR on June 30, 2013, and a valid Medicaid provider agreement for the ICF/MR during fiscal year 2014 or (2) the ICF/MR undergoes a change of operator that takes effect during fiscal year 2014, the exiting operator has a valid Medicaid provider agreement for the ICF/MR on the day immediately preceding the effective date of the change of operator,

and the entering operator has a valid Medicaid provider agreement for the ICF/MR during fiscal year 2014.

An ICF/MR's modified rate is its rate as determined in accordance with Revised Code provisions governing the Medicaid reimbursement rates for ICFs/MR with the following modifications:

(1) In place of the inflation adjustment otherwise made in determining the ICF/MR's rate for other protected costs, its other protected costs, excluding the franchise permit fee component of those costs, from calendar year 2012 is to be multiplied by 1.0123.

(2) In place of the maximum cost per case-mix unit otherwise established for the ICF/MR's peer group, its maximum costs per case-mix unit is to be \$108.21 if it has more than eight beds or \$102.21 if it has eight or fewer beds.

(3) In place of the inflation adjustment otherwise calculated in determining the ICF/MR's rate for direct care costs, an inflation adjustment of 1.0123 is to be used.

(4) In place of the maximum rate for the indirect care costs of the ICF/MR's peer group, the maximum rate for the indirect care costs for its peer group is to be \$68.98 if it has more than eight beds or \$59.60 if it has eight or fewer beds.

(5) In place of the inflation adjustment otherwise calculated in determining the ICF/MR's rate for indirect care costs, an inflation adjustment of 1.0123 is to be used.

(6) In place of the efficiency incentive otherwise calculated in determining its rate for indirect care costs, its efficiency incentive for indirect care costs is to be \$3.69 if it has more than eight beds or \$3.19 if it has eight or fewer beds.

(7) The ICF/MR's efficiency incentive for capital costs is to be reduced by 50%.

An ICF/MR's capped rate is to be its rate as determined in accordance with Revised Code provisions governing the Medicaid reimbursement rates for ICFs/MR reduced by the percentage by which the mean of such rates for all ICFs/MR, weighted by May 2013 Medicaid days and calculated as of July 1, 2013, exceeds \$282.84.

ODODD is required by the bill to reduce the amount it pays ICFs/MR for fiscal year 2013 if the U.S. Centers for Medicare and Medicaid Services requires that the ICF/MR franchise permit fee be reduced or eliminated. The amount of the reduction is to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.



Fiscal year 2015 Medicaid rates for ICF/MR services

(Section 259.210)

The bill provides for an existing ICF/MR's Medicaid reimbursement rate for fiscal year 2015 to be the average of its modified and capped rates unless the mean of such rates for all existing ICFs/MR is other than \$282.77, in which case the ICF/MR's rate is to be adjusted by a percentage that equals the percentage by which the mean rate is greater or less than \$282.77. An ICF/MR is considered to be an existing ICF/MR if (1) the provider of the ICF/MR has a valid Medicaid provider agreement for the ICF/MR on June 30, 2014, and a valid Medicaid provider agreement for the ICF/MR during fiscal year 2015 or (2) the ICF/MR undergoes a change of operator that takes effect during fiscal year 2015, the exiting operator has a valid Medicaid provider agreement for the ICF/MR on the day immediately preceding the effective date of the change of operator, and the entering operator has a valid Medicaid provider agreement for the ICF/MR during fiscal year 2015.

An ICF/MR's modified rate is its rate as determined in accordance with Revised Code provisions governing the Medicaid reimbursement rates for ICFs/MR with the following modifications:

(1) In place of the inflation adjustment otherwise made in determining the ICF/MR's rate for other protected costs, its other protected costs, excluding the franchise permit fee component of those costs, from calendar year 2013 is to be multiplied by 1.0123.

(2) In place of the maximum cost per case-mix unit otherwise established for the ICF/MR's peer group, its maximum costs per case-mix unit is to be \$108.21 if it has more than eight beds or \$102.21 if it has eight or fewer beds.

(3) In place of the inflation adjustment otherwise calculated in determining the ICF/MR's rate for direct care costs, an inflation adjustment of 1.0123 is to be used.

(4) In place of the maximum rate for the indirect care costs of the ICF/MR's peer group, the maximum rate for the indirect care costs for its peer group is to be \$68.98 if it has more than eight beds or \$59.60 if it has eight or fewer beds.

(5) In place of the inflation adjustment otherwise calculated in determining the ICF/MR's rate for indirect care costs, an inflation adjustment of 1.0123 is to be used.

(6) In place of the efficiency incentive otherwise calculated in determining its rate for indirect care costs, its efficiency incentive for indirect care costs is to be \$3.69 if it has more than eight beds or \$3.19 if it has eight or fewer beds.



(7) The ICF/MR's efficiency incentive for capital costs is to be reduced by 50%.

An ICF/MR's capped rate is to be its rate as determined in accordance with Revised Code provisions governing the Medicaid reimbursement rates for ICFs/MR reduced by the percentage by which the mean of such rates for all ICFs/MR, weighted by May 2014 Medicaid days and calculated as of July 1, 2014, exceeds \$282.77.

ODODD is required by the bill to reduce the amount it pays ICFs/MR for fiscal year 2015 if the U.S. Centers for Medicare and Medicaid Services requires that the ICF/MR franchise permit fee be reduced or eliminated. The amount of the reduction is to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.

Medicaid cost reports

(R.C. 5124.10 (primary), 5124.01, 5124.101, 5124.102, 5124.107, 5124.108, 5124.109, and 5124.522)

Cost report deadline extension

Generally, ICFs/MR are required by continuing law to file annual cost reports with ODODD. Cost reports are a factor in determining the Medicaid payment rates for ICFs/MR.

An annual cost report is to cover the calendar year or portion of the calendar year during which an ICF/MR participated in the Medicaid program. It is due not later than 90 days after the end of the calendar year, or portion of the calendar year, that the cost report covers. However, ODODD, for good cause, may grant a 14-day extension of the time for filing a cost report on written request from an ICF/MR.

There are exceptions to the requirement discussed above. A new ICF/MR is to submit a cost report not later than 90 days after the end of its first three full calendar months of operation. An ICF/MR that undergoes a change of provider that is an arm's length transaction is to submit a cost report not later than 90 days after the end of its first three full calendar months of operation under the new provider. A new ICF/MR that opens, and an ICF/MR that undergoes a change of provider that is an arm's length transaction after the first day of October in a calendar year is not required to file a cost report for that calendar year. ODODD's authority to extend a 14-day extension to file an annual cost report does not expressly apply to a cost report for a new ICF/MR or an ICF/MR that undergoes a change of provider that is an arm's length transaction. The bill expressly applies the 14-day extension authority to such cost reports.

Cost reports for downsized and partially converted ICFs/MR

The bill permits an ICF/MR that becomes a downsized ICF/MR or partially converted ICF/MR to file with ODODD a cost report sooner than it otherwise would if it meets two conditions. An ICF/MR becomes a downsized ICF/MR by permanently reducing its Medicaid-certified capacity pursuant to a plan approved by ODODD. An ICF/MR becomes a partially converted ICF/MR by converting some, but not all, of its beds to providing home and community-based services under the Individual Options (IO) Medicaid waiver.

To be able to file a cost report sooner than it otherwise would, an ICF/MR must have both of the following on the day it becomes a downsized ICF/MR or partially converted ICF/MR:

(1) A Medicaid-certified capacity that is at least 10% less than its Medicaid-certified capacity on the day immediately preceding the day it becomes a downsized ICF/MR or partially converted ICF/MR;

(2) At least five fewer beds certified as ICF/MR beds than it has on the day immediately preceding the day it becomes a downsized ICF/MR or partially converted ICF/MR.

The cost report of a downsized ICF/MR or partially converted ICF/MR is to cover the period that begins with the day that it becomes a downsized ICF/MR or partially converted ICF/MR and ends on the first day of the month immediately following the first three full months of operation as a downsized ICF/MR or partially converted ICF/MR. ODODD must refuse to accept a cost report if either of the following apply:

(1) Unless ODODD grants a 14-day extension for good cause, the ICF/MR fails to file the cost report not later than 90 days after the last day of the period the cost report covers;

(2) The cost report is incomplete or inadequate.

If ODODD accepts a cost report, it must determine the ICF/MR's Medicaid payment rate using that cost report. The bill specifies the period for which the ICF/MR is to be paid a rate based on the cost report. The period is to begin on the day that the ICF/MR becomes a downsized ICF/MR or partially converted ICF/MR if that day is the first day of a month. Otherwise, the period is to begin on the first day of the month immediately following the month that the ICF/MR becomes a downsized ICF/MR or partially converted ICF/MR. The period is to end on the first day of the fiscal year for which the ICF/MR begins to be paid a rate determined using its next annual cost report. It is to file its next annual cost report at the regular time for filing annual cost reports if

the ICF/MR became a downsized ICF/MR or partially converted ICF/MR on or before the first day of October. An annual cost report is to cover the portion of the first calendar year that the ICF/MR operated as a downsized ICF/MR or partially converted ICF/MR. If the ICF/MR becomes a downsized ICF/MR or partially converted ICF/MR after the first day of October of a calendar year, it is not required to file an annual cost report for that calendar year but must file an annual cost report for the immediately following calendar year.

Evaluation of Medicaid payment rate formula for ICFs/MR

(Section 259.230)

H.B. 153 of the 129th General Assembly required ODM (ODJFS at the time H.B. 153 was enacted) and ODODD to study issues regarding Medicaid payment rates for ICF/MR services. A workgroup was created to assist with the study. The bill requires that ODODD retain the workgroup for the purpose of assisting ODODD during fiscal years 2014 and 2015 with an evaluation of revisions to the formula used to determine Medicaid payment rates for ICF/MR services. In conducting the evaluation, ODODD and the workgroup must (1) focus primarily on the service needs of individuals with complex challenges that ICFs/MR are able to meet and (2) pursue the goal of reducing the Medicaid-certified capacity of individual ICFs/MR and the total number of ICF/MR beds in the state for the purpose of increasing the service choices and community integration of individuals eligible for ICF/MR services.

Use of county subsidies to pay nonfederal share of ICF/MR services

(Section 259.240)

The bill requires the ODODD Director to pay the nonfederal share of a claim for ICF/MR services using funds otherwise appropriated for subsidies to county DD boards if (1) Medicaid covers the ICF/MR services, (2) the ICF/MR services are provided to a Medicaid recipient who is eligible for the ICF/MR services and the recipient does not occupy a bed in the ICF/MR that used to be included in the Medicaid-certified capacity of another ICF/MR certified by the ODH Director before June 1, 2003, (3) the ICF/MR services are provided by an ICF/MR whose Medicaid certification by the ODH Director was initiated or supported by a county DD board, and (4) the provider of the ICF/MR services has a valid Medicaid provider agreement for the services for the time that the services are provided.

ICF/MR franchise permit fee

(R.C. 5168.60)

Continuing law imposes an annual assessment on ICFs/MR. The assessment is termed a "franchise permit fee." Revenue raised by the franchise permit fee is to be used for the expenses of the programs ODODD administers and ODODD's administrative expenses.

The bill revises the rate at which the ICF/MR franchise permit fee is assessed. The rate is currently \$18.32 per bed per day. Under the bill, the rate is \$18.24 for fiscal year 2014 and \$18.17 for fiscal year 2015 and thereafter.

Home and community-based services

Medicaid rates for certain Individual Options (IO) services

(Section 259.250)

H.B. 153 of the 129th General Assembly required ODODD to increase the rate paid to a provider under the IO Medicaid waiver by 52¢ for each 15 minutes of routine homemaker/personal care provided to an individual for up to a year if all of the following applied:

(1) The individual was a resident of a developmental center immediately prior to enrollment in the waiver;

(2) The provider began serving the individual on or after July 1, 2011;

(3) The ODODD Director determined that the increased rate was warranted by the individual's special circumstances, including the individual's diagnosis, service needs, or length of stay at the developmental center, and that serving the individual through the IO waiver was fiscally prudent for the Medicaid program.

The bill continues the rate increase for fiscal years 2014 and 2015 and provides for the higher rate to be provided under more circumstances. The higher rate is to be paid for routine homemaker/personal care services to which both of the following apply:

(1) The services are provided to an IO waiver enrollee (a) who began to receive the services from the provider on or after July 1, 2011, (b) who resided in a



developmental center, converted facility,²¹ or public hospital immediately before enrolling in the IO waiver, and (c) for whom the ODODD Director has determined that paying the higher rate is warranted because of the enrollee's special circumstances, including the enrollee's diagnosis, service needs, or length of stay at the developmental center, converted facility, or public hospital.

(2) The provider of the services has a valid Medicaid provider agreement for the services for the period during which the enrollee receives the services from the provider.

A provider is to receive the regular Medicaid payment rate rather than the rate discussed above if ODODD sets the regular rate at an amount higher than the rate discussed above.

Fees charged county DD boards for home and community-based services

(R.C. 5123.0412; Section 323.390)

Continuing law requires ODODD to charge each county DD board an annual fee equal to 1.25% of the total value of all Medicaid paid claims for home and community-based services provided during the year to an individual eligible for services from the county DD board. No fee is to be charged, however, for home and community-based services provided under the Transitions Developmental Disabilities waiver program.

Under current law, the fees are deposited into two funds: the ODODD Administration and Oversight Fund and the ODJFS Administration and Oversight Fund. ODODD and ODJFS are required to enter into an interagency agreement to specify which portion of the fees is to be deposited into each fund respectively.

The bill abolishes the ODJFS Administration and Oversight Fund and provides for all of the fees to be deposited into the ODODD Administration and Oversight Fund.

County DD board share of nonfederal Medicaid expenditures

(Section 259.60)

The bill requires the ODODD Director to establish a methodology to be used in fiscal years 2014 and 2015 to estimate the quarterly amount each county DD board is to pay of the nonfederal share of the Medicaid expenditures for which the board is responsible. With certain exceptions, continuing law requires the board to pay this

²¹ A converted facility is an ICF/MR, or former ICF/MR, that converted some or all of its beds to providing home and community-based services under the IO waiver.

share for home and community-based services provided to an individual who the board determines is eligible for board services.²² (ODODD was similarly required to establish the methodology for fiscal years 2012 and 2013.)

Each quarter, the Director must submit to the board written notice of the amount for which the board is responsible. The notice must specify when the payment is due.

Developmental center services

(Section 259.150)

The bill continues a temporary provision of H.B. 153 of the 129th General Assembly that permits an ODODD-operated residential center for persons with mental retardation and developmental disabilities (i.e., a developmental center) to provide services to persons with mental retardation and developmental disabilities living in the community or to providers of services to these persons. ODODD is permitted to develop a method for recovery of all costs associated with the provision of the services.

Innovative pilot projects

(Section 259.180)

For fiscal years 2014 and 2015, the bill continues a temporary provision of H.B. 153 of the 129th General Assembly that permits the ODODD Director to authorize innovative pilot projects that are likely to assist in promoting the objectives of state law governing ODODD and county DD boards. Under the bill, a pilot project may be implemented in a manner inconsistent with the laws or rules governing ODODD and county DD boards; however, the Director cannot authorize a pilot project to be implemented in a manner that would cause Ohio to be out of compliance with any requirements for a program funded in whole or in part with federal funds. Before authorizing a pilot project, the Director must consult with entities interested in the issue of developmental disabilities, including the Ohio Provider Resource Association, Ohio Association of County Boards of Developmental Disabilities, and ARC of Ohio.

²² R.C. 5126.0510.

