
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.
- Specifies that any prevocational services provided by a county DD board must be provided in accordance with an individual service plan and occur over a specified period of time with specific outcomes sought to be achieved.

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 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 individuals with intellectual disabilities

- Replaces "intermediate care facility for the mentally retarded" (ICF/MR) in state law with "intermediate care facility for individuals with intellectual disabilities" (ICF/IID).
- Relocates and reorganizes the law governing Medicaid coverage of ICF/IID services as part of the process of ODODD assuming many duties of the Ohio Department of Medicaid (ODM) regarding those services.



- Provides that the contract between ODODD and ODM that provides for ODODD to assume the powers and duties of ODM with regard to the Medicaid program's coverage of ICF/IID services may provide for ODM to perform one or more of ODODD's duties regarding ICFs/IID that undergo a change of operator, close, or cease to participate in Medicaid.
- Modifies, effective July 1, 2014, Medicaid payments for capital costs of ICFs/IID by (1) halving, except under a certain circumstance, the efficiency incentive payments to ICFs/IID with more than eight beds, (2) eliminating, except under certain circumstances, nonextensive renovation payments to ICFs/IID with more than eight beds, and (3) eliminating return on equity payments to all ICFs/IID.
- Uses an ICF/IID's annual average case-mix score for the calendar year immediately preceding the fiscal year for which the rate will be paid to determine an ICF/IID's annual Medicaid payment rate for direct care costs rather than a quarterly case-mix score to determine an ICF/IID's quarterly rate.
- Reduces to 45 (from 80) the number of days that an ICF/IID has to submit corrected resident assessment data before ODODD may assign a case-mix score to the ICF/IID for failure to submit the corrected data.
- Requires that the average of specified case-mix scores be used for certain calculations for the purpose of determining an ICF/IID's fiscal year 2014 Medicaid payment rate for direct care costs.
- Uses, for the purpose of determining an ICF/IID's fiscal year 2015 rate, the ICF/IID's case-mix score for the first quarter of calendar year 2013 determined by using resident assessment data that ODODD, or any entity under contract with ODODD, compiled if the ICF/IID did not submit resident assessment data for that quarter.
- Reduces, beginning with fiscal year 2016, the efficiency incentive that is part of the Medicaid payment rate for the indirect care costs of ICFs/IID with more than eight beds that do not obtain ODODD's approval to become downsized ICFs/IID.
- Updates, in the law governing Medicaid payments for ICF/IID services, terminology related to the Consumer Price Index and Employment Cost Index published by the U.S. Bureau of Labor Statistics.
- Permits ODODD, subject to ODM's approval, to pay a qualifying ICF/IID a Medicaid rate add-on for outlier ICF/IID services provided 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.

- For fiscal year 2014, requires ODODD to determine modified Medicaid payment rates for existing and new ICFs/IID and provides for an existing or new ICF/IID to be paid its modified rate, unless the mean of such rates for all existing and new ICFs/IID is other than \$282.84, in which case the ICF/IID'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 Medicaid payment rates for existing and new ICFs/IID and provides for an existing or new ICF/IID to be paid its modified rate, unless the mean of such rates for all existing and new ICFs/IID is other than \$282.77, in which case the ICF/IID'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.
- Requires the ODODD Director, in consultation with certain organizations, to study (1) establishing a new grouper methodology to be used when determining ICFs/IID's case-mix scores for fiscal year 2015, (2) whether the amounts set as the maximum costs per case-mix units that may be used in determining fiscal year 2015 direct care rates will avoid or minimize rate reductions, and (3) specifying additional diagnoses and special care needs that individuals must have to meet criteria for special rates for outlier services and sources of funding for, or mechanisms to ensure the budget neutrality of, the additional diagnoses and special care needs.
- Requires ODODD to strive to achieve, not later than July 1, 2018, statewide reductions in the number of ICF/IID beds.
- Requires ODODD, in its efforts to achieve the ICF/IID bed reductions, to collaborate with the Ohio Association of County Boards Serving People with Developmental Disabilities, the Ohio Provider Resource Association, the Ohio Centers for Intellectual Disabilities formed by the Ohio Health Care Association, and the Values and Faith Alliance.
- Increases to 600 (from 500) the number of (1) Medicaid waiver slots for which the ODM Director may seek federal approval as part of continuing law regarding ICFs/IID that convert to providing Medicaid waiver services and (2) ICF/IID beds that may be so converted.
- Permits an ICF/IID that downsizes or partially converts to providing home and community-based services on or after July 1, 2013, to file a Medicaid cost report if the ICF/IID 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 or at least five fewer ICF/IID beds than it has on the day before.



- Permits a new ICF/IID also to file a Medicaid cost report if its beds are from a downsized ICF/IID and the downsized ICF/IID either has reduced its Medicaid-certified capacity by at least 10% or reduced the number of its ICF/IID-certified beds by at least five.
- Provides for the cost report for a downsized or partially converted ICF/IID to cover the period that begins with the day the ICF/IID downsizes or partially converts and ends on the last day of the last month of the first three full months of operation as a downsized ICF/IID or partially converted ICF/IID.
- Provides for the cost report for a new ICF/IID to cover the period that begins with the day that the ICF/IID's provider agreement takes effect and ends on the last day of the last month of the first full three months that the provider agreement is in effect.
- Provides for the cost report for a downsized or partially converted ICF/IID to be used to determine the ICF/IID'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 immediately following the month the ICF/IID downsizes or partially converts; and
 - (2) Ending on the last day of the fiscal year immediately preceding the fiscal year for which it begins to be paid a rate determined using a cost report filed in accordance with regular filing procedures.
- Provides for the cost report for a new ICF/IID to be used to determine the ICF/IID's Medicaid payment rate for the period beginning on the day that the ICF/IID's provider agreement takes effect and ending on the last day of the fiscal year immediately preceding the fiscal year for which it begins to be paid a rate determined using a cost report filed in accordance with regular filing procedures.
- Revises the law governing adjustments to new ICFs/IID's initial total Medicaid payment rates.
- Provides that ODODD is permitted, rather than required, to increase an existing ICF/IID's Medicaid payment rate for capital costs when Medicaid-certified beds are added to, or replaced at, the ICF/IID.
- Requires ODODD and a workgroup to evaluate revisions to the formula used to determine Medicaid payment rates for ICF/IID services.

- Requires the ODODD Director to pay the nonfederal share of a claim for ICF/IID 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/IID that was included in the Medicaid-certified capacity of another ICF/IID certified before June 1, 2003;
 - (3) The services are provided by an ICF/IID 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/IID at \$18.24 for fiscal year 2014 and \$18.17 for fiscal year 2015 and thereafter.
- Provides that the authority of an individual with mental retardation or other developmental disability, other than such an individual for whom a guardian has been appointed, to make decisions regarding the receipt of services or participation in programs applies to decisions regarding ICF/IID services.

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, 5126.01, 5126.05, and 5126.051; Sections 259.90 and 259.100)

Employment First policy

The act adds to preexisting 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. 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 act 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, Ohio Department of Job and Family Services, 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 act 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 act 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

Each county board of developmental disabilities (county DD board) is required by the act to do both 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.

The act modifies continuing 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. Prior law provided that those services are optional and are in addition to sheltered employment and work activities.

Regarding prevocational services, the act provides that these services must be provided in accordance with an individual service plan and occur over a specified period of time with specific outcomes sought to be achieved. It defines "prevocational services" as services, including services as a volunteer, that provide learning and work experiences from which an individual can develop general strengths and skills that are not specific to a particular task or job but contribute to employability in community employment, supported work at community-based sites, or self-employment.

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 act to file with ODODD an annual cost report detailing the council's or board's income and expenditures.²⁷ 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.

²⁷ 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, not in the act.



County DD board vacancy

(R.C. 5126.026)

Under the act, 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 four-year terms, the appointing authority can request a waiver from the ODODD Director to allow that member to serve an additional four-year term. The act requires the ODODD Director to determine if the extenuating circumstances warrant the granting of such a waiver.²⁸

Intermediate care facilities for individuals with intellectual disabilities

(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 these services. Prior to the act, state law included many provisions regarding Medicaid's coverage of ICF/MR services but did not expressly include ICF/MR services as part of Medicaid. The act 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 a facility for which the provider has a valid Medicaid provider agreement.
- (3) Federal financial participation is available for the services.

Although federal Medicaid statutes use the term "intermediate care facility for the mentally retarded," federal Medicaid regulations instead use "intermediate care facility for individuals with intellectual disabilities" (ICF/IID).²⁹ Federal Medicaid regulations refer to services of intermediate care facilities for the mentally retarded as ICF/IID services. An ICF/IID is the same type of facility as an ICF/MR.

²⁸ See R.C. 5126.021, not in the act, for provisions of continuing law governing county DD board membership and conditions for reappointment.

²⁹ 42 U.S.C. 1396d(d) and 42 C.F.R. 440.150.



The act replaces references in state law to ICFs/MR and ICF/MR services with references to ICFs/IID and ICF/IID services. The act defines "ICF/IID" as an ICF/MR, as defined in a federal Medicaid statute, and provides that "ICF/IID services" has the same meaning as in a federal Medicaid regulation. The federal definitions are as follows:

--"ICF/MR" – as an institution (or distinct part thereof) for persons with mental retardation or related conditions that (1) has the primary purpose of providing health or rehabilitative services for such persons, (2) meets such standards as may be prescribed by the U.S. Secretary of Health and Human Services, and (3) provides active treatment covered by Medicaid to the persons with respect to whom the institution requests Medicaid payments.³⁰

--"ICF/IID services" – those items and services furnished in an ICF/IID if (1) the ICF/IID fully meets the requirements for a state license to provide services that are above the level of room and board, (2) the primary purpose of the ICF/IID is to furnish health or rehabilitative services to persons with intellectual disability or persons with related conditions, (3) the ICF/IID meets the standards specified in federal regulations, (4) the beneficiary of the services receives active treatment, and (5) the ICF/IID has been certified to meet federal requirements, as evidenced by a valid agreement between the state Medicaid agency and the ICF/IID furnishing the services.³¹

Administration of Medicaid coverage of ICF/IID 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 required that the Ohio Department of Medicaid (ODM)³² 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/IID services. The act relocates and reorganizes the law governing Medicaid coverage of ICF/IID services as part of the process of ODODD assuming many of ODM's duties regarding ICF/IID 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 act renumbers or otherwise relocates the authorizing statute. The citations are to be updated as the Director amends the rules for other purposes.

³⁰ 42 U.S.C. 1396d(d).

³¹ 42 C.F.R. 440.150.

³² At the time H.B. 153 was enacted, the state's Medicaid agency was the Ohio Department of Job and Family Services.



Not all of ODM's responsibilities regarding Medicaid's coverage of ICF/IID 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/IID.³³ The act specifies that the ODODD Director is to adopt rules governing Medicaid's coverage to the extent authorized by rules adopted by the ODM Director.³⁴

The act permits the contract between ODODD and ODM to provide for ODM to perform one or more of ODODD's duties regarding ICFs/IID that undergo a change of operator, close, or cease to participate in Medicaid. These were duties that ODM had before ODODD assumed responsibilities regarding the Medicaid program's coverage of ICF/IID services.

Obsolete provisions

As part of the process of ODODD assuming responsibilities regarding Medicaid coverage of ICF/IID services, the act eliminates the following laws that cease to be applicable:

--A law that made ODODD responsible for the nonfederal share of only certain ICF/IID Medicaid claims. Under that law, ODODD was responsible for the nonfederal share of Medicaid claims submitted for ICF/IID services if (1) the services were provided on or after July 1, 2003, (2) the ICF/IID received initial certification by the Director of Health as an ICF/IID on or after June 1, 2003, (3) the ICF/IID, or a portion of the ICF/IID, was licensed by the ODODD Director as a residential facility, and (4) there was a valid Medicaid provider agreement for the ICF/IID. ODODD was not responsible for Medicaid claims submitted for an ICF/IID if a residential facility license was obtained or modified for the ICF/IID without obtaining approval of a plan for the proposed residential facility. That law provided, however, that the provisions discussed above applied only to the extent, if any, provided in the contract regarding the transfer of the powers and duties regarding ICF/IID services.

--A law that permitted ODODD to notify ODM of a reduction in the licensed capacity of a residential facility that was an ICF/IID. 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 facility is involuntarily committed to a state-operated ICF/IID. On receiving the notice about the reduction, ODM was permitted by the law that is eliminated to transfer to ODODD the savings in the

³³ 42 C.F.R. 431.107(b).

³⁴ 42 C.F.R. 431.10(e)(1)(ii).



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/IID.

ICFs/IID's Medicaid rates for capital costs

(R.C. 5124.17, 5124.01, 5124.21, and 5124.28)

Capital costs are part of an ICF/IID's costs that are used in determining the ICF/IID's total Medicaid payment rate. Under prior law, there were four components to an ICF/IID'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 act modifies, effective July 1, 2014, the Medicaid payments for the capital costs of ICFs/IID by (1) halving, except under a certain circumstance, the efficiency incentive payments to ICFs/IID with more than eight beds, (2) eliminating, except under certain circumstances, nonextensive renovation payments to ICFs/IID with more than eight beds, and (3) eliminating return on equity payments to all ICFs/IID.

Efficiency incentive

Under prior law, the efficiency incentive for an ICF/IID with more than eight beds was to equal 50% of the difference between its costs of ownership and a limit on costs of ownership payments. The act provides that, beginning July 1, 2014, the efficiency incentive for an ICF/IID 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. However, the reduction does not apply to an ICF/IID with more than eight beds that obtains ODODD's approval to become a downsized ICF/IID and the approval is conditioned on the downsizing being completed not later than July 1, 2018. An ICF/IID becomes a downsized ICF/IID by permanently reducing its Medicaid-certified capacity pursuant to a plan approved by ODODD.

Nonextensive renovations

Prior law used inconsistent terminology regarding the part of an ICF/IID's Medicaid payment for renovations. Continuing law defines "capital costs" as costs of ownership and costs of nonextensive renovation. However, the provision of prior law that governed the amount of an ICF/IID's Medicaid payment for nonextensive renovations used the terms "renovation" and "nonextensive renovations." The act uses only the term "nonextensive renovation."

Prior law established only two conditions for an ICF/IID to qualify for a Medicaid payment for nonextensive renovations. First, at least five years must have elapsed since the ICF/IID's date of licensure or date of an extensive renovation of the portion of the ICF/IID 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/IID 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 act adds a third condition for an ICF/IID with more than eight beds to qualify for a Medicaid payment for nonextensive renovations: either ODODD approved the nonextensive renovation before July 1, 2013, or the nonextensive renovation is part of a project that results in the ICF/IID becoming a downsized ICF/IID or partially converted ICF/IID. An ICF/IID becomes a partially converted ICF/IID by converting some, but not all, of its beds to providing home and community-based services under the Individual Options (IO) Medicaid waiver, including such a conversion that occurs after the ICF/IID is acquired through a request for proposals that the ODODD Director issues after the previous provider's license for the ICF/IID was revoked or surrendered. The act does not add an additional condition for an ICF/IID with eight or fewer beds.

ICFs/IID's Medicaid rates for direct care costs

(R.C. 5124.19 and 5124.192; Sections 259.200, 529.210, 605.30, 605.31, and 812.20)

Direct care costs are part of an ICF/IID's costs that are used in determining the ICF/IID's total Medicaid payment rate. Prior law required ODODD to establish each ICF/IID's rate for direct care costs quarterly. The act requires ODODD to determine each ICF/IID's rate for direct care costs for each fiscal year. As part of the change from quarterly to annual rate determinations, the act revises the first step in determining the rate. Under prior law, the first step in determining the rate for a quarter was to multiply the lesser of the ICF/IID's cost per case-mix unit or the maximum cost per case-mix unit for the ICF/IID's peer group by the ICF/IID's average case-mix score determined for the calendar quarter that preceded the immediately preceding calendar quarter. Under the act, the first step in determining the rate for a fiscal year is to multiply the lesser of the ICF/IID's cost per case-mix unit or the maximum cost per case-mix unit for the ICF/IID's peer group by the ICF/IID's annual average case-mix score for the calendar year immediately preceding the fiscal year.

Continuing law requires ODODD to determine an ICF/IID's case-mix score quarterly as part of the process of determining the ICF/IID's Medicaid payment rate for direct care costs. Generally, an ICF/IID's case-mix score is determined by using resident assessment data the ICF/IID submits to ODODD. Under certain circumstances, ODODD may assign a case-mix score that is 5% less than the ICF/IID's case-mix score for the immediately preceding quarter. The circumstances include when the ICF/IID fails to timely submit complete and accurate resident assessment data necessary to determine



the ICF/IID's case-mix score for a quarter. ODODD must permit an ICF/IID to correct the data before assigning a case-mix score due to the submission of incorrect resident assessment data. Under prior law, ODODD could assign the case-mix score if the ICF/IID failed to submit the corrected resident assessment data not later than 80 days after the end of the quarter to which the data pertained or a later due date specified in rules. The act reduces to 45 the number of days that an ICF/IID has to submit corrected resident assessment data before ODODD may assign a case-mix score to the ICF/IID for failure to submit the corrected data.

H.B. 303 of the 129th General Assembly permitted ODODD to conduct or contract with another entity to conduct, for the first quarter of calendar year 2013, resident assessments for all ICFs/IID. Continuing law permitted an ICF/IID to conduct its own resident assessment for that quarter as well. H.B. 303 required ODODD to use the data obtained from the resident assessments it or its contract entity conducts for the first quarter of calendar year 2013 in determining each ICF/IID's case-mix score for that quarter. The case-mix scores so determined for that quarter were to be used in calculating ICFs/IID's fiscal year 2014 Medicaid rates for direct care costs. The act requires instead that ODODD use the average of the following in calculating each ICF/IID's fiscal year 2014 Medicaid rate for direct care costs:

(1) The ICF/IID's case-mix score determined or assigned for the last quarter of calendar year 2012;

(2) The ICF/IID's case-mix score determined for the first quarter of calendar year 2013 determined using the resident assessment data obtained by ODODD or its contract entity;

(3) Unless the ICF/IID did not submit resident assessment data for the first quarter of calendar year 2013, the ICF/IID's case-mix score for the first quarter of calendar year 2013 determined using the resident assessment data submitted by the ICF/IID.

H.B. 303 required ODODD to use, for the purpose of determining an ICF/IID's fiscal year 2015 Medicaid rate for direct care costs, the case-mix score determined for the first quarter of calendar year 2013 using the resident assessment data obtained by ODODD or its contract entity. The act provides that ODODD is to use that resident assessment data in determining an ICF/IID's fiscal year 2015 Medicaid rate only if the ICF/IID does not submit resident assessment data for the first quarter of calendar year 2013.

Return on equity payments

The act eliminates, effective July 1, 2014, the requirement that ODODD pay ICFs/IID a return on their net equity. A return on net equity was a part of their Medicaid payments for capital costs. Under prior law, a return on net equity payment was 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/IID's return on net equity could exceed one dollar per patient day. In calculating an ICF/IID's rate for return on net equity, ODODD had to use the greater of the ICF/IID'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%.

ICFs/IID's efficiency incentives for indirect care costs

(R.C. 5124.21)

Indirect care costs are part of an ICF/IID's costs that are used in determining the ICF/IID's total Medicaid payment rate. A Medicaid payment rate for indirect care costs is determined for each ICF/IID individually and a maximum payment rate for indirect care costs is determined for each peer group of ICFs/IID. An ICF/IID'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 act reduces, beginning with fiscal year 2016, the efficiency incentive that is included in determining the individual Medicaid payment rate for the indirect care costs of an ICF/IID with more than eight beds other than such an ICF/IID that obtains ODODD's approval to become a downsized ICF/IID and the approval is conditioned on the downsizing being completed not later than July 1, 2018.

Under prior law, the efficiency incentive for an ICF/IID with more than eight beds was, for a fiscal year ending in an even-numbered calendar year, 7.1% of the maximum rate established for the ICF/IID's peer group. Its efficiency incentive for a fiscal year ending in an odd-numbered calendar year was the amount calculated for the preceding fiscal year. The act does not change the efficiency incentive for an ICF/IID with more than eight beds if the ICF/IID obtains ODODD's approval to become a downsized ICF/IID and the approval is conditioned on the downsizing being completed not later than July 1, 2018. The efficiency incentive for an ICF/IID with more than eight beds that does not obtain such approval is to be the following beginning in fiscal year 2015:

- (1) For fiscal year 2015, one-half of its efficiency incentive for fiscal year 2014;



(2) For fiscal year 2016 and each even-numbered fiscal year thereafter, 3.55% of the maximum rate established for the ICF/IID's peer group;

(3) For fiscal year 2017 and each odd-numbered fiscal year thereafter, the amount calculated for the ICF/IID for the immediately preceding fiscal year.

Terminology related to federal inflation data

(R.C. 5124.106, 5124.17, 5124.19, and 5124.21)

Inflation adjustments are made in determining ICFs/IID's Medicaid payment rates. The Consumer Price Index (CPI) and Employment Cost Index (ECI) published by the U.S. Bureau of Labor Statistics are used for this purpose. The act updates certain terminology used in connection with these indexes as follows:

(1) In making an inflation adjustment to determine ICFs/IID's rates for capital costs, the CPI for shelter costs for all urban consumers for the Midwest Region, rather than the North Central Region, is to be used.

(2) In making an inflation adjustment to determine ICFs/IID's rates for indirect care costs and in determining a reduction to an ICF/IID's total rate due to a late, incomplete, or inadequate Medicaid cost report, the CPI for all items for all urban consumers for the Midwest Region, rather than the North Central Region, is to be used.

(3) In making an inflation adjustment to determine ICFs/IID's rates for direct care costs, the health care and social assistance component, rather than the health services component of the ECI for Total Compensation, is to be used.

Medicaid rate add-on for outlier ICF/IID services

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

The act permits ODODD, subject to ODM's approval, to pay a Medicaid rate add-on to an ICF/IID for outlier ICF/IID services the ICF/IID provides to qualifying ventilator-dependent residents on or after September 29, 2013 (the act's 90-day effective date) if the ICF/IID applies to ODODD to receive the rate add-on and ODODD approves the application. ODODD may approve an ICF/IID's application if both of the following apply:

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

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



An ICF/IID that is approved to provide outlier ICF/IID 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/IID services from an ICF/IID, a resident of the ICF/IID 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 with ODM 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. 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.

Fiscal year 2014 Medicaid rates for ICF/IID services

(Section 259.200)

The act provides for an existing or new ICF/IID's Medicaid payment rate for fiscal year 2014 to be its modified rate unless the mean of such rates for all existing and new ICFs/IID is other than \$282.84, in which case the ICF/IID'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/IID is considered to be an existing ICF/IID if (1) the provider of the ICF/IID has a valid Medicaid provider agreement for the ICF/IID on June 30, 2013, and a valid Medicaid provider agreement for the ICF/IID during fiscal year 2014 or (2) the ICF/IID undergoes a change of operator that takes effect during fiscal year 2014, the exiting operator has a valid Medicaid provider agreement for the ICF/IID 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/IID during fiscal year 2014. A new ICF/IID is an ICF/IID for which an initial provider agreement is obtained during fiscal year 2014.

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

(1) In place of the inflation adjustment otherwise made in determining the ICF/IID's rate for other protected costs, its other protected costs (excluding the franchise permit fee component of those costs) from calendar year 2012 are to be multiplied by 1.014.



(2) In place of the maximum cost per case-mix unit otherwise established for the ICF/IID's peer group, its maximum costs per case-mix unit is to be \$123.05 if it has more than eight beds or \$117.22 if it has eight or fewer beds.

(3) In place of the inflation adjustment otherwise calculated in determining the ICF/IID's rate for direct care costs, an inflation adjustment of 1.014 is to be used.

(4) In place of the maximum rate for the indirect care costs of the ICF/IID'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/IID's rate for indirect care costs, an inflation adjustment of 1.014 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/IID's efficiency incentive for capital costs is to be reduced by 50%.

A new ICF/IID's initial total modified rate is its initial rate as determined in accordance with a Revised Code provision governing the initial Medicaid payment rates for new ICFs/IID with the following modifications:

(1) In place of the initial rate for direct care costs otherwise determined for the ICF/IID when there is no cost or resident assessment data for the ICF/IID, its initial rate for direct care costs is to be determined as follows:

(a) Using the costs per case-mix units determined for ICFs/IID pursuant to the act's provision governing ICFs/IID's fiscal year 2014 rates for direct care costs, determine the median of the costs per case-mix units of each peer group (see "**ICFs/IID's Medicaid rates for direct care costs**," above);

(b) Multiply the median determined above by the median of the averages determined for the ICFs/IID in the ICF/IID's peer group pursuant to the act's provision governing ICFs/IID's fiscal year 2014 rates for direct care costs;

(c) Multiply the product determined above by 1.014.

(2) In place of the initial rate for indirect care costs otherwise determined for the ICF/IID, its initial rate for indirect care costs is to be \$69.98 if it has more than eight beds or \$59.60 if it has eight or fewer beds.

(3) In place of the initial rate for other protected costs otherwise determined for the ICF/IID, its initial rate for other protected costs is to be 115% of the median fiscal year 2014 rate determined for existing ICFs/IID.

A new ICF/IID's initial total modified rate is to be adjusted at the time new ICFs/IID's rates are ordinarily adjusted (see "**Adjustment of new ICFs/IID's initial Medicaid rates**," below). If the adjustment affects the ICF/IID's rate for services provided during fiscal year 2014, the modifications that are to be applied under the act to existing ICFs/IID apply to the adjustment.

ODODD is required by the act to reduce the amount it pays ICFs/IID for fiscal year 2014 if the U.S. Centers for Medicare and Medicaid Services requires that the ICF/IID 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/IID services

(Section 259.210)

The act provides for an existing or new ICF/IID's Medicaid payment rate for fiscal year 2015 to be its modified rate unless the mean of such rates for all existing and new ICFs/IID is other than \$282.77, in which case the ICF/IID'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/IID is considered to be an existing ICF/IID if (1) the provider of the ICF/IID has a valid Medicaid provider agreement for the ICF/IID on June 30, 2014, and a valid Medicaid provider agreement for the ICF/IID during fiscal year 2015 or (2) the ICF/IID undergoes a change of operator that takes effect during fiscal year 2015, the exiting operator has a valid Medicaid provider agreement for the ICF/IID 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/IID during fiscal year 2015. A new ICF/IID is an ICF/IID for which an initial provider agreement is obtained during fiscal year 2015.

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

(1) In place of the inflation adjustment otherwise made in determining the ICF/IID's rate for other protected costs, its other protected costs (excluding the franchise permit fee component of those costs) from calendar year 2013 are to be multiplied by 1.014.



(2) In place of the maximum cost per case-mix unit otherwise established for the ICF/IID's peer group, its maximum costs per case-mix unit is to be \$114.37 if it has more than eight beds, \$109.09 if it has eight or fewer beds, or the different amount, if any, specified in a future amendment made by the General Assembly.

(3) In place of the inflation adjustment otherwise calculated in determining the ICF/IID's rate for direct care costs, an inflation adjustment of 1.014 is to be used.

(4) In place of the grouper methodology established in rules adopted prior to the act, a new grouper methodology to be established in rules is to be used in determining its case-mix score.

(5) In place of the maximum rate for the indirect care costs of the ICF/IID'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.

(6) In place of the inflation adjustment otherwise calculated in determining the ICF/IID's rate for indirect care costs, an inflation adjustment of 1.014 is to be used.

(7) 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.

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

A new ICF/IID's initial total modified rate is its initial rate as determined in accordance with a Revised Code provision governing the initial Medicaid payment rates for new ICFs/IID with the following modifications:

(1) In place of the initial rate for direct care costs otherwise determined for the ICF/IID when there is no cost or resident assessment data for the ICF/IID, its initial rate for direct care costs is to be determined as follows:

(a) Using the costs per case-mix units determined for ICFs/IID pursuant to the act's provision governing ICFs/IID's fiscal year 2014 rates for direct care costs, determine the median of the costs per case-mix units of each peer group (see "**ICFs/IID's Medicaid rates for direct care costs**," above);

(b) Multiply the median determined above by the median annual average case-mix score for its peer group for calendar year 2013;

(c) Multiply the product determined above by 1.014.



(2) In place of the initial rate for indirect care costs otherwise determined for the ICF/IID, its initial rate for indirect care costs is to be \$69.98 if it has more than eight beds or \$59.60 if it has eight or fewer beds.

(3) In place of the initial rate for other protected costs otherwise determined for the ICF/IID, its initial rate for other protected costs is to be 115% of the median fiscal year 2015 rate determined for existing ICFs/IID.

A new ICF/IID's initial total modified rate is to be adjusted at the time new ICFs/IID's rates are ordinarily adjusted (see "**Adjustment of new ICFs/IID's initial Medicaid rates**," below). If the adjustment affects the ICF/IID's rate for services provided during fiscal year 2015, the modifications that are to be applied under the act to existing ICFs/IID apply to the adjustment.

ODODD is required by the act to reduce the amount it pays ICFs/IID for fiscal year 2015 if the U.S. Centers for Medicare and Medicaid Services requires that the ICF/IID 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.

The act requires the ODODD Director to study certain issues related to ICFs/IID's fiscal year 2015 rates. The Director is to study the issues in consultation with the Ohio Provider Resource Association, Values and Faith Alliance, Ohio Association of County Boards of Developmental Disabilities, and Ohio Health Care Association/Ohio Centers for Intellectual Disabilities. All of the following are to be studied:

(1) Establishing a new grouper methodology to be used when determining ICFs/IID's case-mix scores for fiscal year 2015;

(2) Whether the maximum costs per case-mix units established by the act (\$114.37 for ICFs/IID with more than eight beds and \$109.09 for ICFs/IID with eight or fewer beds) are set at levels that will avoid or minimize rate reductions for fiscal year 2015;

(3) Specifying additional diagnoses and special care needs that individuals must have to meet the criteria for admission to designated outlier ICFs/IID or units and sources of funding for, or mechanisms to ensure the budget neutrality of, the additional diagnoses and special care needs.

The Director is required to adopt rules not later than March 31, 2014, to do the following:

(1) If the Director and organizations with which the Director consults for the studies discussed above agree, not later than December 31, 2013, to the terms of a new



grouper methodology, prescribe a new methodology that is consistent with the agreed upon terms;

(2) If the Director and organizations do not agree on such terms by that date, prescribe a new grouper methodology that provides for at least six classes based on data available to the Director on September 28, 2013 (the day before the provision's effective date);

(3) Specify additional diagnoses and special care needs that individuals must have to meet the criteria for admission to designated outlier ICFs/IID or units.

The act requires the Director and organizations, if they agree that the maximum costs per case-mix units established by the act are not set at levels that will avoid or minimize rate reductions for fiscal year 2015, to recommend that the General Assembly revise the maximums. The recommendations are to be made not later than March 31, 2014. The act states that it is the General Assembly's intent to revise the maximums if the Director and organizations recommend the revisions.

Reduction in number of ICF/IID beds

(R.C. 5124.67 (primary), 5124.01, 5124.63, and 5124.64; Section 125.11.03)

The act requires ODODD to strive to achieve, not later than July 1, 2018, the following statewide reductions in ICF/IID beds:

(1) At least 500 and not more than 600 beds in ICFs/IID that, before becoming downsized ICFs/IID, have 16 or more beds;

(2) At least 500 and not more than 600 beds in ICFs/IID with any number of beds that convert some or all of their beds from providing ICF/IID services to providing home and community-based services under ODODD-administered Medicaid waiver programs.

In its efforts to achieve these reductions, ODODD must collaborate with the Ohio Association of County Boards Serving People with Developmental Disabilities, the Ohio Provider Resource Association, the Ohio Centers for Intellectual Disabilities formed by the Ohio Health Care Association, and the Values and Faith Alliance. The collaboration efforts may include the following:

(1) Identifying ICFs/IID that may reduce the number of their beds to help achieve the reductions;

(2) Encouraging ICFs/IID to reduce the number of their beds;



(3) Establishing interim time frames for making progress in achieving the reductions;

(4) Creating incentives for, and removing impediments to, the reductions;

(5) In the case of ICF/IID beds that are converted to providing home and community-based services, developing a mechanism to compensate ICFs/IID for beds that permanently cease to provide ICF/IID services.

ODODD must meet not less than twice each year with the organizations specified above to review the progress being made in achieving the reductions, prepare written reports on the progress, and identify additional measures needed to achieve the reductions.

The act increases to 600 (from 500) the number of (1) Medicaid waiver slots for which the ODM Director may seek federal approval as part of continuing law regarding ICFs/IID that convert to providing home and community-based services under ODODD-administered Medicaid waiver programs and (2) ICF/IID beds that may be so converted.

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/IID 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/IID.

An annual cost report is to cover the calendar year or portion of the calendar year during which an ICF/IID 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/IID.

There are exceptions to the requirement discussed above. A new ICF/IID 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/IID 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/IID that opens, and an ICF/IID 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.

Under prior law, ODODD's authority to grant a 14-day extension to file an annual cost report was not expressly applied to a cost report for a new ICF/IID or an ICF/IID that undergoes a change of provider that is an arm's length transaction. The act expressly applies the 14-day extension authority to such cost reports.

Cost reports for downsized, partially converted, and new ICFs/IID

The act permits an ICF/IID that becomes a downsized ICF/IID or partially converted ICF/IID on or after July 1, 2013, to file with ODODD a cost report sooner than it otherwise would if it meets certain conditions. To be able to file a cost report sooner than it otherwise would, a downsized or partially converted ICF/IID must have either of the following on the day it becomes a downsized ICF/IID or partially converted ICF/IID:

(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/IID or partially converted ICF/IID;

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

The act also permits a new ICF/IID to file a cost report if its beds are from a downsized ICF/IID and the downsized ICF/IID has either of the following on the day it becomes a downsized ICF/IID:

(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/IID;

(2) At least five fewer ICF/IID-certified beds than it had on the day immediately preceding the day it becomes a downsized ICF/IID.

The cost report of a downsized ICF/IID or partially converted ICF/IID is to cover the period that begins with the day that it becomes a downsized ICF/IID or partially converted ICF/IID and ends on the last day of the last month of the first three full months of operation as a downsized ICF/IID or partially converted ICF/IID. The cost report of a new ICF/IID is to cover the period that begins with the day that the ICF/IID's provider agreement takes effect and ends on the last day of the last month of the first



full three months that the provider agreement is in effect. 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/IID 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 use the cost report to determine the ICF/IID's Medicaid payment rate for ICF/IID services the ICF/IID provides during a certain period. In the case of an ICF/IID that becomes a downsized or partially converted ICF/IID, the period is to begin on the day that the ICF/IID becomes a downsized or partially converted ICF/IID if that day is the first day of a month or, if that is not the case, the first day of the month immediately following the month that the ICF/IID becomes a downsized or partially converted ICF/IID. In the case of a new ICF/IID, the period is to begin on the day that the ICF/IID's provider agreement takes effect. The period is to end for downsized, partially converted, and new ICFs/IID on the last day of the fiscal year that immediately precedes the fiscal year for which the ICF/IID begins to be paid a rate determined using its next, or, in the case of a new ICF/IID, first, annual cost report.

An ICF/IID is to file its next or first annual cost report at the regular time for filing the annual cost report if the ICF/IID becomes a downsized or partially converted ICF/IID on or before the first day of October or, in the case of a new ICF/IID, the ICF/IID's provider agreement takes effect on or before that date. The annual cost report is to cover the portion of the first calendar year that the ICF/IID operated as a downsized or partially converted ICF/IID or, in the case of a new ICF/IID, the portion of the first calendar year during which its provider agreement was in effect. If an ICF/IID becomes a downsized or partially converted ICF/IID after the first day of October or if a new ICF/IID's provider agreement takes effect after that date, the ICF/IID 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.

Adjustment of new ICFs/IID's initial Medicaid rates

(R.C. 5124.151)

The act revises the law governing when ODODD is to adjust a new ICF/IID's initial total Medicaid payment rate. Under prior law, ODODD was to adjust a new ICF/IID's initial total rate at both of the following times:

(1) On the first day of July to reflect new rate determinations for all ICFs/IID;



(2) Following the ICF/IID's submission of its first cost report, which is due not later than 90 days after the end of the ICF/IID's first three full months of operation.

The act eliminates the requirement for ODODD to adjust a new ICF/IID's initial total rate following the ICF/IID's submission of its first cost report. In addition, the act requires ODODD to adjust a new ICF/IID's initial total rate in accordance with the act's provisions regarding cost reports for new ICFs/IID that obtain their beds from downsized ICFs/IID rather than on the first day of July if ODODD accepts a cost report from the ICF/IID under those provisions. (See "**Cost reports for downsized, partially converted, and new ICFs/IID,**" above.)

ICF/IID Medicaid rate reconsideration

(R.C. 5124.38)

Under the act, ODODD is permitted, rather than required as under prior law, to increase an existing ICF/IID's Medicaid payment rate for capital costs through a rate reconsideration process when Medicaid-certified beds are added to the ICF/IID or replaced at the same site.

Evaluation of Medicaid payment rate formula for ICFs/IID

(Section 259.230)

H.B. 153 of the 129th General Assembly required ODM³⁵ and ODODD to study issues regarding Medicaid payment rates for ICF/IID services. A workgroup was created to assist with the study. The act 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/IID services. In conducting the evaluation, ODODD and the workgroup must (1) focus primarily on the service needs of individuals with complex challenges that ICFs/IID are able to meet, (2) pursue the goal of reducing the Medicaid-certified capacity of individual ICFs/IID and the total number of ICF/IID beds in Ohio for the purpose of increasing the service choices and community integration of individuals eligible for ICF/IID services, and (3) consider the impact that exception reviews have on ICFs/IID's case-mix scores.

³⁵ At the time H.B. 153 was enacted, the state's Medicaid agency was the Ohio Department of Job and Family Services.



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

(Section 259.240)

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

ICF/IID franchise permit fee

(R.C. 5168.60)

Continuing law imposes an annual assessment on ICFs/IID. 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 act revises the rate at which the ICF/IID franchise permit fee is assessed. Under prior law, the rate was \$18.32 per bed per day. Under the act, the rate is \$18.24 for fiscal year 2014 and \$18.17 for fiscal year 2015 and thereafter.

Decision-making by individuals with MR/DD

(R.C. 5126.043)

Continuing law provides that an individual with mental retardation or a developmental disability is allowed to make decisions regarding receipt of a service or participation in a program provided for, or funded under, state law governing ODODD or county DD boards unless a guardian has been appointed for the individual. The act provides that such an individual also may make decisions regarding ICF/IID services.



Home and community-based services

Medicaid rates for certain Individual Options services

(Section 259.250)

H.B. 153 of the 129th General Assembly required ODODD to increase the rate paid to a provider under the Individual Options (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 act 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,³⁶ 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.

³⁶ A converted facility is an ICF/IID, or former ICF/IID, that converted some or all of its beds to providing home and community-based services under the IO waiver.

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 prior law, the fees were deposited into two funds: the ODODD Administration and Oversight Fund and the ODJFS Administration and Oversight Fund. ODODD and the Ohio Department of Job and Family Services were required to enter into an interagency agreement to specify which portion of the fees was to be deposited into each fund respectively.

The act 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 act 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 share for home and community-based services provided to an individual who the board determines is eligible for board services.³⁷ ODODD was similarly required to establish the methodology for fiscal years 2012 and 2013 under H.B. 153 of the 129th General Assembly.

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 act 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

³⁷ R.C. 5126.0510, not in the act.

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. Similar provisions were included in H.B. 153 of the 129th General Assembly.

Innovative pilot projects

(Section 259.180)

For fiscal years 2014 and 2015, the act 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 act, 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, the Values and Faith Alliance, and ARC of Ohio. Similar provisions were included in H.B. 153 of the 129th General Assembly.

