Background

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

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

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

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

A reasonable cost is one that is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs and that do not exceed what a prudent buyer pays for a given item or services. The costs of goods, services and facilities furnished to a provider by a related party are includable in the allowable costs of the provider at the reasonable cost to the related party.

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

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

Relation to Other Services

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

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

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

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

Peer Groups

Peer Groups are used to establish the direct care, indirect care and capital rate components for intermediate care facility for individuals with intellectual disabilities rates. There are three peer groups. Peer Group 1 consists of all intermediate care facilities for individuals with intellectual disabilities with a Medicaid certified capacity greater than 8 beds. Peer Group 2 consists of each intermediate care facility for individuals with intellectual disabilities with a Medicaid certified capacity of eight or fewer beds which is not in Peer Group 3. Peer Group 3 consists of each intermediate care facility for individuals with intellectual disabilities to which all of the following apply:

1) The intermediate care facility for individuals with intellectual disabilities is first certified after July 1, 2014;

2) The intermediate care facility for individuals with intellectual disabilities has a Medicaid certified capacity not exceeding six beds;

3) The intermediate care facility for individuals with intellectual disabilities has a contract with DODD that is for fifteen years and includes a provision for DODD to approve all admissions to and discharges from the facility;

4) The residents are admitted to the intermediate care facility for individuals with intellectual disabilities directly from a state operated developmental center or have been determined by DODD to be at risk of admission to a developmental center.

Direct Care

Calculation of the provider case mix score

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

1 – Chronic Medical
2 – Overriding Behaviors
3 – Chronic Behaviors and High Adaptive Needs
4 – Non-significant Behaviors and High Adaptive Needs
5 – Chronic Behaviors and Typical Adaptive Needs Current Resident
5N - Chronic Behaviors and Typical Adaptive Needs New Resident in Peer Group 1
6 - Non-significant Behaviors and Typical Adaptive Needs Current Resident
6N - Non-significant Behaviors and Typical Adaptive Needs New Resident in Peer Group 1

Rate for RAC Groups 5N and 6N

The rate paid for an individual in RAC groups 5N and 6N shall be as follows:

If the individual is in RAC group 5N the rate shall be $206.90.
If the individual is in RAC group 6N the rate shall be $174.88.

Allowable costs for direct care

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

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

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

A direct care per diem rate is established for each intermediate care facility for individuals with intellectual disabilities except for those in Resident Assessment Classification groups 5N and 6N using allowable direct care costs as reported by each facility in accordance with the following calculation:

1) Calculate the direct care cost per diem for each provider by dividing the allowable direct care costs by the inpatient days reported on the same cost report.

2) Calculate the direct care cost per case mix unit for each provider by dividing the provider's direct care costs per diem by the annual average case mix score for the provider. The annual average case mix score is the average of the provider's scores for the March 31, June 30, September 30, and December 31 reporting period end dates for the calendar year corresponding to the calendar year for which costs are reported.

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

4) The allowable cost per case mix unit is the lesser of the facility cost per case mix unit or the maximum cost per case mix unit for the peer group.

5) Multiply the allowable cost per case mix unit by the annual average case mix score for the provider and then multiply the product by an inflation factor to determine the direct care per diem for the facility.
   a. For Peer Group 1 and 2 the inflation factor is 1.0140.
   b. For Peer Group 3 the inflation factor is 1.0323.

INDIRECT COSTS

Allowable costs for indirect care

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

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

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

An indirect care per diem rate is established for each intermediate care facility for individuals with intellectual disabilities except for those in Resident Assessment Classification groups 5N and 6N using allowable indirect care costs as reported by each facility in accordance with the following calculation:

1) Divide the allowable indirect care costs by the greater of the inpatient days reported on the same cost report or imputed occupancy.
   a. Imputed Occupancy is 85% of the total number of bed days available based on the number of certified beds for the facility
2) Multiply the result above by an inflation factor to determine the inflated indirect care costs per diem.
   a. For Peer Groups 1 and 2 the inflation factor is 1.0140.
   b. For Peer Group 3 the inflation factor is 1.0211.
3) Determine the maximum inflated indirect care cost per diem for each peer group:
   a. The maximum inflated indirect care cost per diem for Peer Group 1 and Peer Group 2 shall be calculated as follows:
      (i) Have the amount so determined result in payment of all desk-reviewed, actual, allowable indirect care costs for the same percentage of Medicaid days for ICF's/IID in peer group 1 as for ICF's/IID in peer group 2 as of July 1, 2017, based on May 2017 Medicaid days.
      (ii) Avoid rate adjustments under paragraph 1) of page 19 of Attachment 4.19-D, Supplement 2.
   b. The maximum inflated indirect care cost per diem for Peer Group 3 shall be the rate that is no less than ten and three-tenths per cent above the median desk-reviewed, actual, allowable, per diem inflated indirect care cost for all providers in Peer Group 3 (excluding providers whose inflated indirect care costs are more than three standard deviations from the mean desk-reviewed, actual, allowable, per diem inflated indirect care cost for all providers in peer group 3) for the calendar year immediately preceding the fiscal year in which the rate will be paid.
4) Determine the maximum efficiency incentive for each peer group:
   a. The maximum efficiency incentive for Peer Group 1 is $3.69.
   b. The maximum efficiency incentive for Peer Group 2 is $3.19.
   c. The maximum efficiency incentive for Peer Group 3 is seven percent of the maximum inflated indirect care cost per diem.
5) The allowable indirect care per diem rate is:
   a. If the inflated indirect care cost per diem is higher than the maximum inflated indirect care cost per diem for the peer group, the indirect care per diem rate is equal to the maximum inflated indirect care cost per diem for the peer group.
   b. If the inflated indirect care cost per diem is lower than the maximum inflated indirect care cost per diem for the peer group, the indirect care cost per diem is equal to:
      i. The inflated indirect care cost per diem plus:
         1) For Peer Group 1 if the intermediate care facility for individuals with intellectual disabilities has obtained DODD's approval to downsize or convert to home and community based services at least 10% of their Medicaid certified bed capacity or 5

beds, whichever is fewer, an efficiency incentive equal to either the maximum efficiency incentive for the peer group or a reduced efficiency incentive if the maximum efficiency incentive would cause the indirect care per diem rate to be above the maximum inflated indirect care cost per diem for the peer group.

2) For Peer Group 1 if the intermediate care facility for individuals with intellectual disabilities has not obtained DODD's approval to downsize or convert to home and community based services at least 10% of their Medicaid certified bed capacity or 5 beds, whichever is fewer, an efficiency incentive equal to either one half of the maximum efficiency incentive for the peer group; or an efficiency incentive equal to one half of the reduced efficiency incentive if the maximum efficiency incentive would cause the indirect care per diem rate to be above the maximum inflated indirect care cost per diem for the peer group.
3) For Peer Group 2 and 3 an efficiency incentive equal to either the maximum efficiency incentive for the peer group or a reduced efficiency incentive if the maximum efficiency incentive would cause the indirect care per diem rate to be above the maximum inflated indirect care cost per diem for the peer group.

CAPITAL COSTS

Allowable costs for Capital

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

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

Depreciation

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

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

A capital per diem rate is established for each intermediate care facility for individuals with intellectual disabilities except for those in Resident Assessment Classification groups 5N and 6N using allowable capital costs as reported by each facility in accordance with the following calculation:

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

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

1) Divide the allowable cost of ownership costs as reported by each facility by the greater of the inpatient days reported on the same cost report or imputed occupancy.
    a. Imputed occupancy is 95% of the total number of bed days available based on the number of certified beds for the facility.
2) The cost of ownership per diem is the lower of the results of the calculation above or the cost of ownership ceilings which are set in accordance with Section 5124.17 of the Ohio Revised Code (effective July 1, 2016):
    a. For Peer Group 1, the ceiling ranges from $2.58 - $14.28 (then adjusted for inflation). The precise ceiling for each facility is determined in accordance with the above-reference statute, and is based on the original date of licensure of each bed in the facility and represents a weighted average of all beds in the facility.
    b. For Peer Groups 2 and 3, the ceiling is $18.32 (then adjusted for inflation).

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

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

1) Divide the allowable non-extensive renovations costs as reported by each facility by the greater of the inpatient days reported on the same cost report or imputed occupancy
    a. Imputed occupancy is 95% of the total number of certified beds for the facility
2) The non-extensive renovations per diem is the lower of the result of the calculation in #1 above or the maximum non-extensive renovations per diem which is $8.08 (then adjusted for inflation in the same manner as the cost of ownership ceilings) set in accordance with Section 5124.17 of the Ohio Revised Code (effective July 1, 2016).

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

1) For Peer Group 1 if the intermediate care facility for individuals with intellectual disabilities has obtained DODD's approval to downsize or convert to home and community based services at least 10% of their Medicaid certified bed capacity or 5 beds, whichever is fewer, twenty-five percent of the difference between the allowable cost of ownership calculation in #1 under Cost of Ownership per diem above and the inflated maximum cost of ownership per diem for the facility calculated in Cost of Ownership #2 above.
2) For Peer Group 1 if the intermediate care facility for individuals with intellectual disabilities has not obtained DODD's approval to downsize or convert to home and community based services at least 10% of their Medicaid certified bed capacity or 5 beds, whichever is fewer, twelve and a half percent of the difference between the allowable cost of ownership calculation in #1 under Cost of Ownership per diem above and the inflated maximum cost of ownership per diem for the facility calculated in Cost of Ownership #2 above.
3) For Peer Group 2 twenty-five percent of the difference between the allowable cost of ownership calculation in #1 under Cost of Ownership per diem above and the inflated maximum cost of ownership per diem for the facility calculated in Cost of Ownership #2 above.
    a. For Peer Group 2, the maximum cost of ownership efficiency incentive is $3.00 (then adjusted for inflation in the same manner as the cost of ownership ceilings) set in accordance with Section 5124.17 of the Ohio Revised Code (effective July 1, 2016).
4) For Peer Group 3, fifty percent of the difference between the allowable cost of ownership calculation in #1 under Cost of Ownership per diem above and the inflated maximum cost of ownership per diem for the facility calculated in Cost of Ownership #2 above.
    a. For Peer Group 3, the maximum cost of ownership efficiency incentive is $3.00 (then adjusted for inflation in the same manner as the cost of ownership ceilings) set in accordance with Section 5124.17 of the Ohio Revised Code (effective July 1, 2016).

The total capital per diem rate for a facility in Peer Group 2 or Peer Group 3 cannot exceed the sum of the maximum amounts for the Cost of Ownership per diem and the Non-Extensive Renovations per diem as described above.

Other Protected Costs

Allowable costs for other protected

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

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

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

Another protected per diem rate is established for each intermediate care facility for individuals with intellectual disabilities except for those in Resident Assessment Classification groups 5N and 6N using allowable other protected costs as reported by each facility in accordance with the following calculation:

1) Subtract allowable franchise permit fee costs from the total allowable other protected costs;
2) Divide the amount in #1 above by the total inpatient days reported on the same cost report for the facility to determine the other protected costs per diem;
3) For Peer Groups 1 and 2, multiply the other protected costs per diem by an inflation factor which is 1.0140;
4) For Peer Group 3, multiply the other protected costs per diem by an inflation factor which is 1.0196;
5) Add Medicaid's portion of the franchise permit fee per diem rate to determine the other protected costs per diem rate.

Franchise Permit Fee

The State assesses all providers of Intermediate care facility services for individuals with intellectual disabilities a franchise permit fee based on the provider's certified bed count. The franchise permit fee is calculated using projected net patient revenue and bed counts for the provider class, in accordance with the Indirect Guarantee Percentage as defined in federal regulations (section 1903(w)(4)(C)(ii) of the Social Security Act, 120 Stat. 2994 (2006), 42 U.S.C. 1396b(w)(4)(C)(ii), as amended). The amount of the franchise fee is $18.02 per bed per day.

Non-Standard Rates

Change of Operator (CHOP)

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

New Facility in Peer Group 1 or 2

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

1) The direct care rate component shall be calculated as follows:
    a. If there is no cost or resident assessment data available, the rate shall be the median cost per case-mix unit calculated for standard rates (as calculated in the direct care section of this Attachment) multiplied by the median annual average case-mix score for the peer group for that period and by the rate of inflation estimated for standard rates.
    b. If the facility is a replacement facility and the facility or facilities being replaced are in operation immediately before the replacement facility opens, the rate shall be the same as the rate for the replaced facility or facilities, proportionate to the number of beds in each replaced facility.
2) The rate for indirect care costs shall be the maximum rate for the facility's peer group as calculated for the standard rates.
3) The rate for capital costs shall be the median of all standard capital rates (as calculated in the capital section of this Attachment).
4) The rate for other protected costs shall be 115 percent of the median rate for intermediate care facilities for individuals with intellectual disabilities calculated for the standard rates (as calculated in the other protected section of this Attachment) and shall include the franchise permit fee rate if the beds were subject to the franchise permit fee during the fiscal year.
5) The rate for the direct support personnel payment shall be the median rate value of the direct support personnel payment rates calculated in that section of this Attachment.
6) The rates calculated above will be adjusted effective the first date of July, to reflect new rate calculations for standard rates

New Facility in Peer Group 3

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

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

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

3) The rate for Capital shall be $29.61.

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

Direct Support Personnel Payment

Each intermediate care facility in Peer Groups 1 and 2 shall receive a direct support personnel payment equal to 3.04% of the provider's allowable direct care per diem costs.

Rate Adjustments

1) If the mean total per diem rate for all ICFs-IID in Peer Groups 1 and 2 and active on July 1, 2017, weighted by May 2017 Medicaid days is other than $290.10, for fiscal year 2018, the total per diem rate for each ICF-IID is adjusted by a percentage that is equal to the percentage by which the mean total per diem rate is greater or less than $290.10.
2) An intermediate care facility for individuals with intellectual disabilities may request a reconsideration of a rate on the basis of an extreme hardship on the facility as follows:
    1. Upon direct admission of a resident from a state-operated developmental center to the intermediate care facility.

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

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

Capacity reductions

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

1) The ICF-IID will submit a cost report for the first 3 full months following the permanent reduction of capacity.
2) The 3 month cost report will be used to recalculate the facility's total rate including:
   a. Direct Care - as calculated in the direct care section of this Attachment except for the following:
      i. In place of the annual average case mix score otherwise used in determining the ICF/IID's per Medicaid day payment rate for direct care costs in paragraph 2 of page 6, the ICF/IID's case mix score in effect on the last day of the calendar quarter that ends during the period the cost report covers (or, if more than one calendar quarter ends during that period, the last of those calendar quarters) shall be used to determine the ICF/IID's per Medicaid day payment rate for direct care costs.
   b. Indirect Care - as calculated in the indirect care section of this Attachment
   c. Capital - as calculated in the capital section of this Attachment except for the following:
      i. The ICF/IID shall not be subject to the limit on the costs of ownership per diem payment rate or non-extensive renovations specified in page 10.
      ii. The ICF/IID shall be subject to the limit on the total payment rate for costs of ownership, capitalized costs of non-extensive renovations, and the efficiency incentive specified in page 11 regardless of whether the ICF/IID is in peer group 1 or peer group 2.
   d. Other protected - as calculated in the other protected section of this Attachment

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

1) The new ICF-IID will submit a cost report for the first 3 full months following the certification.
2) The 3 month cost report will be used to recalculate the facility's total rate including:
   a. Direct Care - as calculated in the direct care section of this Attachment except for the following:
      i. In place of the annual average case mix score otherwise used in determining the ICF/IID's per Medicaid day payment rate for direct care costs in paragraph 2 of page 6, the ICF/IID's case mix score in effect on the last day of the calendar quarter that ends during the period the cost report covers (or, if more than one calendar quarter ends during that period, the last of those calendar quarters) shall be used to determine the ICF/IID's per Medicaid day payment rate for direct care costs.
   b. Indirect Care - as calculated in the indirect care section of this Attachment
   c. Capital - as calculated in the capital section of this Attachment
   d. Other protected - as calculated in the other protected section of this Attachment

Outlier

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

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

Individuals must receive prior approval from the Department of Developmental Disabilities for outlier services.

Coverage and Payment for Bed Hold Days

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

Coverage and Payment for short term respite stays

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