

**Attachment 4.19-D
NF Supplement 1**

Payment for Services

Background

Facility-specific nursing home rates are established prospectively using prices calculated using the base year cost report. Each rate is the sum of the direct care rate component, the ancillary and support services price, the capital price, the tax rate component, and the per Medicaid day quality payment rate.

Cost reports reflect allowable costs (costs determined by the Ohio Department Medicaid 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 service. 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 Nursing Facility Services

In order to be eligible for Medicaid payments the operator of a nursing facility shall enter into a provider agreement with the department, apply for and maintain a valid license to operate if so required by law, and comply with all applicable state and federal laws and rules. The operator of a nursing facility that chooses to be a Medicaid provider must maintain Medicare certification for all beds participating in the Medicaid program.

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Base Year

The base year, first used for rates in state fiscal year 2017, is calendar year 2014.

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Relation to Other Services

The nursing facility per diem rate is a comprehensive rate that includes many items and services for which the provider is not paid directly by the Medicaid program. The following items and services are included in the nursing facility per diem rate:

- 1) Personal hygiene services provided by facility staff or contracted personnel;
- 2) The purchase and administration of tuberculin tests;
- 3) Drawing specimens and forwarding specimens to a laboratory;
- 4) Medical supplies, defined as items with a very limited life expectancy (e.g., atomizers, nebulizers, bed pans, catheters, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits);
- 5) Needed medical equipment, defined as items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for use in the facility (e.g., hospital beds, wheelchairs other than custom wheelchairs, and intermittent positive-pressure breathing machines). For dates of service on and after January 1, 2014, custom wheelchairs are not included in the nursing facility rate and are covered on a fee for service basis;
- 6) Emergency oxygen;
- 7) Over the counter drugs and nutritional supplements;
- 8) Physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants;
- 9) Respiratory therapy services, including physician ordered administration of aerosol therapy rendered by a licensed respiratory care professional;
- 10) Resident transportation other than medically necessary transportation by ambulance or wheelchair van. Medically necessary transportation of residents who do not require an ambulance or wheelchair van is paid through the NF per diem rate;
- 11) Private rooms when residents require one due to medical necessity such as the need for infection control, or when semiprivate or ward accommodations are not available. In both cases, Medicaid payment is considered payment in full, and no supplemental payment may be requested or accepted from a resident, or from a resident's authorized representative or family. If semiprivate or ward accommodations are available but the resident or resident's representative makes a written request for a private room, the private room is considered a non-covered service for which the facility may seek supplemental payment from the resident or resident's representative. The supplemental payment amount shall be no more than the difference between the charge to private pay residents for a semiprivate room and the charge to private pay residents for a private room.

The following items and services are not included in the nursing facility per diem rate but are paid directly to the provider by the Medicaid program:

- 1) Covered dental services provided by licensed dentists;
- 2) Laboratory and x-ray procedures covered under the Medicaid program;

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- 3) Ventilators;
- 4) Prostheses and orthoses;
- 5) Pharmaceuticals, subject to the following conditions:
 - a) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient;
 - b) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years;
 - c) A receipt for drugs delivered to a NF must be signed by the facility representative at the time of delivery; a copy must be maintained by the pharmacy.
- 6) Behavioral health services;
- 7) Physician services;
- 8) Podiatry services;
- 9) Vision care services;
- 10) Custom wheelchairs;
- 11) Non-emergency oxygen;
- 12) Medically necessary resident transportation by ambulance or wheelchair van;
- 13) Acupuncture services in accordance with Attachment 3.1-A.

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Peer Groups

Peer groups are used to establish the direct care, ancillary and support and capital price components for nursing facility rates and to establish rates for individual providers. Providers are assigned to peer groups based on the provider's geographical location and the number of licensed beds reported on the provider's annual cost report for the calendar year preceding the fiscal year for which the rate is established. For a provider new to the Medicaid program, the initial number of licensed beds documented in the provider agreement shall be used; subsequently the number of beds reported on the provider's annual cost report will be used. In the case of a change of operator, the entering operator shall be assigned to the peer group that had been assigned to the exiting operator on the day immediately preceding the date on which the change of operator occurred; subsequently the number of licensed beds reported on the annual cost report shall be used. No adjustment will be made to the provider's placement in a peer group due to a change in bed size until the first day of the next fiscal year.

Direct Care

Three peer groups are used to establish the direct care component for nursing facility rates. Peer Group 1 consists of facilities located in Brown, Butler, Clermont, Clinton, Hamilton and Warren counties.

Peer Group 2 consists of facilities located in Allen, Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Stark, Summit, Trumbull, Union and Wood counties.

Peer Group 3 consists of facilities located in Adams, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot counties.

Ancillary and Support and Capital – Establishing Price Components

Six peer groups are used to establish the ancillary and support and capital price components for nursing facility rates. Peer Group 1 consists of facilities with fewer than 100 beds located in Brown, Butler, Clermont, Clinton, Hamilton and Warren counties. Peer Group 2 consists of facilities in those counties with 100 or more beds.

The current price components for Peer Group 3 were calculated using reported costs for facilities with fewer than 100 beds located in Allen, Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Stark, Summit, Trumbull, Union and Wood counties. Peer Group 4 consists of facilities in those counties with 100 or more beds.

The current price components for Peer Group 5 were calculated using reported costs for facilities with fewer than 100 beds located in Adams, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot counties. Peer Group 6 consists of facilities in those counties with 100 or more beds.

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Ancillary and Support and Capital – Calculating Rates

Six peer groups are used to assign price components for ancillary and support and capital when calculating nursing facility rates. Peer Group 1 consists of facilities with fewer than 100 beds located in Brown, Butler, Clermont, Clinton, Hamilton and Warren counties. Peer Group 2 consists of facilities in those counties with 100 or more beds.

Peer Group 3 consists of facilities with fewer than 100 beds located in Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Stark, Summit, Union and Wood counties. Peer Group 4 consists of facilities in those counties with 100 or more beds.

Peer Group 5 consists of facilities with fewer than 100 beds located in Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot counties. Peer Group 6 consists of facilities in those counties with 100 or more beds.

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Direct Care**Costs Included in Direct Care**

Direct care costs are reasonable costs incurred for the following:

- 1) Registered nurses, licensed practical nurses and nurse aides employed by the facility;
- 2) Direct care staff, administrative nursing staff, medical directors, respiratory therapists, and other persons holding degrees qualifying them to provide therapy;
- 3) Purchased nursing services;
- 4) Quality assurance;
- 5) Consulting and management fees related to direct care;
- 6) Allocated direct care home office costs;
- 7) Habilitation staff, other than habilitation supervisors;
- 8) Medical supplies, habilitation supplies and universal precaution supplies;
- 9) Emergency oxygen;
- 10) Over the counter pharmacy products;
- 11) Physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, and audiologists;
- 12) Training and staff development, employee benefits, payroll taxes, workers' compensation premiums, and costs for self-insurance claims for individuals whose wages are included in direct care;
- 13) Other direct care resources.

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Calculation of Direct Care Price

A direct care price is established for each peer group using the base year costs reported by providers in that peer group using the following calculation:

- 1) Group providers into the peer groups defined above.
- 2) Using calendar year 2014 as the base year, calculate the direct care cost per diem for each provider by dividing the direct care costs the provider reported on the base year Ohio Medicaid cost report by the inpatient days reported on the same cost report.
- 3) Calculate the direct care cost per case mix unit (CPCMU) for each provider by dividing the provider's direct care cost per diem by the annual average case mix score for the provider during the base year. The annual average case mix score is the average of the quarterly case mix scores for all residents regardless of payer during the base year.
- 4) Determine the CPCMU of the provider at the twenty-fifth percentile in each peer group. When making this determination, exclude providers without a 12 month cost report in the base year and providers whose direct care costs are more than one standard deviation from the mean direct care costs in the peer group.
- 5) Multiply the CPCMU of the provider at the twenty-fifth percentile by 102%.
- 6) Multiply the result in the step above by the rate of inflation for the eighteen month period beginning on the first day of July in the base year and ending on the last day of December in the following calendar year. Inflation is measured using the employment cost index for total compensation, health services component, published by the United States Bureau of Labor Statistics, as the index existed on July 1, 2005. When a new base year is selected, the employment cost index for total compensation, nursing and residential care facilities occupational group, published by the United States Bureau of Labor Statistics will be used.
- 7) Increase the result in the previous step by one dollar and eighty-eight cents.
- 8) Multiply the result in the previous step by 105.08% to calculate the peer group price.

Calculating the Direct Care Rate

A facility specific direct care rate component is calculated by multiplying the peer group price by a facility specific semi-annual case mix score. For rates effective on the first day of July 2011 the fiscal year, the price is multiplied by the semi-annual Medicaid case mix score for the quarters ended June 30, 2010 and October 31, 2010. Subsequently, rates are adjusted for changes in acuity effective July 1 and January 1 of the fiscal year. The July 1 acuity adjustment will be made using the semi-annual Medicaid case mix scores for the preceding quarters ended December 31 and March 31. The January 1 acuity adjustment will be made using semi-annual Medicaid case mix scores for the preceding quarters ended June 30 and September 30.

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Case Mix Payment System**Minimum Data Set Version 3.0 (MDS 3.0) Resident Assessment Instrument**

Each facility's rate for direct care costs is based on a case mix payment system. The case mix payment system begins with the Minimum Data Set version 3.0 (MDS 3.0), the resident assessment instrument used in Ohio for implementing standardized assessments and for facilitating care management in nursing facilities. The MDS 3.0 is used in Ohio to comply with regulations specified in 42 C.F.R. 483.20 that require nursing facilities to provide comprehensive, accurate, standardized, reproducible assessments of each long term care facility resident's functional capacity, including assessments of medical conditions. The MDS 3.0 also includes Ohio-specific data elements designated as Section S.

All nursing facilities must submit encoded, accurate, and complete MDS 3.0 data for all residents of Medicaid certified beds, regardless of pay source or anticipated length of stay. Data must be encoded in accordance with 42 C.F.R. 483.20 and with federal MDS 3.0 data submission specifications.

MDS 3.0 data submitted by nursing facilities is used to calculate quarterly, semiannual, and annual case mix scores, which in turn are used to calculate the direct care component of each nursing facility's per diem rate.

Resource Utilization Groups (RUG) Classification System

The Ohio case mix payment system uses the resource utilization groups (RUG) classification system, which is a methodology for grouping nursing facility residents into case mix groups in a way that is clinically meaningful, and uses criteria that sufficiently differentiates one group from another. Ohio uses the following versions of the RUG classification system:

- 1) For rates paid for services provided before July 1, 2016, version III (RUG III). Based on the items in the MDS 3.0, if a resident meets the criteria for placement in more than one group, the resident will be placed in a group within the highest major category of resident types according to the hierarchy unless the activities of daily living (ADL) index score is not met for placement within the highest major category of resident types. In descending order, the hierarchy of RUG III major categories using the forty-five grouper model as used in Ohio is as follows:
 - a) Extensive services.
 - b) Special rehabilitation
 - c) Special care.
 - d) Clinically complex.
 - e) Impaired cognition.
 - f) Behavior problems.
 - g) Reduced physical function.

- 2) For rates paid for services provided July 1, 2016 and thereafter, version IV (RUG IV). Based on items in the MDS 3.0, if a resident meets the criteria for placement in more than one group, the resident will be placed in a group according to the hierarchy. In descending order, the hierarchy of RUG IV major categories using the forty-eight, fifty-seven, or sixty-six grouper model is as follows:
 - a) Rehabilitation plus extensive services (sixty-six grouper model only).
 - b) Rehabilitation.
 - c) Extensive services.
 - d) Special care high.
 - e) Special care low.
 - f) Clinically complex.
 - g) Behavioral symptoms and cognitive performance.
 - h) Reduced physical function.

Each of the RUG groups is assigned a relative resource weight. The relative resource weight indicates the relative amount of staff time required on average for workers in the registered nurse (RN), licensed practical nurse (LPN), and nurse aide (NA) worker classifications to deliver care to residents in a particular RUG group. Relative resource weights are calculated as follows using the average minutes per worker classification per RUG group provided by the United States Department of Health and Human Services (HHS), and the most recent available three-year averages of RN, LPN, and NA wages in Ohio Medicaid certified nursing facilities as reported on the Ohio Medicaid annual cost report:

- 1) By setting the NA wage weight at one, wage weights for RNs and LPNs are calculated by dividing the NA wage into the RN or LPN wage.

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- 2) To calculate the total weighted minutes for each RUG group, the wage weight for each worker classification is multiplied by the average number of minutes that classification of workers spends caring for a resident in the RUG group, and then the products for each RUG group are summed.
- 3) Relative resource weights are calculated by dividing the lowest group's total weighted minutes into each group's total weighted minutes. Weight calculations are rounded to the fourth decimal place. The RUG group with the lowest total weighted minutes receives a relative resource weight of 1.0000.

Residents whose MDS 3.0 forms contain missing or out-of-range responses to data elements used to determine the RUG classification shall be assigned to a default group. The lowest relative resource weight for the RUG groups (1.0000) is used as the weight for the default group.

APPENDIX A

RUG CLASSIFICATION SYSTEM
RELATIVE RESOURCE WEIGHTS

	RUG III CLASS - 45 GROUPER	RELATIVE WEIGHT
1	SE3	3.6037
2	SE2	2.9532
3	SE1	2.5253
4	RUC	2.7812
5	RUB	2.0327
6	RUA	1.6546
7	RVC	2.4192
8	RVB	2.2206
9	RVA	1.7320
10	RHC	2.6820
11	RHB	2.2565
12	RHA	1.8480
13	RMC	2.8835
14	RMB	2.3328
15	RMA	2.0480
16	RLB	2.4124
17	RLA	1.7119
18	SSC	2.4449
19	SSB	2.2715
20	SSA	2.1546
21	CC2	2.4231
22	CC1	2.1474
23	CB2	1.9681
24	CB1	1.8232
25	CA2	1.7925
26	CA1	1.6009
27	IB2	1.5112
28	IB1	1.4600
29	IA2	1.2366
30	IA1	1.1481
31	BB2	1.4861
32	BB1	1.4116
33	BA2	1.2090
34	BA1	1.0259
35	PE2	1.7400
36	PE1	1.6983
37	PD2	1.5821
38	PD1	1.5509
39	PC2	1.4489
40	PC1	1.3925
41	PB2	1.1054
42	PB1	1.0892
43	PA2	1.0503
44	PA1	1.0000
45	BC1	1.0000

	RUG IV CLASS - 48 GROUPER	RELATIVE WEIGHT
1	ES3	6.5333
2	ES2	4.9111
3	ES1	4.6889
4	RAE	3.6667
5	RAD	3.4889
6	RAC	2.9778
7	RAB	2.4222
8	RAA	1.7778
9	HE2	4.2444
10	HE1	3.3111
11	HD2	3.7333
12	HD1	2.9778
13	HC2	3.4444
14	HC1	2.7333
15	HB2	3.3111
16	HB1	2.6889
17	LE2	3.6000
18	LE1	2.8222
19	LD2	3.4444
20	LD1	2.7333
21	LC2	2.8444
22	LC1	2.2667
23	LB2	2.6667
24	LB1	2.1111
25	CE2	3.0667
26	CE1	2.7556
27	CD2	2.8889
28	CD1	2.5778
29	CC2	2.4000
30	CC1	2.1333
31	CB2	2.0889
32	CB1	1.8889
33	CA2	1.6222
34	CA1	1.4222
35	BB2	1.8222
36	BB1	1.6667
37	BA2	1.2889
38	BA1	1.2000
39	PE2	2.8000
40	PE1	2.6000
41	PD2	2.5778
42	PD1	2.3778
43	PC2	2.0667
44	PC1	1.8889
45	PB2	1.5556
46	PB1	1.4444
47	PA2	1.1111
48	PA1	1.0000

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**RUG CLASSIFICATION SYSTEM
RELATIVE RESOURCE WEIGHTS**

	RUG IV CLASS - 57 GROUPER	RELATIVE WEIGHT
1	RUC	3.9556
2	RUB	3.8667
3	RUA	2.4000
4	RVC	3.7333
5	RVB	2.8667
6	RVA	2.7111
7	RHC	3.7111
8	RHB	2.9556
9	RHA	2.2444
10	RMC	3.6222
11	RMB	3.2667
12	RMA	2.0667
13	RLB	3.6667
14	RLA	1.8000
15	ES3	6.4889
16	ES2	4.9111
17	ES1	4.0667
18	HE2	4.2444
19	HE1	3.3111
20	HD2	3.7333
21	HD1	2.9778
22	HC2	3.4444
23	HC1	2.7333
24	HB2	3.3111
25	HB1	2.6889
26	LE2	3.6000
27	LE1	2.8222
28	LD2	3.4444
29	LD1	2.7333
30	LC2	2.8444
31	LC1	2.2667
32	LB2	2.6667
33	LB1	2.1111
34	CE2	3.0667
35	CE1	2.7556
36	CD2	2.8889
37	CD1	2.5778
38	CC2	2.4000
39	CC1	2.1333
40	CB2	2.0889
41	CB1	1.8889
42	CA2	1.6222
43	CA1	1.4222
44	BB2	1.8222
45	BB1	1.6667
46	BA2	1.2889
47	BA1	1.2000
48	PE2	2.8000
49	PE1	2.6000
50	PD2	2.5778
51	PD1	2.3778
52	PC2	2.0667
53	PC1	1.8889
54	PB2	1.5556
55	PB1	1.4444
56	PA2	1.1111
57	PA1	1.0000

	RUG IV CLASS - 66 GROUPER	RELATIVE WEIGHT
1	RUX	6.6444
2	RUL	6.2667
3	RVX	6.6222
4	RVL	5.3556
5	RHX	6.2000
6	RHL	5.1778
7	RMX	5.9556
8	RML	5.0889
9	RLX	5.4000
10	RUC	3.8667
11	RUB	3.7778
12	RUA	2.4000
13	RVC	3.7111
14	RVB	2.7333
15	RVA	2.6889
16	RHC	3.5333
17	RHB	2.8889
18	RHA	2.2444
19	RMC	3.3556
20	RMB	2.9778
21	RMA	2.0667
22	RLB	3.6667
23	RLA	1.8000
24	ES3	6.4889
25	ES2	4.9111
26	ES1	4.0667
27	HE2	4.2444
28	HE1	3.3111
29	HD2	3.7333
30	HD1	2.9778
31	HC2	3.4444
32	HC1	2.7333
33	HB2	3.3111
34	HB1	2.6889
35	LE2	3.6000
36	LE1	2.8222
37	LD2	3.4444
38	LD1	2.7333
39	LC2	2.8444
40	LC1	2.2667
41	LB2	2.6667
42	LB1	2.1111
43	CE2	3.0667
44	CE1	2.7556
45	CD2	2.8889
46	CD1	2.5778
47	CC2	2.4000
48	CC1	2.1111
49	CB2	2.0889
50	CB1	1.8889
51	CA2	1.6222
52	CA1	1.4222
53	BB2	1.8222
54	BB1	1.6667
55	BA2	1.2889
56	BA1	1.2000
57	PE2	2.8000
58	PE1	2.6000
59	PD2	2.5778
60	PD1	2.3778
61	PC2	2.0667
62	PC1	1.8889
63	PB2	1.5556
64	PB1	1.4444
65	PA2	1.1111
66	PA1	1.0000

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Calculation of Nursing Facility Case Mix Scores

After processing MDS 3.0 resident assessment data and classifying residents using the RUG classification system, the Department of Medicaid calculates quarterly, semiannual, and annual nursing facility case mix scores. Two quarterly facility average case mix scores are calculated each quarter. The first is the quarterly facility average total case mix score. The second is the quarterly facility average Medicaid case mix score. For each nursing facility that submits timely, accurate, and sufficient resident assessment data, the quarterly facility average total case mix score is calculated as follows:

- 1) Add together all resident case mix scores for the quarter, including resident case mix scores in the RUG default group. The lowest weight for the RUG groups (1.0000) is used as the weight for the default group.
- 2) Divide the sum of the resident case mix scores by the total number of residents.

For each nursing facility that submits timely, accurate, and sufficient resident assessment data, the quarterly facility average Medicaid case mix score is calculated as follows:

- 1) Add together all Medicaid resident case mix scores for the quarter, including Medicaid resident case mix scores in the RUG default group. The lowest weight for the RUG groups (1.0000) is used as the weight for the default group.
- 2) Divide the sum of the Medicaid resident case mix scores by the total number of Medicaid residents.

Data is considered timely when the nursing facility submits the resident assessment data by the filing date, and the data includes assessments for all residents in Medicaid certified beds as of the reporting period end date. Data is considered accurate and sufficient when data that is submitted timely provides sufficient information for accurately classifying at least 90% of all residents in Medicaid certified beds into RUG non-default groups. Additionally, data is considered accurate and sufficient when data that is submitted timely and corrected timely provides sufficient information for accurately classifying at least 90% of all residents in Medicaid certified beds into RUG non-default groups. For each nursing facility that does not submit timely, accurate, or sufficient resident assessment data, the department shall assign a penalty score that is 5% less than that facility's quarterly facility average case mix score for the preceding calendar quarter.

The semiannual facility average Medicaid case mix score is determined as follows:

- 1) The semiannual facility average Medicaid case mix score for the payment period beginning the first day of July for a given fiscal year shall be the average of the quarterly facility average Medicaid case mix score from the preceding December and March reporting quarters. If a facility does not have a quarterly facility average Medicaid case mix score for both the December and March reporting quarters, the median annual facility average case mix score for the nursing facility's peer group shall be assigned as the semiannual facility average Medicaid case mix score.
- 2) The semiannual facility average Medicaid case mix score for the payment period beginning the first day of January for a given fiscal year shall be the average of the quarterly facility average Medicaid case mix score from the preceding June and

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September reporting quarters. If a facility does not have a quarterly facility average Medicaid case mix score for both the June and September reporting quarters, the median annual facility average case mix score for the nursing facility's peer group shall be assigned as the semiannual facility average Medicaid case mix score.

The annual facility average case mix score is calculated as follows:

- 1) Add all qualifying case mix scores.
- 2) Divide the sum of the qualifying case mix scores by the total number of quarters of qualifying scores.

Qualifying case mix scores are scores for facilities that have at least two quarterly facility average total case mix scores, and that also submitted resident assessment data timely, accurately, and sufficiently. If the department assigned a nursing facility a quarterly facility average total case mix score but the facility did not submit resident assessment data timely, accurately, or sufficiently, the assigned score is not used to calculate the facility's annual average case mix score.

In addition, for any score that was adjusted, the adjusted score is substituted according to the following hierarchy:

- 1) Adjusted quarterly facility average total case mix scores established by a rate reconsideration decision resulting from an exception review of resident assessment information conducted according to Section 001.8.4 of Attachment 4.19-D, Supplement 1 before the effective date of the rate.
- 2) Adjusted quarterly facility average total case mix scores as a result of exception review findings from an exception review conducted according to Section 001.8.4 of Attachment 4.19-D, Supplement 1.

Exception Reviews

An exception review is a review of minimum data set (MDS) resident assessment data. Exception reviews are conducted at selected nursing facilities by registered nurses or other appropriate licensed or certified health professionals as determined by the Department of Medicaid who are employed by or under contract with the department to identify any patterns or trends related to resident assessments that could result in inaccurate case mix scores. Facilities may be selected for an exception review based on the findings of a Medicaid certification survey conducted by the Department of Health, a risk analysis, or prior performance of the nursing facility.

If an exception review is conducted before the effective date of a nursing facility's rate for direct care costs, and the exception review results in findings that exceed tolerance levels specified by the department and indicate the facility received a higher rate than it was entitled to receive, the department will use the exception review findings to calculate or recalculate individual resident case mix scores, and to calculate or recalculate the nursing facility's quarterly facility average total case mix scores, quarterly and semiannual facility average Medicaid case mix scores, and annual facility average case mix scores. The department will use the nursing facility's quarterly facility average total case mix scores, quarterly and semiannual facility average Medicaid case mix scores, and annual facility average case mix scores based on exception review findings to calculate or recalculate the facility's rate for direct care costs for the appropriate six month period.

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APPENDIX A
EXCEPTION REVIEW
RESIDENT INITIAL SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Initial Sample Size Required
1-4	All
5-10	5
11-20	8
21-40	10
41-44	11
45-48	12
49-52	13
53-56	14
57-75	15
76-80	16
81-85	17
85-90	18
91-95	19
96-100	20
101-105	21
106-110	22
111-115	23
116-160	24
161-166	25
167-173	26
174-180	27

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APPENDIX A
EXCEPTION REVIEW
RESIDENT INITIAL SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Initial Sample Size Required
181-186	28
187-193	29
194-300	30
301-310	31
311-320	32
321-330	33
331-340	34
341-350	35
351-360	36
361-370	37
371-380	38
381-400	39
401-410	40
411-420	41
421-430	42
431-440	43
441-450	44
451-460	45
461-470	46
471-480	47
481-490	48
491-500	49
501 or greater	50

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APPENDIX B
EXCEPTION REVIEW
RESIDENT EXPANDED SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (Includes Initial Sample)
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10-11	10
12	11
13	12
14-15	13
16	14
17	15
18-19	16
20	17
21-22	18
23	19
24-25	20
26	21
27-28	22

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APPENDIX B
EXCEPTION REVIEW
RESIDENT EXPANDED SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (Includes Initial Sample)
29-30	23
31	24
32-33	25
34-35	26
36-37	27
38-39	28
40-41	29
42-43	30
44-45	31
46-47	32
48-50	33
51-52	34
53-55	35
56-57	36
58-60	37
61-62	38
63-65	39
66-68	40
69-71	41
72-74	42
75-77	43
78-81	44

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APPENDIX B
EXCEPTION REVIEW
RESIDENT EXPANDED SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (Includes Initial Sample)
82-84	45
85-88	46
89-92	47
93-95	48
96-100	49
101-104	50
105-108	51
109-113	52
114-118	53
119-123	54
124-128	55
129-134	56
135-140	57
141-146	58
147-152	59
153-159	60
160-167	61
168-174	62
175-183	63
184-191	64
192-201	65
202-211	66

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APPENDIX B
EXCEPTION REVIEW
RESIDENT EXPANDED SAMPLE SELECTION

Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (Includes Initial Sample)
212-221	67
222-232	68
233-245	69
246-258	70
259-272	71
273-287	72
288-304	73
305-322	74
323-342	75
343-364	76
365 or greater	77

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Ancillary and Support**Costs Included In Ancillary and Support**

For dates of service before January 1, 2014, ancillary and support costs are reasonable costs incurred by a nursing facility that are not direct care costs, capital costs, or tax costs. They include, but are not limited to, costs incurred for the following:

- 1) Activities;
- 2) Social services;
- 3) Pharmacy consultants;
- 4) Habilitation supervisors, qualified mental retardation professionals, and program directors.
- 5) Program and incontinence supplies;
- 6) Food, enterals, dietary supplies, and dietary personnel;
- 7) Laundry and housekeeping;
- 8) Security;
- 9) Administration, bookkeeping, purchasing department, human resources, and communication;
- 10) Medical equipment, minor equipment, and wheelchairs;
- 11) Utilities;
- 12) Liability and property insurance;
- 13) Travel;
- 14) Dues, license fees, and subscriptions;
- 15) Home office costs not otherwise allocated;
- 16) Legal and accounting services;
- 17) Resident transportation;
- 18) Maintenance and repairs; maintenance and repairs are necessary and proper to maintain an asset in a normally efficient working condition and do not extend the useful life of the asset two years or more. Maintenance and repairs include, but are not limited to ordinary repairs such as painting and wallpapering.
- 19) Help wanted and informational advertising;
- 20) Start-up costs and organizational expenses;
- 21) Other interest;
- 22) Training and staff development, employee benefits, payroll taxes, workers' compensation premiums, and costs for self-insurance claims for individuals whose wages are included in ancillary and support.

For dates of service on or after January 1, 2014, ancillary and support costs are reasonable costs incurred by a nursing facility that are not direct care costs, capital costs, or tax costs. They include, but are not limited to, costs incurred for the following:

- 1) Activities;
- 2) Social services;
- 3) Pharmacy consultants;
- 4) Habilitation supervisors, qualified mental retardation professionals, and program directors.
- 5) Program and incontinence supplies;
- 6) Food, enterals, dietary supplies, and dietary personnel;

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- 7) Laundry and housekeeping;
- 8) Security;
- 9) Administration, bookkeeping, purchasing department, human resources, and communication;
- 10) Medical equipment, minor equipment, and wheelchairs other than custom wheelchairs;
- 11) Utilities;
- 12) Liability and property insurance;
- 13) Travel;
- 14) Dues, license fees, and subscriptions;
- 15) Home office costs not otherwise allocated;
- 16) Legal and accounting services;
- 17) Resident transportation other than medically necessary transportation by ambulance or wheelchair van;
- 18) Maintenance and repairs; maintenance and repairs are necessary and proper to maintain an asset in a normally efficient working condition and do not extend the useful life of the asset two years or more. Maintenance and repairs include, but are not limited to ordinary repairs such as painting and wallpapering.
- 19) Help wanted and informational advertising;
- 20) Start-up costs and organizational expenses;
- 21) Other interest;
- 22) Training and staff development, employee benefits, payroll taxes, workers' compensation premiums, and costs for self-insurance claims for individuals whose wages are included in ancillary and support.

Calculating the Ancillary and Support Price and Rate

An ancillary and support price is established for each peer group using the base year costs reported by providers in that peer group using the following calculation:

- 1) Group providers into the peer groups defined above.
- 2) Calculate the ancillary and support cost per diem for each provider by dividing the ancillary and support costs the provider reported on the base year cost report by the greater of inpatient days or 90% of licensed bed days available. For purposes of calculating the facility's occupancy rate and licensed bed days available, the department shall include any beds the nursing facility removes from its Medicaid certified capacity unless the nursing facility also removes the beds from its licensed bed capacity.
- 3) Determine the ancillary and support per diem of the provider at the twenty-fifth percentile in each peer group. When making this determination, exclude providers without a 12 month cost report in the base year and providers whose ancillary and support costs are more than one standard deviation from the mean ancillary and support costs in the peer group.
- 4) Multiply the result in the step above by the rate of inflation for the eighteen month period beginning on the first day of July in the base year and ending on the last day of December in the following calendar year. Inflation is measured using the consumer price index for all items for all urban consumers for the north central region, published by the United States Bureau of Labor Statistics, as the index existed on July 1, 2005. When a new base year is selected, the consumer price index for all items for all urban consumers for the midwest region, published by the United States Bureau of Labor Statistics will be used.
- 5) Multiply the result in the previous step by 105.08% to calculate the peer group price.
- 6) The provider's ancillary and support rate component is equal to the ancillary and support price for the peer group.

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Capital**Costs Included in Capital**

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

- 1) Buildings and building improvements;
- 2) Equipment;
- 3) Transportation equipment
- 4) Land improvements;
- 5) Leasehold improvements;
- 6) Financing costs.

Depreciation, amortization and interest for capital assets costing less than \$500 per item may be considered capital costs in accordance with the provider's practice. Depreciation for costs paid or reimbursed by a government agency shall not be included in cost reports unless that part of the payment is used to reimburse the government agency. Amortization of the cost of acquiring operating rights for the relocated beds is not an allowable cost.

Capital costs also include rent and lease expense for land building and equipment. Allowable lease expense is determined as follows:

- (1) For a lease of a facility that was effective on May 27, 1992, the entire lease expense is an allowable expense.
- (2) For a renewal of a lease of a facility that was effective on May 27, 1992 that is pursuant to a renewal option in existence on May 27, 1992, the entire lease expense is an allowable expense.
- (3) For a renewal of a lease between the same parties and for the same lease payment as a lease in effect on May 27, 1992, the entire lease expense is an allowable expense.
- (4) For a lease of a facility in existence on May 27, 1992 but not operated under a lease on that date, the allowable lease expense is the lesser of the annual lease expense or depreciation and interest calculated using the lessor's historical capital asset cost basis adjusted for one half of the change in the consumer price index for all items for all urban consumers as published by the United State Bureau of Labor Statistics during the time the lessor held each asset until the beginning of the lease. Interest will be imputed at the lessor of the prime rate plus two percent or ten percent.
- (5) For a lease of a facility with a date of licensure on or after May 27, 1992 that is initially operated under a lease, the entire lease expense is an allowable capital cost if there was a substantial commitment of money for construction of the facility after December 22, 1992 and before July 1, 1993.
- (6) For a lease of a facility with a date of licensure on or after May 27, 1992 that is initially operated under a lease, if there was not a substantial commitment of money for construction of the facility after December 22, 1992 and before July 1, 1993, the allowable lease expense is the lesser of the annual lease expense or the sum of the following:
 - (a) Depreciation calculated at the inception of the lease using the lessor's capital asset cost basis; and

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- (b) The greater of the lessor's actual annual amortization of financing costs and interest expense at the inception of the lease or imputed interest calculated using 70% of the lessor's capital asset cost basis.
- (7) For the lease of a facility with a date of licensure on or after May 27, 1992, that was not initially operated under a lease and has been in existence for ten years, the allowable capital costs are the lesser of the annual lease expense or depreciation and interest calculated using the lessor's historical capital asset cost basis adjusted for one half of the change in the consumer price index for all items for all urban consumers as published by the United State Bureau of Labor Statistics during the time the lessor held each asset until the beginning of the lease. Interest will be imputed at the lessor of the prime rate plus two percent or ten percent.
- (8) For a subsequent lease of a facility that was operated under a lease on May 27, 1992, allowable capital costs are the lesser of the annual lease expense or the annual old lease payment. If the old lease was in effect for at least ten years, the old lease payment will be adjusted by one half of the change in the consumer price index for all items for all urban consumers, as published by the United States Bureau of Labor Statistics, from the beginning of the old lease to the beginning of the new lease.
- (9) For a subsequent lease of a facility not in existence or not operated under a lease on May 27, 1992, allowable capital costs equal the lesser of the annual lease expense or the allowable capital costs under the old lease. If the old lease was in effect for at least ten years, the old lease payment will be adjusted by one half of the change in the consumer price index for all items for all urban consumers, as published by the United States Bureau of Labor Statistics, from the beginning of the old lease to the beginning of the new lease.
- (10) A revision of a lease does not change the allowable capital costs under a lease.
- (11) The allowable capital costs for a lease to a related party equal the lesser of the annual lease expense or the reasonable cost to the lessor.

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Calculating the Capital Price and Rate

A capital price is established for each peer group using the base year costs reported by providers in that peer group using the following calculation:

- 1) Group providers into the peer groups defined above.
- 2) Using calendar year 2014 as the base year, calculate the capital cost per diem for each provider by dividing the capital costs the provider reported on the base year Ohio Medicaid cost report by the licensed bed days available. For purposes of calculating the facility's licensed bed days available, the department shall include any beds the nursing facility removes from its Medicaid certified capacity unless the nursing facility also removes the beds from its licensed bed capacity.
- 3) Determine the capital per diem of the provider at the twenty-fifth percentile in each peer group.
- 4) Multiply the result in the previous step by 105.08% to calculate the peer group price.
- 5) The provider's capital rate component equals the capital price for the provider's peer group.

Capital Cost Basis

The capital cost basis of nursing facility assets is determined as follows:

- (1) For facilities with dates of licensure on or before June 30, 1993 that have not undergone a change of operator since that date, the capital cost basis equals the actual allowable cost basis listed on the facility's cost report.
- (2) For facilities with dates of licensure after June 30, 1993, the capital cost basis is determined in accordance with the principles of the Medicare program.
- (3) If a provider transfers an interest in the facility to a related party, there is no increase in the cost basis of the asset unless the related party is a relative of the owner, the provider making the transfer retains no interest in the facility, and the Department of Job and Family Services determines that the transfer is an arm's length transaction.
- (4) If a facility undergoes a change of operator after June 30, 1993 and the transfer is not to a related party, the basis of the asset is adjusted by one half the change in the consumer price index for all items for all urban consumers as published by the United States Bureau of Labor Statistic during the time the transferor held the asset.

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Depreciation

All assets are depreciated using the straight-line method of depreciation. Buildings are depreciated over forty years or a different period approved by the department. Components and equipment shall be depreciated over a period consistent with the guidelines of the American Hospital Association or a different period approved by the department. If additional guidance is needed, the Internal Revenue Service Publication 946 "How to Depreciate Property" shall be used to determine the useful life of that 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.

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Taxes

The tax rate component is calculated on a facility specific basis and reflects costs incurred for real estate taxes, personal property taxes and corporate franchise taxes. To calculate the tax rate component, the tax costs reported on the facility's cost report in the base year are divided by the licensed bed days available in the base year. The result is multiplied by 105.08%.

If a nursing facility had a credit regarding its real estate taxes reflected on its cost report for calendar year 2003, the facility's rate for tax costs (until the fiscal year for which the department redetermines all nursing facilities' rates for tax costs) will be calculated using the tax costs paid for calendar year 2004 by the number of licensed bed days available in calendar year 2004.

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Franchise Permit Fee

In state fiscal year 2012, the franchise permit fee rate component is \$11.47. The franchise permit fee rate component is eliminated for state fiscal year 2013 and thereafter.

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Quality Indicators and Quality Payment Rate**Quality Indicators**

Department of Medicaid determines the per Medicaid day quality payment rate for nursing facilities based on the number of quality points nursing facilities earn for meeting various quality indicators.

The Department of Medicaid will use data from the calendar year immediately preceding the calendar year in which the state fiscal year begins to determine quality points.

A nursing facility may earn a maximum of one point for each of the following quality indicators during the measurement period. For the pressure ulcer quality indicator and the antipsychotic medication quality indicator, nursing facilities may earn a maximum of one point each for rates for short-stay residents and a maximum of one point each for rates for long-stay residents. Based on the number of quality indicator points earned, the Department of Medicaid will calculate a per Medicaid day quality payment rate for each nursing facility. To earn a point for each of the quality indicators, the nursing facility shall meet the following criteria.

- 1) *Pressure Injuries*
Score no more than the 40th percentile for pressure injury rates. The Department of Medicaid obtains pressure injury rates from the Centers for Medicare and Medicaid Services (CMS) website using the CMS quality measure for short-stay residents who have a new or worsened pressure ulcer, and the CMS quality measure for long-stay residents with pressure ulcers. If a nursing facility has insufficient data to calculate a pressure injury rate, the facility shall not receive a quality point for this indicator.
- 2) *Antipsychotic Medications*
Score no more than the 40th percentile, as established by ODM, for antipsychotic medication use rates. If a nursing facility has insufficient data to calculate an antipsychotic medication use rate, the facility shall not receive a quality point for this indicator.
- 3) *Unplanned Weight Loss*
Score no more than the 40th percentile of the long-stay nursing facility residents' unplanned weight loss rate. The Department of Medicaid obtains the unplanned weight loss rate from the CMS website using the CMS quality measure for long-stay residents who lose too much weight.
- 4) *Employee Retention*
Attain an employee retention target rate of at least the 75th percentile. The Department of Medicaid calculates the percentile using the employee retention rates from all Medicaid nursing facility annual cost reports. If a nursing facility enters a "NO" response or does not provide a response in the employee retention portion of the Medicaid nursing facility annual cost report, the facility shall not receive a quality point for this indicator.

5) *Satisfaction Survey*

For even-numbered state fiscal years, attain a target rate of at least the fiftieth percentile of the overall score for all participating nursing facilities on the Ohio Department of Aging's most recently published resident satisfaction survey. For odd-numbered state fiscal years, attain a target rate of at least the fiftieth percentile of the overall score for all participating nursing facilities on the Ohio Department of Aging's most recently published family satisfaction survey.

Religious nonmedical health care institutions (RNHCIs) shall receive one point each for the pressure injury, antipsychotic medication, and unplanned weight loss quality indicators.

Calculation of the Quality Payment Rate

For state fiscal year 2017 and each fiscal year thereafter, the Ohio Department of Medicaid shall calculate the per Medicaid day quality payment rate for each nursing facility as follows:

- 1) Determine the number of inpatient Medicaid days reported by each nursing facility on the Medicaid nursing facility annual cost report for the calendar year preceding the fiscal year in which the quality payment will be paid.
- 2) Determine the total number of inpatient Medicaid days reported by all nursing facilities on the Medicaid nursing facility annual cost report for the calendar year preceding the fiscal year in which the quality payment will be paid.
- 3) Determine the number of quality points earned by each nursing facility during the applicable measurement period as specified in section 001.17 of Attachment 4.19-D, Supplement 1.
- 4) For each nursing facility, multiply the number of inpatient Medicaid days as determined in paragraph 1) above for the nursing facility by the number of quality points earned by the nursing facility as determined in paragraph 3) above. This product is the point days earned by each nursing facility.
- 5) Determine the total number of point days for all nursing facilities.
- 6) Multiply \$1.79 by the total number of Medicaid days delivered by all nursing facilities as determined in paragraph 2) above. This product is the total amount of quality funds to be paid to nursing facilities by the Ohio Department of Medicaid in the applicable fiscal year.
- 7) Divide the total amount of quality funds to be paid as calculated in paragraph 6) above by the total number of point days for all nursing facilities as determined in paragraph 5) above.
- 8) Multiply the amount calculated in accordance with paragraph 7) above by the quality points earned by each nursing facility as determined in paragraph 3) above. This product is the per Medicaid day quality payment for each nursing facility.

The largest per Medicaid day quality payment for a fiscal year shall be paid to nursing facilities that meet all of the quality indicators for the measurement period.

If a nursing facility undergoes a change of operator during a state fiscal year, the per Medicaid day quality payment rate to be paid to the entering operator for nursing facility services that the nursing facility provides during the period beginning on the effective date of the change of operator and ending on the last day of the state fiscal year shall be the same amount as the per Medicaid day quality payment rate that was in effect on the day immediately preceding the effective date of the change of operator and paid to the nursing facility's exiting operator. For the immediately following state fiscal year, the per Medicaid day quality payment rate shall be the mean per Medicaid day quality payment rate for all nursing facilities for the state fiscal year.

Nursing facility providers may request a rate reconsideration on the basis of a possible error in the calculation of the per Medicaid day quality payment rate.

Calculation of the Quality Incentive Payment Rate

For the second half of state fiscal year 2020 and all of each state fiscal year thereafter, each nursing facility's per Medicaid day quality incentive payment rate shall be determined as follows:

- 1) Determine the sum of the quality scores determined according to the Quality Scores section below.
- 2) Determine the average quality score by dividing the sum determined in paragraph 1) above by the number of nursing facilities for which a quality score was determined.
- 3) Determine the following:
 - a) For the second half of state fiscal year 2020, the sum of the total number of Medicaid days for the second half of calendar year 2018 for all nursing facilities for which a quality score was determined.
 - b) For all of state fiscal year 2021 and each state fiscal year thereafter, the sum of the total number of Medicaid days for the measurement period applicable to the state fiscal year for all nursing facilities for which a quality score was determined.
- 4) Multiply the average quality score determined in paragraph 2) above by the sum determined in paragraph 3) above.
- 5) Determine the value per quality point by determining the quotient of the following:
 - a) The following:
 - i. For the second half of state fiscal year 2020, the sum determined in paragraph 1) b) of the Fiscal Year Amounts section below.
 - ii. For all of state fiscal year 2021 and each state fiscal year thereafter, the sum determined in paragraph 2) b) of the Fiscal Year Amounts section below.
 - b) The product determined in paragraph 4) above.
- 6) Multiply the value per quality point determined in paragraph 5) above by the nursing facility's quality score determined according to the Quality Scores section below.

Quality Scores

A nursing facility's quality score for a state fiscal year shall be the sum of the total number of points that CMS assigned to the nursing facility under CMS's nursing facility five-star quality rating system for the following quality metrics:

- 1) The percentage of the nursing facility's long-stay residents at high risk for pressure ulcers who had pressure ulcers during the measurement period.
- 2) The percentage of the nursing facility's long-stay residents who had a urinary tract infection during the measurement period.
- 3) The percentage of the nursing facility's long-stay residents whose ability to move independently worsened during the measurement period.
- 4) The percentage of the nursing facility's long-stay residents who had a catheter inserted and left in their bladder during the measurement period.

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In determining a nursing facility's quality score for a state fiscal year, the Department of Medicaid shall make the following adjustment to the number of points that CMS assigned to the nursing facility for each of the quality metrics specified above:

- 1) Divide the number of the nursing facility's points for the quality metric by 20.
- 2) If CMS assigned the nursing facility to the lowest percentile for the quality metric, reduce the number of the nursing facility's points for the quality metric to zero.

A nursing facility's quality score shall be zero for a state fiscal year if it is not to receive a quality incentive payment for that state fiscal year, other than the second half of state fiscal year 2020, if the nursing facility's licensed occupancy percentage is less than 80%. This does not apply to a nursing facility for a state fiscal year if either of the following apply:

- 1) The nursing facility has a quality score of at least 15 points.
- 2) The nursing facility was initially certified for participation in the Medicaid program.

A nursing facility's licensed occupancy percentage for a state fiscal year shall be determined as follows:

- 1) Multiply the nursing facility's licensed capacity on the last day of the measurement period applicable to the state fiscal year by the number of days in that measurement period.
- 2) Divide the number of the nursing facility's inpatient days for the measurement period applicable to the state fiscal year by the product determined in paragraph 1) above.

Fiscal Year Amounts

The total amount to be spent on quality incentive payments for a state fiscal year shall be the following:

- 1) For the second half of state fiscal year 2020, the amount determined as follows:
 - a) Determine the following amount for each nursing facility, including those that do not receive a quality incentive payment due to having licensed occupancy below 80%.
 - i. The amount that is 2.4% of the nursing facility's base rate for nursing facility services provided on January 1, 2020.
 - ii. Multiply the amount determined in paragraph i above by the number of the nursing facility's Medicaid days for the second half of calendar year 2018.
 - b) Determine the sum of the products determined in paragraph ii above for all nursing facilities for which the product was determined for the second half of state fiscal year 2020.
- 2) For all of state fiscal year 2021 and each state fiscal year thereafter, the amount determined as follows:
 - a) Determine the following amount for each nursing facility, including those that do not receive a quality incentive payment due to having licensed occupancy below 80%.

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- i. The amount that is 2.4% of the nursing facility's base rate for nursing facility services on the first day of the state fiscal year.
 - ii. Determine the sum of the amounts determined in paragraph i above.
 - iii. Multiply the sum determined in paragraph ii above by the number of the nursing facility's Medicaid days for the measurement period applicable to the state fiscal year.
- b) Determine the sum of the products determined in paragraph iii above for all nursing facilities for which the product was determined for the state fiscal year.

Modified Stop Loss

State fiscal year 2012 is the final year of the transition to full implementation of the reimbursement methodology. For that year, a stop loss provision will limit the decrease in a provider's rate if the rate determined for the provider for fiscal year 2012 is less than 90% of the rate the provider was paid on June 30, 2011. For those providers, the amount of the decrease in their rate that exceeds 10% will be reduced by 50%.

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Non-Standard Rates

Change of Operator (CHOP)

For an entering operator that begins participation in the Medicaid program, the operator's initial rate shall be the rate the exiting operator would have received had the exiting operator continued to participate in the Medicaid program.

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New Facility

The initial rate for a facility with a first date of licensure or Medicaid certification on or after July 1, 2006, including a facility that replaces one or more existing facilities shall be calculated as follows:

- 1) The direct care rate component equals the product of the direct care price determined for the facility's peer group and the facility's case mix score.
 - a) If the nursing facility replaces an existing facility that participated in the Medicaid program immediately prior to the first day the new facility begins to participate in the Medicaid program, the case mix score is the semiannual case mix score most recently determined for the facility being replaced, adjusted for any difference in the number of beds between the new facility and the facility being replaced.
 - b) For all other new facilities, the case mix score shall be the median annual average case-mix score for the facility's peer group.
- 2) The ancillary and support rate component equals the ancillary and support price determined for the facility's peer group.
- 3) The capital cost rate component equals the capital price determined for the facility's peer group.
- 4) The tax rate component equals the amount determined by dividing a facility's projected tax costs by the number of inpatient days the facility would have for the calendar year in which it obtains an initial provider agreement if its occupancy rate were 100%. If a new facility does not submit the documentation required to support its projected tax costs, or if the Department of Medicaid determines the documentation to be unsatisfactory, the tax rate component equals the median tax rate component for the facility's ancillary and support peer group.
- 5) The quality incentive payment equals the mean quality incentive payment made to nursing facilities.

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Added and Replaced Beds

If a nursing facility adds or replaces one or more Medicaid certified beds, the rate for the added or replaced bed equals the rate for the nursing facility's existing bed.

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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 MDS 3.0 or who serve residents with special care needs otherwise qualifying for consideration. An outlier rate is a contracted rate and may differ from a standard rate as follows:

- 1) The direct care rate component may be increased if deemed necessary based on analysis of historical direct care costs if the provider had previously been a Medicaid provider, a comparison of direct care costs and staffing ratios of facilities caring for individuals with similar needs, a comparison of payment rates paid by private insurers or other states, and an analysis of the impact on historical costs if there are plans to change the patient mix.
- 2) The ancillary and support rate component may be increased due to increased expenses deemed necessary by the Ohio Department of Medicaid for treatment of individuals requiring outlier services.
- 3) The capital rate component may be adjusted to reflect costs of specialized high cost equipment or their capital expenditures necessary for treatment of individuals requiring outlier services.

Individuals must receive prior approval for outlier services.

Low Resource Utilization Residents

The per diem rate for nursing facility services provided to low resource utilization residents shall be a flat rate instead of the facility-specific total per diem rate. Low resource utilization residents are those residents who are assigned to the PA1 and PA2 resource utilization groups, which are assigned the two lowest relative resource weights possible: 1.0000 and 1.1111.

Beginning in October 2019, payment for low resource utilization residents shall be a flat rate of \$115.00 per Medicaid day, as set by the Ohio General Assembly.

Ventilator Program

Under the Ohio Department of Medicaid (ODM) nursing facility (NF) ventilator program, ODM will pay an enhanced per-Medicaid-day payment rate to NFs that request and receive ODM approval to provide services to ventilator-dependent individuals, and that elect to participate in an alternative purchasing model for the provision of services to ventilator-dependent individuals. NFs can request and receive ODM approval to provide ventilator-only services, or both ventilator and weaning services to residents.

A NF that provides ventilator-only services, or both ventilator and weaning services, must meet all of the following criteria in order to receive enhanced payments under the ODM NF ventilator program:

- 1) Be a licensed and Medicaid-certified NF and meet the requirements for NFs in accordance with 42 U.S.C. 1396r.
- 2) Provide services to individuals who are ventilator-dependent and have Medicaid as their primary payer.
- 3) Comply with the provisions of State law regarding provider agreements, including the execution and maintenance of provider agreements between ODM and the operator of a NF.
- 4) Cooperate with ODM or its designee during all provider oversight and monitoring activities including but not limited to:
 - a) Being available to answer questions pertaining to the ODM NF ventilator program;
 - b) Providing necessary requested documentation;
 - c) Providing required quarterly reports; and
 - d) As applicable, submitting a plan of action if requested by ODM.
- 5) Designate a discrete unit within the NF for the use of individuals in the ODM NF ventilator program.
- 6) Have ventilators connected to emergency outlets, which are connected to an on-site backup generator sufficient to meet the needs of the ventilator-dependent individuals.
- 7) Have not been in the Centers for Medicare and Medicaid Services (CMS) special focus facility (SFF) program for the previous six months.
- 8) Have a valid ODM 03623 form "Ohio Medicaid Provider Agreement for Long-Term Care Facilities" and an approved ODM 10198 form, "Addendum to Provider Agreement for Ventilator Services in Nursing Facilities."

In addition to the above, approved nursing facilities must provide all of the following services:

- 1) For at least five hours per week, the services of a licensed respiratory care professional (RCP) or the services of a registered nurse (RN) who has worked for a minimum of one year with ventilator-dependent individuals. The licensed RCP or the RN, as applicable, shall provide direct care to the ventilator-dependent individuals.
- 2) If ordered by a physician, initial assessments for physical therapy, occupational therapy, and speech therapy within 48 hours of receiving the order for a ventilator-dependent individual.

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- 3) If ordered by a physician, up to two hours of therapies per day, six days per week for each ventilator-dependent individual.
- 4) In emergency situations as determined by a physician, access to laboratory services that are available 24 hours per day, seven days per week, with a turnaround time of four hours.
- 5) For new admissions, administer pain medications to a ventilator-dependent individual within two hours from the receipt of the physician order.

Additionally, nursing facilities approved for ventilator weaning must meet the following criteria:

- 1) Have an approved ODM 10198 with approval to provide ventilator weaning services.
- 2) Have a ventilator weaning protocol in place established by a physician trained in pulmonary medicine who is available by phone 24 hours per day, seven days per week while ventilator weaning services are provided.
- 3) Have an RCP with training in basic life support on-site eight hours per day, seven days per week, and available by phone during the remaining hours of the day while ventilator weaning services are provided.
- 4) Have an RN with training in basic life support on-site 24 hours per day, seven days per week while ventilator weaning services are provided.

Enhanced Payment for Ventilator Services

The total per-Medicaid-day payment rate for services provided by a NF under the NF ventilator program for each state fiscal year shall be as follows:

- 1) For ventilator weaning services, 60% of the statewide average of the total per-Medicaid-day payment rate for those individuals receiving ventilator services in a long-term acute care hospital for the prior calendar year. Payment at the enhanced ventilator weaning rate is limited to 90 days per calendar year per individual and includes a post-ventilator-weaning evaluation period of up to 14 days.
- 2) For ventilator-only services, 50% of the statewide average of the total per-Medicaid-day payment rate for those individuals receiving ventilator services in a long-term acute care hospital for the prior calendar year.

NFs may have their enhanced NF ventilator program payment rate or rates reduced by a maximum of 5% if their number of ventilator-associated pneumonia (VAP) episodes exceeds, for two consecutive quarters, the maximum number of VAP episodes determined by ODM. The reduced payment or payments will become effective during the next full quarter and shall remain in effect for the entire quarter.

In the case of a change of operator (CHOP), if the exiting provider participated in the ODM NF ventilator program and the entering provider wishes to continue to participate in the program, the entering provider should submit the ODM 10227 to nfpolicy@medicaid.ohio.gov. If the ODM 10227 is submitted within 60 days of the effective date of the CHOP and ODM approves the ODM 10198, the entering provider is eligible to receive the enhanced rate or rates retroactive to the effective date of the CHOP or the date the requirements to participate in the NF ventilator program are met, whichever occurs later. If the ODM 10227 is not submitted within 60 days of the effective date of the

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CHOP but ODM approves the ODM 10198, the entering provider is eligible to receive the enhanced rate or rates effective on the date of ODM approval. If there is no approved ODM 10198, the entering provider's participation in the ODM NF ventilator program shall cease effective on the effective date of the CHOP.

ODM shall terminate a NF from the ODM NF ventilator program if ODM determines that the NF has failed to meet the requirements of this program. If a NF fails to continue to meet the requirements for weaning services, but meets the requirements for ventilator-only services, ODM will terminate the NF's ability to provide ventilator weaning services and to receive the enhanced rate for ventilator weaning. The NF may continue to provide ventilator-only services and to receive the enhanced rate for ventilator-only services as long as the eligibility requirements for ventilator-only services are met.

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Medicaid Maximum Allowable Reimbursement Rate

(For Medicare Part A cost-sharing provisions, see Appendix to Item 3 of Supplement 1 to Attachment 4.19-B, page 1 of 1)

The Medicaid maximum allowable reimbursement rate is 109% of the nursing facility's Medicaid per diem. Effective January 1, 2012 and thereafter, the Medicaid maximum allowable reimbursement is 100% of the nursing facility's Medicaid per diem.

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TN 14-023

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Cost Sharing Other than Medicare Part A

The nursing facility per diem rate includes Medicaid payments for Medicare or other third-party insurance cost sharing, including coinsurance or deductible payments, associated with services that are included in the nursing facility per diem rate.

Neither the nursing facility resident nor the Ohio Department of Medicaid is responsible for any Medicare or other third-party insurance cost sharing, including coinsurance or deductibles, associated with services that are included in the nursing facility per diem rate.

Cost Reports**Cost Report Filing**

Nursing facilities shall file annual Medicaid cost reports not later than 90 days after the end of the calendar year for each cost reporting period via the Medicaid information technology system (MITS) web portal or other electronic means designated by the Department. The cost report shall be filed using software that is available on the Department of Medicaid's website at least 60 days before the due date of the cost report.

The cost reports shall cover a calendar year or portion of a calendar year during which the nursing facility participated in the Medicaid program.

- 1) In the case of a nursing facility that has a change of operator during a calendar year, the cost report by the new provider shall cover the portion of the calendar year following the change of operator encompassed by the first day of participation up to and including December 31st.
- 2) In the case of a new nursing facility with an initial provider agreement that goes into effect after October 1st, the provider shall file the first cost report for the immediately following calendar year.
- 3) In the case of a nursing facility that begins participation after January 1st and ceases participation before December 31st of the same calendar year, the reporting period shall be the first day of participation to the last day of participation.

The minimum level of detail to be included in the Medicaid nursing facility cost report shall be established using a chart of accounts. A chart of accounts is a numbered list of accounts that categorizes each class of nursing facility costs for which money is spent. The accounts include the four main cost centers: ancillary costs, capital costs, direct care costs and tax costs.

Filing Extensions

A nursing facility may submit a cost report within 14 days after the original due date if the facility receives written approval from the Department prior to the original due date of the cost report. Extension requests must be in writing and explain the need for an extension. If a nursing facility does not submit the cost report within 14 days after the original due date or by an approved extension due date, or if the nursing facility submits an incomplete or inadequate cost report, the Department shall provide immediate written notice to the facility that its provider agreement will be terminated in 30 days unless the facility submits a complete and adequate cost report within 30 days of receiving the notice.

Late File Penalty

If a cost report is not received by the original due date or by an approved extension due date, the Department may assess a late file penalty of \$2.00 for each day a complete and adequate cost report is not received beginning on the day after the original due date or the day after the extension due date, whichever is applicable, and shall continue until the complete and adequate cost report is received or the nursing facility is terminated from the Medicaid program. The late file penalty shall

be a reduction to the facility's per diem Medicaid payment. The penalty may be assessed even if the Department has provided written notice of termination to a facility. No penalty shall be imposed during a 14-day extension granted by the Department.

Addendum for Disputed Costs

The cost report shall include an Addendum for Disputed Costs that may be used by a facility to set forth costs the facility believes may be disputed by the Department. The Department of Medicaid may consider such costs in determining a nursing facility's Medicaid payment rate. If the Department subsequently includes such costs in a facility's payment rate, the Department shall pay the provider interest at a reasonable rate for the period that the rate excluded the costs.

Desk Reviews

The Department of Medicaid shall conduct a desk review of each cost report it receives. The desk review is a process of reviewing information pertaining to the cost report without detailed verification and is designed to identify problems warranting additional review.

Audits

The Department of Medicaid may conduct an audit of any cost report. Audits shall be conducted by auditors under contract with or employed by the Department. The decision whether to conduct an audit and the scope of the audit, which may be a desk audit or a field audit, may be determined based on the facility's prior performance, or on a risk analysis or other evidence that gives the Department reason to believe the facility has reported costs improperly. A desk or field audit may be performed annually, but is required when a provider does not pass the risk analysis tolerance factors. The Department of Medicaid shall issue the audit report no later than three years after the cost report is filed, or upon the completion of a desk or field audit on the cost report or a cost report for a subsequent cost reporting period, whichever is earlier. During the time within which the Department may issue an audit report, the nursing facility provider may amend the cost report if the provider discovers a material error in the cost report or discovers additional information to be included in the cost report.

Rate Reconsiderations

After final rates have been issued, a nursing facility that disagrees with a desk review decision may request a rate reconsideration.

Revised Cost Reports

A nursing facility may revise a cost report within 60 days after the original due date without the revised information being considered an amended cost report.

Amended Cost Reports

A nursing facility may amend a cost report within three years of filing the cost report if the facility discovers a material error in the cost report or discovers additional information to be included in the cost report. A nursing facility may not amend a cost report if the Department of Medicaid has notified the facility that an audit of the cost report or a cost report of the facility for a subsequent cost reporting period is to be conducted.

Disclosure Requirements

Nursing facility providers are required to disclose upon request all contracts in effect during the cost report period for which the cost of the service from any individual or organization is \$10,000 or more in a 12-month period. In addition, nursing facility providers are required to identify all of the following on their cost reports:

- 1) All known related parties;
- 2) Each known individual, group of individuals, or organization not otherwise publicly disclosed who owns or has common ownership in whole or in part of any mortgage, deed of trust, property, or asset of the facility;
- 3) If the provider is a corporation, each corporate officer or director;
- 4) If the provider is a partnership, each partner;
- 5) Each provider, whether participating in the Medicare or Medicaid program or not, which is part of an organization that is owned, or through any other device controlled, by the organization of which the provider is a part;
- 6) Any director, officer, manager, employee, individual, or organization having 5% or more direct or indirect ownership or control of the provider, or who has been convicted of or pleaded guilty to a civil or criminal offense related to involvement in programs established by Title XVIII, Title XIX, or Title XX of the Social Security Act;
- 7) Any individual currently employed by or under contract with the provider, or a related party organization in a managerial, accounting, auditing, legal, or similar capacity who was employed within the previous 12 months by the Ohio Department of Medicaid, the Ohio Department of Health, the Ohio Office of the Attorney General, the Ohio Department of Developmental Disabilities, the Ohio Department of Commerce, or the Industrial Commission of Ohio.

Providers are further required to furnish upon request all contracts in effect during the cost report period that contain either of the following provisions:

- 1) The cost of the service from any individual or organization is \$10,000 or more in a 12-month period.
- 2) The services of a sole proprietor or partnership incurs no cost and the imputed value of the service is \$10,000 or more in a 12-month period.

Records Retention

Nursing facility providers shall retain financial, statistical, and medical records supporting cost reports and claims for services for the greater of seven years after a cost report is filed if the Department of Medicaid issues an audit report, or six years after all appeal rights relating to the audit report are exhausted.

Penalties

Nursing facility providers who fail to retain the required financial, statistical, or medical records are liable for the greater of the following amounts:

- 1) \$1,000 per audit;
- 2) 25% of the amount by which the un-documented cost increased Medicaid payments to the provider during the fiscal year.

Additionally, nursing facility providers who fail to retain the required financial, statistical, or medical records to the extent that filed cost reports are not auditable shall incur one of the penalties specified above. Providers with records that are not auditable will be allowed sixty days to provide the necessary documentation. If at the end of the sixty days the required records have been provided and are determined auditable, the proposed penalty will be withdrawn.

Refusing legal access to financial, statistical, or medical records also shall result in a penalty as specified above for outstanding medical services until such time as the requested information is made available to the Department of Medicaid.

Rate Recalculations and Overpayments

The Ohio Department of Medicaid may recalculate a nursing facility's rate if the Department determines the facility has received a higher rate than it was entitled to receive. Any of the following may result in such a determination:

- 1) A nursing facility provider properly amends its cost report.
- 2) The Department of Medicaid makes a finding based on an audit.
- 3) The Department of Medicaid makes a finding based on an exception review of resident assessment data conducted after the effective date of the rate for direct care costs that is based on the assessment information.
- 4) The department makes a finding based on a post-payment review.

The Department of Medicaid will apply the recalculated rate to the periods when the nursing facility received the incorrect rate to determine the amount of the overpayment that must be refunded by the nursing facility. In addition to requiring a refund, the Department may charge the nursing facility interest at the following rates from the time the overpayment was made:

- 1) The interest shall be no greater than two times the average bank prime rate if the overpayment was equal to or less than 1% of the total Medicaid payments to the provider for the fiscal year for which the overpayment was made.
- 2) The interest shall be no greater than two and one-half times the average bank prime rate if the overpayment was greater than 1% of the total Medicaid payments to the provider for the fiscal year for which the overpayment was made.

The Department will deduct any amount a facility is required to refund, along with the amount of any interest charged, from the next available Medicaid payment to the facility.

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Penalties

The Ohio Department of Medicaid may impose the following penalties and fines:

- 1) If a nursing facility provider does not furnish invoices or other documentation that the Department requests during an audit within 60 days after the request, no more than the greater of \$1,000 per audit or 25% of the cumulative amount by which the costs for which documentation was not furnished increased the total Medicaid payments to the provider during the fiscal year for which the costs were used to establish a rate.
- 2) If a nursing facility owner or operator fails to provide notice of a facility closure, voluntary withdrawal or voluntary termination of participation in the Medicaid program, or change of operator, no more than the current average bank prime rate plus 4% of the last two monthly Medicaid payments.
- 3) The Department shall fine a nursing facility provider if the report of an audit regarding a cost report for the facility includes either of the following:
 - a) Adverse findings that exceed 3% of the total amount of Medicaid-reimbursable costs reported in the cost report.
 - b) Adverse findings that exceed 20% of Medicaid-reimbursable costs for a particular cost center reported in the cost report.
- 4) A fine issued under paragraph 3) above shall equal the greatest of the following:
 - a) If the adverse findings exceed 3% but do not exceed 10% of the total amount of Medicaid-reimbursable costs reported in the cost report, the greater of 3% of those reported costs or \$10,000.
 - b) If the adverse findings exceed 10% but do not exceed 20% of the total amount of Medicaid-reimbursable costs reported in the cost report, the greater of 6% of those reported costs or \$25,000.
 - c) If the adverse findings exceed 20% of the total amount of Medicaid-reimbursable costs reported in the cost report, the greater of 10% of those reported costs or \$50,000.
 - d) If the adverse findings exceed 20% but do not exceed 25% of Medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of 3% of the total amount of Medicaid-reimbursable costs reported in the cost report or \$10,000.
 - e) If the adverse findings exceed 25% but do not exceed 30% of Medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of 6% of the total amount of Medicaid-reimbursable costs reported in the cost report or \$25,000.
 - f) If the adverse findings exceed 30% of Medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of 10% of the total amount of Medicaid-reimbursable costs reported in the cost report or \$50,000.

The Department may not collect a fine issued according to paragraph 3) of this section until all appeal rights relating to the audit report that is the basis for the fine are exhausted. The Department will deduct the amount of any penalties or fines imposed on a facility according to this section from the next available Medicaid payment to the facility. The Department and the provider may enter into an agreement under which the amount, together with the interest, is deducted in installments from Medicaid payments to the provider.

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Fines issued under paragraph 3) of this section that have been paid shall be deposited into the State's Health Care Services Administration Fund. The Department shall transmit all other refunds and penalties issued under this section to the Ohio Treasurer of State for deposit in the General Revenue Fund.

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