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State/Territory Name: OH

State Plan Amendment (SPA) #: 23-0026

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

December 18, 2023
Maureen Corcoran, Director
Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: Ohio State Plan Amendment (SPA) 23-0026

Dear Ms. Corcoran:

We have reviewed the proposed amendment to Attachments 4.19-D of your Medicaid State plan submitted under transmittal number 23-0026 titled "Payment for Services: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Payment Changes."

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2023. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Fredrick Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0026

2. STATE: OH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

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

4. PROPOSED EFFECTIVE DATE
July 1, 2023

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 15,351,600
b. FFY 2024 $ 56,584,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, Supp 2, Page 6
Attachment 4.19-D, Supp 2, Page 6a (new)
Attachment 4.19-D, Supp 2, Pages 7, 11, 12, 14, 18, 23, 26

Attachment 4.19-D, Supp 3, Page 4

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D, Supp 2, Pages 6,7,11,12,14,18,23,26 (TN 22-030)

Attachment 4.19-D, Supp 3, Page 4 (20-019)

9. SUBJECT OF AMENDMENT

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

10. GOVERNOR'S REVIEW *(Check One)*

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

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

13. TITLE: **STATE MEDICAID DIRECTOR**

14. DATE SUBMITTED
September 26, 2023

15. RETURN TO

Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED
9/26/2023

17. DATE APPROVED
December 18, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

3. Points assigned to the resident's assessment score for the adaptive skills domain shall be weighted at 35%.

D. The department shall place the resident into an acuity group:

1. If the resident's weighted sum of points is five or lower, group one;
2. If the resident's weighted sum of points is at least six and not more than eight, group two;
3. If the resident's weighted sum of points is nine or10, group three;
4. If the resident's weighted sum of points is 11 or12, group four;
5. If the resident's weighted sum of points is at least 13 and not more than 15, group five; and
6. If the resident's weighted sum of points is 16 or higher, group six.

Allowable costs for direct care

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

1. Registered nurses, licensed practical nurses and nurse aides employed by the ICF
2. Direct care staff, 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 (including habilitation supervisors)
7. Program director, program specialist, activity director and activity staff
8. Social services staff, counselors and other persons holding degrees qualifying them to provide therapy
9. Costs of purchased nursing services
10. Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted under section 5124.03 of the Revised Code, for personnel listed in items 1) through 9) above;
11. Active treatment off-site day programming, including day programming that is provided in an area that is not certified by the director of health as an ICF/IID under Title XIX and regardless of either of the following:

(a) Whether or not the area in which the day programming is provided is less than two hundred feet away from the ICF/IID;

(b) Whether or not the day programming is provided by an individual or organization that is a related party to the ICF/IID provider.

12. Quality assurance
13. Consulting and management fees related to direct care
14. Allocated direct care home office costs
15. Direct care costs that are specified as direct care costs in rules adopted under section 5124.03 of the Revised Code.

Calculation of Direct Care Per Diem for Peer Groups 1-A, 2-A, 3-A, 4-A, and 5-A

A direct care per diem rate is established for each ICF-IID using allowable direct care costs as reported by each facility in accordance with the following calculation:

1) Calculate the direct care cost per diem for each provider by dividing the allowable direct care costs by the inpatient days reported on the same cost report.
2) Calculate the direct care cost per case mix unit for each provider by dividing the provider's direct care costs per diem by the annual average case mix score for the provider. The annual average case mix score is the average of the provider's scores for the March 31, June 30, September 30, and December 31 reporting period end dates for the calendar year corresponding to the calendar year for which costs are reported.
3) Determine the maximum cost per case mix unit for each peer group:
    a. The maximum cost per case-mix unit for a peer group for a fiscal year, other than Peer Group 5-A is the following percentage above the peer group's median cost per case-mix unit for that fiscal year.
        i. For Peer Group 1-A use 16%.
        ii. For Peer Group 2-A use 14%.
        iii. For Peer Group 3-A use 18%.
        iv. For Peer Group 4-A use 22%.
    b. The maximum cost per case mix unit for Peer Group 5-A is equal to the cost per case mix unit of the provider at the 95th percentile of all providers in Peer Group 5-A for the calendar year preceding the fiscal year in which the rate will be paid.
4) The allowable cost per case mix unit is the lesser of the facility cost per case mix unit or the maximum cost per case mix unit for the peer group.
5) Multiply the allowable cost per case mix unit by the annual average case mix score for the provider and then multiply the product by an inflation factor to determine the direct care per diem for the facility.
    a. For Peer Group 1-A, 2-A, 3-A, 4-A, and 5-A the inflation factor is 1.0790.

Calculation of Capital Per Diem for Peer Groups 1-A, 2-A, 3-A, 4-A, and 5-A

A capital per diem rate is established for each ICF-IID based on the determined fair rental value of the facility, allowable secondary buildings, and equipment costs. The result is compared to the facility's actual allowable reported capital costs and limited if the result is greater than costs. Any non-extensive renovations approved under the Retiring Methodology and not covered in this calculation are grandfathered in. The details are as follows:

Facility Fair Rental Value Calculation

1. Square footage cap
    a. From the cost report, determine the total square footage of the facility and the number of beds.
    b. Divide the total square footage by the number of beds to get the number of square feet per bed.
    c. The minimum limit for square feet per bed is 200.
    d. The maximum limit for square feet per bed is set by peer group as follows:
        i. Peer Group 1-A provider has downsized or partially converted five beds or 10% of the previous capacity, whichever is less: 1000
        ii. Peer Group 1-A provider has not downsized or partially converted the minimum required in (d.i.) above: 550
        iii. Peer Group 2-A provider has downsized or partially converted five beds or 10% of the previous capacity, whichever is less: 1000
        iv. Peer Group 2-A provider has not downsized or partially converted the minimum required in (d.iii.) above: 750
        v. Peer Group 3-A: 850
        vi. Peer Group 4-A: 900
        vii. Peer Group 5-A: 900
    e. For purposes of the fair rental value calculation the facility's allowable square footage shall be adjusted to reflect the minimum or maximum limits described above if the facility's calculated square feet per bed falls outside those limits.
2. Value per square foot
    a. The value per square foot is based on the provider's peer group and county.
    b. Use the following values by peer group (updated annually):
        i. Peer Groups 1-A and 2-A: RS Means Construction Cost Estimating Data for Assisted Living, use $227.70;

Facility Fair Rental Value Calculation, continued

ii. Peer Groups 3-A, 4-A, and 5-A: RS Means Construction Cost Estimating Data for Nursing Home, use $252.84.

c. The amount in (2b) is adjusted by a modifier published for each major metropolitan area by RS Means. The modifier applies to the county or counties that contain the metropolitan area. An appropriate proxy is assigned pursuant to Ohio Revised Code Section 5124.17 (effective July 1, 2018) for those counties that do not contain a metropolitan area as published.

3. Effective Age calculation

a. The initial construction year is assumed as the effective age unless renovations and/or additions have been reported.

i. Age is based on the cost report year. For example, a facility built in the cost report year would have the age of zero.

ii. Maximum age of a facility is 40 years.

iii. Minimum age of a facility is zero.

b. Each reported renovation or addition re-ages the facility. The re-aging is calculated as follows:

c. Additions:

i. For each square footage addition (positive value) the provider reports calculate the new bed equivalent.

1. Multiple the square footage of the addition by the value per square foot from Item 2 above.

2. Divide that amount by $70,000 to get the new bed equivalent.

3. Multiply the new bed equivalent by the project age to get the weighted new bed equivalent.

ii. For each bed addition (positive value, ignore reductions) the provider reports calculate the weighted new bed equivalent by multiplying the number of beds added by the age of the addition.

iii. Total the weighted new bed equivalent of all bed and square footage additions for each provider.

d. Renovations:

i. Disregard any renovations reported which are 40 or more years old.

ii. For each allowable renovation reported take the project cost and divide by $70,000 to get the new bed equivalent.

iii. Multiply the new bed equivalent by the age of the renovation to get the weighted age of the renovation.

Secondary Building Fair Rental Value Calculation, continued

1. The current asset value is equal to the cost per square foot type (set at $112.11 for home office/record storage and updated annually) times the allowable square footage.
2. Calculate the depreciation by multiplying the current asset value by the product of the building age (maximum of 40) times the depreciation rate (set at 1.6%).
3. Subtract from the current asset value to get the depreciated asset value.
4. Calculate the land value as 10% of the current asset value and add to the depreciated asset value to get the total base value.
5. Calculate the secondary building fair rental value by multiplying the total base value by the rental rate (equal to 11%).
6. Calculate imputed occupancy for capital as 92% of the total bed days available reported. If the cost report covers less than a full year annualize both the total bed days available and the inpatient days.
7. Divide the secondary building fair rental value by the greater of annualized inpatient days or annualized imputed occupancy to get the secondary building fair rental value per diem.

Equipment Per Diem Calculation

1. Sum the equipment costs reported for the provider on the cost report.
2. Calculate imputed occupancy for equipment costs as 92% of the total bed days available reported.
3. Divide the equipment costs by the greater of inpatient days or imputed occupancy to get the equipment per diem.
4. Compare the equipment costs per diem to the ceiling for the provider's peer group as follows:
    a. Peer Group 1-A: $5.00
    b. Peer Group 2-A: $6.50
    c. Peer Group 3-A: $8.00
    d. Peer Groups 4-A and 5-A: $9.00
5. The allowable equipment cost per diem is equal to the lesser of the provider's equipment cost per diem and the ceiling for the provider's peer group.

Full Capital Rate Per Diem Calculation

1. Calculate the total fair rental value rate as the sum of the facility fair rental value rate, the secondary building fair rental value rate, and the equipment rate.
2. Calculate the capital cost per diem.
    a. Sum the total allowable capital costs as reported on the cost report.

Calculation of Other Protected Per Diem for Peer Groups 1-A, 2-A, 3-A, 4-A, and 5-A

Another protected per diem rate is established for each ICF-IID using allowable other protected costs as reported by each facility in accordance with the following calculation:

1) Subtract allowable franchise permit fee costs from the total allowable other protected costs;
2) Divide the amount in item 1 above by the total inpatient days reported on the same cost report for the facility to determine the other protected costs per diem;
3) For Peer Groups 1-A, 2-A, 3-A, 4-A, and 5-A multiply the other protected costs per diem by an inflation factor which is 1.1232;
4) Add Medicaid's portion of the franchise permit fee per diem rate to determine the other protected costs per diem rate.

Direct Support Personnel Payment

Each ICF-IID shall receive a direct support personnel payment equal to 2.04% of ICF/IID's desk-reviewed, actual, allowable, per Medicaid day direct care costs from the applicable cost report year.

Quality Incentive Payment

1. Calculate the relative weight point value for the fiscal year

    a. Multiply the number of inpatient days the ICF/IID had for the applicable cost report year by the number of quality points the ICF/IID was awarded

    b. Determine the sum of all ICF/IID products calculated under section a

    c. Determine the amount equal to one percent of the total desk-reviewed, actual, allowable direct care costs of all ICF/IID for the applicable cost report year

    d. Divide the amount determined under section c by the sum determined under section b

2. Calculate the number of points the ICF/IID was awarded

3. Multiply the relative weight point value by the points awarded to the ICF/IID

Professional Workforce Development Add On

Each ICF-IID shall receive a professional workforce development payment equal to 13.55% for FY24 and 20.81% for FY25 of the ICF/IID's desk-reviewed, actual, allowable, per Medicaid day direct care costs from the applicable cost report year.

Outliers

An outlier is a facility or unit in a facility serving residents with diagnoses or special care needs that require direct care resources not measured adequately by the Ohio Development Disabilities Profile that serves residents with special care needs otherwise qualifying for consideration. An outlier rate is a contracted rate and may differ from standard rates.

1) For the Ventilator Services outlier, the State provides an add-on payment of $900 per day for each individual authorized to receive ventilator services in the facility.
2) For the Intensive Behavior Support outlier, the State provides an add-on payment of $300 per day for each individual authorized to receive intensive behavioral health support services in the facility.

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

Direct Care Costs

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 employed by the ICF
2) Direct care staff, 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 (including habilitation supervisors)
7) Program director, program specialist, activity director and activity staff
8) Social services staff, counselors and other persons holding degrees qualifying them to provide therapy
9) Costs of purchased nursing services
10) Costs of training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted under section 5124.03 of the Revised Code, for personnel listed in items 1) through 9) above;
11) Active treatment off-site day programming, including day programming that is provided in an area that is not certified by the director of health as an ICF/IID under Title XIX and regardless of either of the following:
    (a) Whether or not the area in which the day programming is provided is less than two hundred feet away from the ICF/IID;
    (b) Whether or not the day programming is provided by an individual or organization that is a related party to the ICF/IID provider.
12) Quality assurance
13) Consulting and management fees related to direct care
14) Allocated direct care and other home office direct care costs
15) Direct care costs that are specified as direct care costs in rules adopted under section 5124.03 of the Revised Code.

Franchise Permit Fee

The State assesses all providers of (ICF-IID) services a franchise permit fee based on the provider's monthly reported inpatient days. If inpatient days are not reported timely, days for that month are calculated based on the ICF-IID's certified bed count. The franchise permit fee is calculated using projected net patient revenue and bed counts for the provider class, in accordance with the Indirect Guarantee Percentage as defined in 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 $24.89 per bed per day.