5160-3-99 **Payment methodology for state-operated intermediate care facilities for ~~the mentally retarded (ICFs-MR)~~ individuals with intellectual disabilities (ICFs/IID).**

This rule describes the methodology for calculating payment rates for state-operated intermediate care facilities ~~for the mentally retarded (ICFs-MR)~~ for individuals with intellectual disabilities (ICFs/IID) and includes provisions for a temporary additional payment for off-site day habilitation/active treatment and associated transportation services.

(A) Definitions.

(1) "State-operated intermediate care facility for ~~the mentally retarded~~ individuals with intellectual disabilities" ~~also referred to as "facility"~~ means an ~~intermediate care facility for the mentally retarded~~ICF/IID as described in ~~paragraph (N) of rule 5101:3-3-01 of the Administrative Code~~section 5163.01 of the Revised Code that is operated under a medicaid provider agreement(s) by the Ohio department of ~~mental retardation and~~ developmental disabilities ~~(ODMRDD)~~(ODODD).

(2) "Cost report" means form number ~~JFS~~ODM 01984, "Developmental Center Cost Report" ~~(2/2004)~~ (7/2014) used to report cost and statistical data for the operation of a state-owned ~~ICF-MR~~ICF/IID. The cost report includes all worksheets as included in appendix A to this rule and covers the period of July first to June thirtieth.

(3) "Direct care costs" means those costs established by summing the amounts on the cost report worksheet B P1, column 16a, line 16 and worksheet C P1, column 16a, line 16 minus worksheet B P2, column 16a, line 16 and minus worksheet C P2, column 16a, line 16.

(4) "Ancillary costs" means those costs established by the amounts on the cost report worksheet B P1, column 16a, lines 17 to 21 and worksheet B P2, column 16a, lines 17 through 21. Ancillary costs include pharmacy, radiology, laboratory, clinic and physician services. Audiology, dental and vision costs are included in clinic services.

(5) "Capital costs" means those costs established by summing the amounts on the cost report worksheet B P2, column 16a, line 16 and worksheet C P2, column 16a, line 16.

(6) "Total inpatient days" means the sum of inpatient days and leave days as reported on worksheet F of the cost report.

(7) "Covered services" means ~~ICF-MR~~ICF/IID covered services.

(8) "Base year" means the period used to establish the interim payment rate for each state-operated ~~ICF-MR~~ICF/IID.

(9) "Rate year" means the period where calculated interim rates are paid using base year cost report data.

(10) "Base year cost report" means form ~~JFS~~ ODM 01984, "Developmental Center Cost Report" ~~(2/2004)~~(7/2014) used to report costs and statistical data as filed during a twelve-month period to determine the interim payment rate for each state-operated ~~ICF-MR~~ICF/IID.

(11) "Rate year cost report" means form ~~JFS~~ODM 01984 used to report costs and statistical data during a twelve-month period to determine the final payment rate for each state-operated ~~ICF-MR~~ICF/IID.

(12) "Interim payment rate" means the rate of payment calculated using the desk reviewed base year cost report data.

(13) "Final payment rate" means the rate of payment calculated using the final rate year cost report data.

(14) "Reasonable and allowable costs" means cost items prepared in accordance with medicare principles governing reasonable and allowable cost reimbursement set forth in the providers' reimbursement manual "CMS Publications 15-1 and 15-2" with the exception of the restrictions related to dental services, available at ~~www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage in effect as of September 8, 2005~~www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.htm in effect as of April 05, 2012.

(15) "Adjusted interim payment rate" means the interim payment rate plus the amount calculated in paragraphs (C)(4) and (C)(5) of this rule applicable for state fiscal year 2006 and 2007 only.

(B) Source data for calculations.

(1) The calculations described in this rule will be based on the most recent desk reviewed base year cost report data submitted to the department in

accordance with division ~~5101:3~~5160-3 of the Administrative Code. The state-operated ~~ICF-MR~~ ICF/IID cost report must:

(a) Be prepared in accordance with medicare principles governing reasonable and allowable cost reimbursement set forth in the providers' reimbursement manual "CMS Publications 15-1 and 15-2" with the exception of the restrictions related to dental services, available at ~~www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage in effect as of September 8, 2005~~ and 45 CFR part 92. The method used to allocate supporting cost centers shall be the step-down method described in centers for medicare and medicaid services (CMS) publication ~~15~~15-1, section 2306.1 available at the above link. The statistics, on the approved cost reporting form, must be used for cost allocation purposes unless alternative statistics which yield a more accurate and/or appropriate allocation of costs are approved by the department. A written request to use alternative statistics must be submitted to and approved by the department prior to the period in which the statistics are to be used; and

(b) Include all information necessary for the proper determination of costs payable under medicaid including financial records and statistical data; and

(c) Include the cost report certification executed ~~ODMRDD~~ODODD fiscal attesting to the accuracy of the cost report; and in addition, all subsequent revisions to the cost report must include an executed certification; and

(d) Include costs for all covered services generally available to medicaid recipients and provided to recipients by the state-operated ~~ICFs-MR~~ICFs/IID , either directly or by arrangement, shall be included in the costs reported by the state-operated ~~ICFs-MR~~ICFs/IID on the form approved by ~~ODJFS~~ODM and shall be reimbursed only to the state-operated ~~ICFs-MR~~ICFs/IID. These costs are subject to all otherwise applicable audit guidelines and tests of reasonableness; and

(e) Not include the cost of pharmacy and legend drugs in their cost reports when these are reimbursed directly to a pharmacy provider.

(2) A desk review will be performed by the ~~ODJFS~~ODM on all annual cost reports for the purpose of updating interim payment rates, all of which are subject to cost settlement. Desk review procedures will take into consideration the relationship between the prior year's audited costs and the current year's

reported costs. Adjustments may be made to the cost report by the department as necessary to determine reasonable and accurate interim payment rates. Adjustments made by ~~ODJFS~~ODM do not preclude findings of additional cost exceptions issued as the result of an audit.

(C) Calculation of interim payment rates.

(1) Interim payment rates for each state-operated ~~ICF-MR~~ICF/IID shall be based upon the source data described in paragraph (B) of this rule.

(2) The interim payment rate shall be calculated as follows:

(a) Calculation of direct care per diem rate.

(i) Calculate the direct care per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing direct care costs by total inpatient days.

(ii) For each facility multiply the facility's direct care per diem by the facility's inpatient days. Sum results for all facilities and divide by the sum of inpatient days for all facilities.

(iii) Calculate the direct care per diem ceiling by taking the amount calculated in paragraph (C)(2)(a)(ii) of this rule and multiplying it by one hundred twelve per cent.

(iv) The interim state-operated ~~ICF-MR~~ICF/IID direct care per diem will be the lower of the amount calculated in paragraph (C)(2)(a)(i) of this rule or the direct care per diem ceiling as calculated in paragraph (C)(2)(a)(iii) of this rule.

(b) Calculate the ancillary cost per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing ancillary costs by total inpatient days.

(c) Calculate the capital cost per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing capital costs by total inpatient days.

(d) The interim payment rate for each state-operated ~~ICF-MR~~ICF/IID shall be the sum of the amounts calculated in paragraphs (C)(2)(a)(iv), (C)(2)(b) and (C)(2)(c) of this rule, inflated from the mid-point of the base year to the midpoint of the rate year using the skilled nursing facility (SNF)

market basket as calculated by "Global Insight" available at www.globalinsight.net or a successor firm, and submitted to ~~ODJFS~~ODM by March thirty-first, before the beginning of the new rate year.

(3) For periods after SFY 2007, a state-operated ~~ICF-MR~~ ICF/IID certified after June 30, 2003 whose cost report includes less than twelve months of complete data shall be reimbursed the statewide average interim payment rate for state-operated ~~ICFs-MR~~ICFs /IID calculated for that rate year by summing the rates for each state-operated ~~ICF-MR~~ICF/IID as described in paragraph (C)(2)(d) of this rule and dividing by the number of state-operated ~~ICFs-MR~~ICFs/IID. Interim payment rates are subject to final settlement as included in paragraph (E) of this rule.

(4) Notwithstanding paragraph (C)(1) of this rule, for the period starting on July 1, 2005 and ending on December 31, 2005 only, the interim payment rate shall be adjusted to arrive at the adjusted interim payment rate for each facility by the following process.

(a) ~~ODMRDD~~ODODD shall determine, by facility, the number of residents of state-operated ~~ICFs-MR~~ICFs/IID who received off-site day habilitation services/active treatment services in SFY 2004. This shall be referred to as the facility specific residency count used in calculating the adjusted interim payment rate.

(b) ~~ODMRDD~~ODODD shall multiply the facility-specific residency count determined under paragraph (C)(4)(a) of this rule by no more than one hundred thirty or a similar estimate of the number of daily units of off-site day habilitation services/active treatment services that each resident of a state-operated ~~ICFs-MR,~~ICFs/IID who receives off-site day habilitation services/active treatment services, will receive between July 1, 2005 and December 31, 2005. This shall be referred to as the six-month projected daily units used in calculating the adjusted interim payment rate.

(c) ~~ODMRDD~~ODODD shall multiply the product calculated under paragraph (C)(4)(b) of this rule by the county-specific rates from appendix B of this rule that are applicable to the counties in which state-operated ~~ICFs-MR~~ICFs/IID are located.

(d) ~~ODMRDD~~ODODD shall divide the product calculated under paragraph (C)(4)(c) of this rule by total inpatient days for SFY 2004 as reported by each state-operated ~~ICF-MR~~ICF/IID on the ~~JFS~~ODM 01984 cost

reports for the period January 1, 2004 to June 30, 2004.

(e) ~~ODMRDD~~ODODD shall add the quotient calculated under paragraph (C)(4)(d) of this rule to the interim payment rates for each facility.

(f) The adjustment process set forth in paragraph (C)(4) of this rule shall apply exclusively to periods between July 1, 2005 and December 31, 2005, and shall not be used for adjustments for any other period. The additional amount to be paid in the rate for off-site day habilitation/active treatment and associated transportation services shall not be subject to the direct care per diem ceiling calculated in accordance with paragraph (C)(2)(a)(iii) of this rule.

(5) Notwithstanding paragraph (C)(1) of this rule, for the period starting on January 1, 2006 and ending on June 30, 2007 only, the interim payment rate shall be adjusted to arrive at the adjusted interim payment rate for each facility by the following process.

(a) ~~ODMRDD~~ ODODD shall for each facility, multiply the six month projected daily units determined under paragraph (C)(4)(b) of this rule by three and then by the county-specific rates in appendix B of this rule . The rates in appendix B to this rule may be amended to reflect revised rates approved by CMS. The rate applicable to a county where the state-operated ~~ICF-MR~~ICF/IID is located shall be used for determining the rate used for this purpose.

(b) ~~ODMRDD~~ ODODD shall divide the product calculated under paragraph (C)(5)(a) of this rule by one-and a half times the total inpatient days for SFY 2004 as reported on the ~~JFS~~ ODM 01984 cost report for each facility to arrive at the adjusted interim payment rate.

(c) ~~ODMRDD~~ODODD shall add the quotient calculated under paragraph (C)(5)(b) of this rule to the interim direct care per diem rate to arrive at the adjusted interim payment rate. The additional amount to be paid in the rate for off-site day habilitation/active treatment and associated transportation services shall not be subject to the direct care per diem ceiling calculated in accordance with paragraph (C)(2)(a)(iii) of this rule.

(d) The adjustment process set forth in paragraph (C)(5) of this rule shall apply exclusively to periods between January 1, 2006 and June 30, 2007, and shall not be used for adjustments for any other period.

(6) Effective for the period of July 1, 2005 to December 31, 2005, the amount included in the ~~JFS~~ODM 01984 cost report shall be the rate paid to off-site providers of day habilitation/active treatment and associated transportation services limited to no more than the county specific rate included in appendix B of this rule times actual units of service.

(7) Effective for the period of January 1, 2006 to September 30, 2006, the amount included in the ~~JFS~~ODM 01984 cost report for payments to off-site providers of day habilitation/active treatment and associated transportation services shall be limited to the lower of:

(a) The county specific rate included in appendix B to this rule times actual units of service; or

(b) Where a state operated ~~ICF-MR~~ICF/IID is in the same county where a non-developmental center/private ~~ICF-MR~~ ICF/IID contracts with a county board of ~~ODMRDD~~ODODD for off-site day habilitation/active treatment and related transportation services, the facility shall be limited to no more than the lowest contracted daily rate as included in a contract in effect during the corresponding fiscal year times the actual units of service provided; or

(c) In those counties where no non developmental center private ~~ICF-MR~~ICF/IID has a contract to provide services for consumers of a county board of ~~MRDD~~DD for offsite day habilitation/active treatment and associated transportation services, the rate shall be limited to the county specific rates in appendix B to this rule times the actual units of services provided.

(8) Effective for the period of October 1, 2006 to June 30, 2007, the amount included in the ~~JFS~~ODM 01984 cost report for payments to off-site providers of day habilitation/active treatment and associated transportation service shall be limited to the lower of:

(a) The county specific rate included in appendix B to this rule times actual units of service; or

(b) Eighty-seven dollars times actual units of service.

(9) For SFY 2006 and 2007 only, each state-operated ~~ICF-MR~~ICF/IID certified after June 30, 2003 whose cost report includes less than twelve months of complete data shall be reimbursed the statewide average interim payment rate

for state-operated ~~ICFs-MR~~ICFs/IID plus an additional amount to be paid in the rate for off-site day habilitation/active treatment and associated transportation services as calculated in paragraphs (C)(4) and (C)(5) of this rule. When the calculation requiring the use of SFY 2004 inpatient days in paragraph (C)(4)(d) or (C)(5)(b) of this rule does not apply then an estimate of inpatient days shall be used.

(10) A state-operated ~~ICF-MR~~ ICF/IID certified cost report shall be filed within one hundred eighty days of the end of the fiscal year. If the cost report is not received within one hundred eighty days of the end of the fiscal year the rate paid will be the lower of ninety per cent of the state wide average or the current rate.

(D) Audit.

(1) ~~ODJFS~~ODM will perform field audits of the most current cost report for each state-operated ~~ICFs-MR~~ICFs/IID at least once every three years. Cost reports for other periods may also be audited as determined necessary by the ~~ODJFS~~ODM. The audits will be performed in accordance with auditing standards adopted by the ~~ODJFS~~ODM. To determine which state-operated ~~ICFs-MR~~ ICFs/IID are subject to audit, ~~ODJFS~~ODM will develop a risk-based methodology.

(2) The audit scope will be determined by the ~~ODJFS~~ODM and will be sufficient to determine if costs reflected in the cost report are accurate, made in compliance with pertinent regulations, and based on actual cost.

(3) ~~ODMRDD~~ODODD must maintain documentation to support all transactions, to permit the reconstruction of all transactions and the proper completion of all reports required by state and federal laws and regulations, and to substantiate compliance with all applicable federal statutes or regulations, state statutes or administrative rules. This documentation must be maintained for the greater of seven years after the cost report is filed or, if ~~ODJFS~~ ODM issues an audit report, six years after all appeal rights relating to the audit report are exhausted. ~~ODMRDD~~ODODD must make available to the ~~ODJFS~~ODM personnel all records necessary to document all transactions, regardless of where records are maintained. Accounting records must include sufficient detail to disclose:

(a) Services provided; and

(b) Administrative costs of services provided; and

(c) Costs of operating the organizations, agencies, program, activities, and functions; and

(d) Accuracy of inpatient days; and

(e) Services claimed are covered under the medicaid program and made in accordance with applicable rules of the Administrative Code; and

(f) Amounts of third-party payments reported are indicative of actual amounts received; and

(g) Costs reported to the ~~ODJFS~~ODM represent actual incurred, reasonable, and allowable costs in accordance with provisions of the CMS provider manual 15-1, Chapter ~~5101:3-3~~5160-3 of the Administrative Code as applicable, and 45 CFR 92 dated ~~October 1, 2000~~October 1, 2014.

(4) Each facility shall collect, report, and maintain separately all data and records sufficient to support the rate calculation including but not limited to statistical and financial data:

(a) Related to costs that are included in or listed in the cost report as reimbursable costs; and

(b) Relate to non-reimbursable costs; and

(c) Related to the contracted rate, amount, time period of those contracts between private ~~ICFs-MR~~ICFs/IID and county boards of ~~MRDD~~DD as included in paragraph (C)(6)(a) of this rule; and

(d) Necessary to support the use of the rate schedule referenced in paragraph (C)(5)(a) of this rule.

(5) ~~ODJFS~~ ODM shall recognize costs subject to this rule as evidenced through executed contracts for off-site day habilitation/active treatment and associated transportation services which comply with paragraphs (C)(6)(a) and (C)(6)(b) of this rule. Where records and data are not available or not provided on request, those costs shall be excluded from the ~~JFS~~ODM 01984 cost report.

(6) ~~ODMRDD~~ODODD must maintain adequate systems of internal control as related to federal funding to ensure:

(a) Accurate and reliable financial and administrative records; and

(b) Efficient and effective use of resources; and

(c) Compliance with pertinent laws and regulations.

(E) Final settlement.

(1) Final settlement is the process where allowable and reasonable costs included in the rate year cost report are used to establish a final payment rate that is reconciled to the interim payment rate.

(2) The rate year cost report shall include adjustments included in paragraphs (B)(2) and (D)(1) to (D)(5) of this rule.

(3) The final payment rate shall be calculated as follows:

(a) Calculation of direct care per diem rate.

(i) Calculate the direct care per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing direct care costs by total inpatient days as described in paragraph (A) of this rule.

(ii) For each facility multiply the facility's direct care per diem by the facility's inpatient days as described in paragraph (A) of this rule. Sum results for all facilities and divide by the sum of inpatient days for all facilities.

(iii) Calculate the direct care per diem ceiling by taking the amount calculated in paragraph (E)(3)(a)(ii) of this rule and multiplying it by one hundred twelve per cent.

(iv) The final state-operated ~~ICF-MR~~ICF/IID direct care per diem will be the lower of the amount calculated in paragraph (E)(3)(a)(i) of this rule or the direct care per diem ceiling as calculated in paragraph (E)(3)(a)(iii) of this rule.

(b) Calculate the ancillary cost per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing ancillary costs by total inpatient days as described in paragraph (A) of this rule.

(c) Calculate the capital cost per diem for each state-operated ~~ICF-MR~~ICF/IID by dividing capital costs by total inpatient days as described in paragraph (A) of this rule. The final rate for each state-operated ~~ICF-MR~~ICF/IID shall be the sum of the amounts calculated in paragraphs (E)(2)(a)(iv), (E)(2)(b) and (E)(2)(c) of this rule.

(d) Calculation of the additional amount paid for off-site day habilitation/active treatment and associated transportation services for SFY 2006 and 2007 only for each state operated facility.

(i) For the period July 1, 2005 to December 30, 2005, divide the allowable costs as restricted by paragraph (C)(6) of this rule by total inpatient days described in paragraph (A) of this rule for July 1, 2005 to December 30, 2005.

(ii) For the period January 1, 2006 to June 30, 2006, divide the allowable costs as restricted by paragraph (C)(7) of this rule by total inpatient days described in paragraph (A) of this rule for January 1, 2006 to June 30, 2006.

(iii) For SFY 2006, add the quotients calculated in paragraphs (E)(3)(d)(i) and (E)(3)(d)(ii) of this rule.

(iv) For the period July 1, 2006 to September 30, 2006, divide the allowable costs as restricted by paragraph (C)(7) of this rule by total inpatient days described in paragraph (A) of this rule for July 1, 2006 to September 30, 2006.

(v) For the period October 1, 2006 to June 30, 2007, divide the allowable costs as restricted by paragraph (C)(8) of this rule by total inpatient days described in paragraph (A) of this rule for October 1, 2006 to June 30, 2007.

(vi) For SFY 2007, add the quotients calculated in paragraphs (E)(3)(d)(iv) and (E)(3)(d)(v) of this rule.

(4) The final payment rate calculated in paragraph (E)(3) of this rule is subtracted from the interim payment rate calculated in paragraph (C)(2) or (C)(3) of this rule, as applicable. The result is multiplied by the paid days and applicable federal financial participation (FFP) rate. The result of this calculation is the final settlement amount. Where the interim rate exceeds the final rate, the

excess payment shall be remitted to ~~ODJFS~~ ODM. If the final rate exceeds the interim rate, ~~ODJFS~~ ODM shall remit the amount to ~~ODMRDD~~ODODD.

(5) For periods after SFY 2007, the final payment rate calculated in paragraph (E)(3) of this rule is subtracted from the adjusted interim payment rate calculated in paragraphs (C)(4), (C)(5) and (C)(7) of this rule, as applicable. The result is multiplied by the paid days and applicable FFP rate. The result of this calculation is the final settlement amount. Where the adjusted interim rate exceeds the final rate, the excess payment shall be remitted to ~~ODJFS~~ODM. If the final rate exceeds the interim rate, ~~ODJFS~~ODM shall remit the amount to ~~ODMRDD~~ODODD. The costs incurred for providing the off-site day program/active treatment and transportation services are included when calculating the direct care ceiling for the purposes of final settlement.

(6) The audit and final settlement shall be issued within thirty-six months of receipt of the cost report for the rate year. If an audit is not issued for final settlement within thirty-six months, the rates calculated using the desk reviewed rate year cost report shall be used for final settlement.

(7) No further adjustments to payments or rates can occur after the implementation of the final cost settlement.

(F) Upper payment limit assurance.

Payments made to state-operated ~~ICFs-MR~~ICFs/IID in accordance with this rule under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts which would have been recognized under Title XVIII (medicare) for comparable services in accordance with 42 CFR 447.272 effective ~~October 31, 2000~~October 1, 2014, and available at www.cms.hhs.gov.

(G) Dispute resolution.

All disputes regarding the application of this rule, including but not limited to desk reviews, payment, rate setting, and audits shall be resolved between ~~ODJFS~~ODM and ~~ODMRDD~~ODODD in accordance with terms set forth in the interagency agreement. Disputes that arise from the application of this rule shall not be subject to hearings conducted under Chapter 119. of the Revised Code.

(H) Rule exclusion.

Excluding those rules referring to reasonableness ceilings, cost limitations, cost reimbursement, occupancy levels, disallowance of costs, payment calculations, payment methodology, and appeals, all other rules which govern the operation of

medicaid-certified intermediate care facilities for the mentally retarded under Chapters ~~5101:3-1~~5160-1 and ~~5101:3-3~~5160-3 of the Administrative Code shall apply to state-operated ~~ICFs-MR~~ICFs/IID. The payment methodology specified in this rule shall govern the reimbursement of medicaid costs for state-operated ~~ICFs-MR~~ICFs /IID.

Effective:

Five Year Review (FYR) Dates: 02/10/2015

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Certification

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Date

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