OHIO LEGISLATIVE SERVICE COMMISSION

Final Analysis

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Sub. H.B. 24

132nd General Assembly
(As Passed by the General Assembly)

Reps. Ginter, Schaffer, Rogers, Cera, Green, Hambley, Retherford, Anielski, Antani, Antonio, Arndt, Ashford, Barnes, Boccieri, Boggs, Boyd, Brown, Butler, Carfagna, Celebrezze, Clyde, Craig, Cupp, Edwards, Faber, Fedor, Galonski, Gavarone, Goodman, Greenspan, Hagan, Henne, Hill, Holmes, Householder, Howse, Huffman, Hughes, Ingram, T. Johnson, Keller, Kent, Kick, Landis, Lanese, Lang, LaTourette, Leland, Lepore-Hagan, Lipps, Manning, McColley, Miller, O'Brien, Patmon, Patterson, Patton, Pelanda, Perales, Ramos, Reece, Reineke, Rezabek, Riedel, Roegner, Romanchuk, Schuring, Sheehy, Sprague, Stein, Strahorn, Sweeney, Thompson, West, Young

Sens. Terhar, Beagle, Hackett, Peterson, Wilson, Bacon, Balderson, Coley, Dolan, Eklund, Gardner, Hoagland, Hottinger, Huffman, Kunze, LaRose, Lehner, Manning, Oelslager, Thomas, Uecker

Effective date: Emergency: March 30, 2018; sections related to ICF Medicaid rates effective July 1, 2018

ACT SUMMARY

Taxation

- Modifies the veterans' organization property tax exemption to include the property of certain 501(c)(4) veterans' organizations.
- Excludes from that exemption property that is not used primarily for meetings, administration, and providing programs and services to veterans.
- Authorizes a property tax exemption for property owned by certain nonprofit organizations that provide housing for individuals with developmental disabilities.
- Enumerates several purposes for which a school district may use revenue from a school safety and security tax levy.
- Codifies an income tax deduction for eligible subsidized health insurance premiums.

- Modifies the law requiring dealers in aviation fuel to register and file monthly reports with the Department of Taxation.

- Makes corrective changes to the motor fuel tax law.

New formula for Medicaid rates for ICF services

- Establishes a new formula to determine Medicaid rates for services provided by intermediate care facilities for individuals with intellectual disabilities (ICFs).

- Provides for an ICF to be paid, until July 1, 2021, the greater of the rates determined under the new formula or, with a few modifications, the old formula.

- Beginning July 1, 2021, requires ICFs to be paid under the new formula.

- Places ICFs into five (instead of three) peer groups for determining rates under the new formula.

- Provides for the new formula to have the same four cost centers as the old formula: capital, direct care, indirect care, and other protected costs.

- Until July 1, 2020, includes in the new formula a direct support personnel payment equal to 3.04% of the ICF's direct care costs.

- Beginning July 1, 2020, includes in the new formula a quality incentive payment based on 13 quality indicators.

- Prescribes the capital component of the new formula as the sum of its nonextensive renovation rate and the lesser of (1) the sum of its fair rental value rate, equipment rate, and secondary building rate and (2) a limit to be determined for this part of the capital component.

- Requires the direct care costs component of the new formula to be determined using cost per case-mix units and case-mix scores and adjusted by an estimated inflation rate.

- Requires an ICF's quarterly case-mix score to be determined using the most recent resident assessment data compiled and revised for its residents and the case-mix scores of its residents.

- Requires the Ohio Department of Developmental Disabilities (ODODD) to perform the initial assessment of an ICF resident as part of the process of determining case-

mix scores, and permits it to perform subsequent assessments under certain circumstances.

- Requires an ICF to submit to ODODD, not later than 15 days after each calendar quarter, revised assessment data for each resident for whom there are changes in assessment data and an attestation for each resident for whom there are no changes.

- Permits the resident assessment instrument used in determining residents' case-mix scores under the new formula to be different from the instrument used under the old formula.

- Requires ODODD to establish six acuity groups for assigning case-mix scores to ICF residents.

- Permits an ICF, if it submits revised assessment data for a resident that results in at least a 15% increase in its case-mix score, to request ODODD, through a rate reconsideration process, to increase its rate for the direct care costs component.

- Limits an ICF's rate for the indirect care costs under the new formula to the lesser of its individual rate and the maximum rate for its peer group.

- Provides for an ICF's rate for the other protected costs under the new formula to be its other protected costs, adjusted for inflation.

- Permits ODODD to establish a pilot program that (1) requires ICFs to submit data regarding their ability to meet proposed quality indicators during the last six months of calendar year 2018 and (2) provides an incentive payment for ICFs that submit the data during FY 2020.

- Provides that the following does not apply to the new formula: a requirement that costs limits for administrators of four or more ICFs equal the limits for administrators of ICFs with 150 or more beds.

- Eliminates a requirement that ODODD adjust the rates under the new formula for ICF services provided during FY 2019 if the mean rate differs from a target amount or the federal government requires that a franchise permit fee imposed on ICFs be reduced or eliminated.

- Revises the method by which a new ICF's rate is to be determined.

- Permits an ICF, if it disagrees with a revised case-mix score resulting from an exception review conducted under the old formula, to request ODODD to

reconsider the revision; and requires ODODD, if it reconsiders the revision and further revises the case-mix score, to use the further revised score.

- Eliminates a cap on the rate for services that certain ICFs provide to Medicaid recipients who are admitted on or after July 1, 2015, and placed in the chronic behaviors and typical adaptive needs classification or the typical adaptive needs and nonsignificant behaviors classification.

- Requires ODODD, when determining rates under the old formula for FYs 2020 and 2021, to make the same modifications and adjustments that continuing law requires be made in determining rates for FY 2019.

- Eliminates a requirement that ODODD reduce the FY 2019 rate determined under the old formula if the federal government requires that a franchise permit fee imposed on ICFs be reduced or eliminated.

NEOMED, Cleveland State, and OU Medical School partnership

- Permits the Ohio University Heritage College of Osteopathic Medicine to join the partnership between the Northeast Ohio Medical University (NEOMED) and Cleveland State University.

Ohio State University land conveyance

- Authorizes the conveyance of real estate located in Franklin County via purchase agreement to the City of Columbus or another purchaser.

Appropriation

- Makes a capital appropriation of $750,000 for the Boys and Girls Club of Newark for the biennium ending June 30, 2020.[1]

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[1] For more information about this appropriation, see page 8 of the LSC Fiscal Note for H.B. 24, As Enacted, available at https://www.legislature.ohio.gov/download?key=9192&format=pdf.

CONTENT AND OPERATION

Taxation

Property tax exemption for veterans' organizations

The act modifies a pre-existing tax exemption for property held or occupied by a veterans' organization by (1) extending eligibility for the exemption to the property of qualifying veterans' organizations that are exempt from federal income tax under section 501(c)(4) of the Internal Revenue Code and (2) excluding from the exemption property that is not used primarily for meetings, administration, and the provision of programs and services to veterans and current members of the U.S. Armed Forces.[2] The modifications apply to tax years ending on or after the act's effective date.[3]

Existing exemption

Under pre-existing law, a veterans' organization's property is tax exempt if the organization qualifies for exemption from federal income tax under section 501(c)(19) or 501(c)(23) of the Internal Revenue Code and the property generates less than $36,000 in gross rental income for the tax year. A veterans' organization qualifies for federal income tax exemption under section 501(c)(19) if it is organized and operated as a nonprofit, at least 75% of its members are veterans and current members of the U.S. Armed Forces, and substantially all the other members of the organization are cadets, spouses, ancestors, or lineal descendants of veterans or of current members of the U.S.

[2] R.C. 5709.17.

[3] Section 3.

Armed Forces. A veterans' organization qualifies under section 501(c)(23) if it was organized before 1880, at least 75% of its members are veterans or current members of the U.S. Armed Forces, and its principal purpose is to provide insurance and other benefits to veterans and their dependents.

Inclusion of 501(c)(4) organizations

The act extends the exemption to property owned or occupied by a veterans' organization that is exempt from federal taxation under section 501(c)(4) of the Internal Revenue Code as a social welfare organization, but only if that organization otherwise meets the criteria for exemption as a 501(c)(19) veterans' organization.

Restrictions on use of exempted property

The act also limits the veterans' organization exemption to property that is used primarily for meetings and administration of the veterans' organization or for providing nonprofit programs and supportive services to veterans or current members of the U.S. Armed Forces or their families. As under pre-existing law, property that generates more than $36,000 annually in rental income will continue to be ineligible for the exemption.[4]

Nonprofit developmental disability housing property tax exemption

The act authorizes a property tax exemption for property owned by a nonprofit organization that provides housing for individuals with developmental disabilities. To qualify, first the organization must meet the following requirements:

(1) It is exempt from federal taxation under 501(c)(3) of the Internal Revenue Code;

(2) Its primary purpose is to acquire, develop, lease, or otherwise provide housing for individuals with developmental disabilities;

(3) It receives all or part of its funding from a county board of developmental disabilities to assist in achieving that purpose.

In addition, the property must be either (a) used by that organization to achieve its primary purpose, (b) leased or otherwise provided by that organization to individuals with developmental disabilities and used by them as housing, or (c) leased or otherwise provided to another charitable organization and used by that other organization exclusively for charitable purposes.

[4] R.C. 5709.17.

The act declares that property that meets these requirements is considered to be "used exclusively for charitable purposes."[5] Under continuing law, property used exclusively for charitable purposes is exempt from property taxation.[6]

The act's authorization of the exemption applies to tax year 2018 and thereafter, and also to any exemption application or appeal pending on the act's effective date.[7]

Tax levy for school safety and security

Under continuing law, a school district may levy a property tax exclusively for school safety and security purposes. The tax may be levied for a term of up to five years.

The act states that the purposes for which revenue from the levy may be allocated include (but are not limited to): funding permanent improvements to provide or enhance security, employing or contracting with safety personnel, providing mental health services and counseling, or providing training in safety and security practices and responses.

Prior law did not specify what types of expenditures fit into the category of "safety and security." The act declares that the purposes described above fit into that category, but does not prohibit the use of revenue for other safety-and-security-related purposes that are not listed and that may be determined by school boards in their reasonable discretion.[8]

Taxation of medical insurance premiums

The act codifies an income tax deduction for eligible subsidized health insurance premiums. A subsidized health plan is one in which an entity (such as an employer) pays a portion of an individual's premiums for health insurance coverage. Examples include employer-sponsored plans, Medicare, and insurance purchased with the help of a subsidy on an exchange.

Continuing law allows a tax deduction for (a) the premiums an individual pays for an unsubsidized health insurance plan (i.e., a plan for which the individual pays the

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[5] R.C. 5709.121(E).

[6] R.C. 5709.12(B), not in the act.

[7] Section 3.

[8] R.C. 5705.21(A).

entire cost) and (b) other "medical care" expenses, provided those expenses exceed 7.5% of the individual's Ohio adjusted gross income (AGI). Generally, "medical care" expenses would include payments for subsidized health insurance, but prior law specifically excluded subsidized health insurance premiums from the deduction.

Before tax year 2017, Ohio income tax returns and instructions were not in accord with prior law, and consequently, taxpayers were able to claim a deduction for certain subsidized health insurance premiums (if such premiums, combined with the taxpayer's other medical care expenses, were greater than 7.5% of the taxpayer's AGI). Beginning with tax year 2017, the Department of Taxation amended the tax return and instructions to accord with prior law, thereby disallowing the deduction. The act reverses this new treatment by codifying the deduction for eligible subsidized insurance premiums, for tax year 2017 and thereafter.[9] Consequently, there will be no break in the continuing availability of the deduction for qualifying taxpayers.

Aviation fuel dealer law changes

Beginning January 1, 2018, certain businesses that obtain aviation fuel in order to sell it in Ohio must register with the Department of Taxation for an aviation fuel dealer's license and file monthly reports with the Department. Aviation fuel is not subject to the motor fuel tax (instead, it is subject to the sales and use tax), so the monthly reporting does not involve paying any tax.

The act makes the following changes to this requirement:

- Specifies that a person is an aviation fuel dealer under the law if the person obtains aviation fuel in order to resell it in Ohio to someone other than an end user. Prior law defined an aviation fuel dealer as someone who sells aviation fuel for consumption (i.e., sells it to an end user).[10]

- Requires aviation fuel dealers to submit their monthly reports on or before the last day, rather than the twenty-third day, of each month.[11]

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[9] R.C. 5747.01(A)(11) and Section 14 (emergency clause). The deduction is available for any premiums that are also eligible to be claimed as an itemized medical expense deduction on a taxpayer's federal tax return. Only premiums that are paid with after-tax money are eligible for the federal deduction; consequently, the Ohio deduction is not available for premiums that are paid by making a pre-tax reduction in a taxpayer's salary (as is done with many employer-sponsored plans).

[10] R.C. 5735.01(II) and 5735.024(A).

[11] R.C. 5735.024(D).

- Provides that, if an aviation fuel dealer (or a motor fuel dealer who also deals in aviation fuel) files a false aviation fuel report, or fails to file a report, the Commissioner may revoke the dealer's license. (A similar requirement applies to motor fuel dealers who file false motor fuel tax returns or fail to file returns.)[12]

Motor fuel tax law: corrective changes

The act also makes corrective changes to two definitions in the motor fuel tax law ("terminal" and "consumer"). The definitions were amended in an early version of H.B. 26 of the 132nd General Assembly, the transportation budget act, but were not reinstated to their original versions when the other changes necessitating their amendment were removed from that act. This act reinstates these definitions to their original versions.[13]

New formula for Medicaid rates for ICF services

The main operating budget act of the 132nd General Assembly, H.B. 49, states the General Assembly's intent to enact legislation establishing a new Medicaid payment formula for services provided by intermediate care facilities for individuals with intellectual disabilities (ICFs) beginning not sooner than July 1, 2018, and not later than January 1, 2019.[14]

The act establishes a new formula. Until July 1, 2021, an ICF is to be paid the greater of the rate determined under the new formula or the rate determined, with a few modifications, under the old formula. Beginning on that date, ICF rates are to be determined under the new formula.[15] Rates are to cease being calculated under the old formula beginning with FY 2022.[16]

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[12] R.C. 5735.024(E) and 5735.04.

[13] R.C. 5735.01(T) and (U).

[14] Section 261.167 of Am. Sub. H.B. 49 of the 132nd General Assembly.

[15] R.C. 5124.15(A).

[16] R.C. 5124.171, 5124.195, 5124.196, 5124.197, 5124.198, 5124.199, 5124.211, 5124.231, 5124.28, 5124.30, 5124.38(D), 5124.39, 5124.40, 5124.41, and 5124.46.

Peer groups

An ICF is placed into a peer group as part of the process of determining its Medicaid rate. The old formula that the act phases out has the following three peer groups:

(1) Peer group 1 (ICFs with a Medicaid-certified capacity of 9 or more);

(2) Peer group 2 (ICFs with a Medicaid-certified capacity of 8 or fewer, other than ICFs in peer group 3);

(3) Peer group 3 (ICFs that are first certified after July 1, 2014; have a Medicaid-certified capacity of 6 or fewer; have contracts with ODODD that are for 15 years and include a provision for ODODD to approve all admissions and discharges; and have residents who are admitted directly from a developmental center or have been determined by ODODD to be at risk of admission to a developmental center).

The act establishes the following five peer groups for the new formula:

(1) Peer group 1-A (ICFs with a Medicaid-certified capacity of 17 or more);

(2) Peer group 2-A (ICFs with a Medicaid-certified capacity of 9 to 16);

(3) Peer group 3-A (ICFs with a Medicaid-certified capacity of 7 or 8);

(4) Peer group 4-A (ICFs with a Medicaid-certified capacity of 6 or fewer, other than ICFs in peer group 5-A);

(5) Peer group 5-A (ICFs in peer group 3 under the old formula).[17]

To avoid confusion between the old and new formulas, the act renames the peer groups used for the old formula as peer groups 1-B, 2-B, and 3-B.[18]

Total rate under the new formula

An ICF's total per Medicaid day (see "**Important terms**" on page 34) rate under the new formula is the sum of the following:

(1) The ICF's per Medicaid day capital component rate;

[17] R.C. 5124.01(PP)(1) and 5124.68.

[18] R.C. 5124.01(PP)(2).

(2) Its per Medicaid day direct care costs component rate;

(3) Its per Medicaid day indirect care costs component rate;

(4) Its per Medicaid day other protected costs component rate;

(5) Until July 1, 2020, a direct support personnel payment equal to 3.04% of its desk-reviewed, actual, allowable, per Medicaid day direct care costs from the applicable cost report year; and

(6) Beginning July 1, 2020, its per Medicaid day quality incentive payment.[19]

As under the old formula for ICFs in peer group 3 (renamed peer group 3-B), ICFs in peer group 5-A cannot have a total rate under the new formula exceeding the average total rate in effect on July 1, 2013, for developmental centers (ICFs maintained and operated by ODODD).[20]

Capital component under the new formula

An ICF's per Medicaid day rate for the capital component of its total rate for a fiscal year under the new formula is to equal the sum of the ICF's per diem nonextensive renovation rate for the fiscal year (see "**Nonextensive renovation per diem rate**" below) and the lesser of the following:

(1) The sum of:

- The ICF's per diem fair rental value rate for the fiscal year;
- Its per diem equipment rate for the fiscal year; and
- Its per diem secondary building rate for the fiscal year.

(2) A limit to be determined for this part of the ICF's capital component rate. (See "**Limit on part of the capital component rate**" below.)[21]

[19] R.C. 5124.15(B).

[20] R.C. 5124.15(D).

[21] R.C. 5124.17(A).

Nonextensive renovation per diem rate

Per diem

The amount of an ICF's per diem nonextensive renovation rate for a fiscal year depends on whether the sum of its per diem costs of nonextensive renovations and costs of ownership for the applicable cost report year (see "**Important terms**" below) is greater than, equal to, or less than the limit on its capital component rate. (See "**Limit on part of the capital component rate**" below.) If the sum of those costs is greater than the limit, the ICF's per diem nonextensive renovation rate is the lesser of (1) its per diem costs of nonextensive renovations for the applicable cost report year and (2) the difference of (a) the sum of its per diem costs of nonextensive renovations and costs of ownership for the applicable cost report year and (b) the limit on its capital component rate. If the sum of its per diem costs of nonextensive renovations and costs of ownership for the applicable cost report year is equal to or less than the limit on its capital component rate, the ICF's per diem nonextensive renovation rate is zero.[22]

Costs of nonextensive renovations

An ICF's per diem costs of nonextensive renovations for an applicable cost report year are determined by dividing its desk-reviewed (see "**Important terms**" below), actual, allowable costs of nonextensive renovations for the year by the greater of (1) the number of the facility's inpatient days (see "**Important terms**" below) for the year and (2) the number of inpatient days it would have had during that year if its occupancy rate had been 92%.[23] An ICF's costs of nonextensive renovations are, for the new formula, the actual expense it incurs for depreciation or amortization and interest on renovations that ODODD approves as nonextensive renovations.[24] A renovation is an ICF's betterment, improvement, or restoration through a capital expenditure that does not increase the facility's square footage.[25]

Costs of ownership

An ICF's per diem costs of ownership for a year are determined by dividing its desk-reviewed, actual, allowable costs of ownership for the year by the greater of (1) the number of the facility's inpatient days for the year and (2) the number of inpatient days

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[22] R.C. 5124.17(H).

[23] R.C. 5124.17(I).

[24] R.C. 5124.01(I)(1).

[25] R.C. 5124.01(WW).

it would have had during that year if its occupancy rate had been 92%.[26] An ICF's costs of ownership are, for the new formula, its actual expenses for (1) depreciation and interest on any capital assets that cost $500 or more per item, (2) amortization and interest on land improvements and leasehold improvements, (3) amortization of financing costs, and (4) lease and rent of land, building, and equipment (other than equipment treated as an indirect care cost). The costs of capital assets of less than $500 per item may be considered costs of ownership in accordance with an ICF's practice.[27]

Fair rental value per diem rate

Per diem

An ICF's per diem fair rental value rate for a fiscal year is to be the facility's fair rental value divided by the greater of (1) the number of the facility's inpatient days for the applicable cost report year and (2) the number of inpatient days the facility would have had during the applicable cost report year if its occupancy rate had been 92% that year.[28]

Fair rental value

An ICF's fair rental value is the product of (1) the sum of the facility's land value and its depreciated current asset value and (2) 11%.[29]

Land value

An ICF's land value is the product of (1) the facility's current asset value and (2) 10%.[30]

Depreciated current asset value

An ICF's depreciated current asset value is its current asset value depreciated by the product of (1) the facility's effective age and (2) 1.6%.[31]

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[26] R.C. 5124.17(J).

[27] R.C. 5124.01(J).

[28] R.C. 5124.17(B).

[29] R.C. 5124.17(C)(1).

[30] R.C. 5124.17(C)(10).

[31] R.C. 5124.17(C)(2).

Current asset value

An ICF's current asset value is the product of (1) the facility's value per square foot and (2) the lesser of the facility's square footage and the following:

- If the ICF is in peer group 1-A and is a downsized ICF (see "**Important terms**" below), its Medicaid-certified capacity on the last day of the applicable cost report year multiplied by 1,000.

- If the ICF is in peer group 1-A and is not a downsized ICF, its Medicaid-certified capacity on the last day of the applicable cost report year multiplied by 550.

- If the ICF is in peer group 2-A and is a downsized ICF, its Medicaid-certified capacity on the last day of the applicable cost report year multiplied by 1,000.

- If the ICF is in peer group 2-A and is a not downsized ICF, its Medicaid-certified capacity on the last day of the applicable cost report year multiplied by 750.

- If the ICF is in peer group 3-A, its Medicaid-certified capacity on the last day of the applicable cost report year multiplied by 850.

- If the ICF is in peer group 4-A or 5-A, its Medicaid-certified capacity on the last day of the applicable cost report year multiplied by 900.[32]

Effective age

An ICF's effective age is to be determined as follows:

(1) Determine the sum of the numbers of the ICF's new bed equivalents for renovations for the applicable cost report year and the preceding 39 calendar years.[33] The number, for a year, of an ICF's new bed equivalents for renovations is the quotient of (a) the facility's desk-reviewed, actual, allowable renovation costs for the year and (b) $70,000.[34]

[32] R.C. 5124.17(C)(3).

[33] R.C. 5124.17(C)(5)(a).

[34] R.C. 5124.17(C)(7)(a).

(2) Determine the sum of the numbers of the ICF's new bed equivalents for additions (see "**Important terms**" below) that do *not* increase the facility's Medicaid-certified capacity for the applicable cost report year and the preceding 39 calendar years.[35] The number, for a year, of an ICF's new bed equivalents for additions that do *not* increase its Medicaid-certified capacity is the quotient of (a) the value of such additions made to the facility that year and (b) $70,000. The value of additions that do *not* increase a facility's Medicaid-certified capacity is the product of (a) the total square footage of the additions and (b) the facility's value per square foot.[36]

(3) Determine the sum of numbers of the ICF's new beds resulting from additions that increase its Medicaid-certified capacity for the applicable cost report year and the preceding 39 calendar years.[37] The number, for a year, of new beds resulting from additions that increase a facility's Medicaid-certified capacity is the number by which the new beds increased the facility's Medicaid-certified capacity that year.[38]

(4) Determine the sum of the sums determined under (1), (2), and (3).[39]

(5) Determine the difference of the ICF's Medicaid-certified capacity on the last day of the applicable cost report year and the lesser of the facility's Medicaid-certified capacity on the last day of the applicable cost report year and the sum determined under (4).[40]

(6) For the purpose of determining the weighted age of the ICF's original beds, determine the product of the difference determined under (5) and the facility's age.[41]

(7) Determine the sum of the weighted ages of the ICF's new bed equivalents for renovations for the applicable cost report year and the preceding 39 calendar years.[42] The weighted age, for a year, of such new bed equivalents is the product of the number, for that year, of those new bed equivalents and the age of those new bed equivalents.

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[35] R.C. 5124.17(C)(5)(b).

[36] R.C. 5124.17(C)(8)(a) and (b).

[37] R.C. 5124.17(C)(5)(c).

[38] R.C. 5124.17(C)(9)(a).

[39] R.C. 5124.17(C)(5)(d).

[40] R.C. 5124.17(C)(5)(e).

[41] R.C. 5124.17(C)(5)(f).

[42] R.C. 5124.17(C)(5)(g).

The age of such new bed equivalents is the difference of the calendar year in which occurs the last day of the period covered by the cost report being used to determine the ICF's Medicaid rate and the calendar year the renovations were completed.[43]

(8) Determine the sum of the weighted ages of the ICF's new bed equivalents for additions that do *not* increase its Medicaid-certified capacity for the applicable cost report year and the preceding 39 calendar years.[44] The weighted age, for a year, of such new bed equivalents is the product of the number, for that year, of those new bed equivalents and the age of those new bed equivalents. The age of such new bed equivalents is the difference of the calendar year in which occurs the last day of the period covered by the cost report being used to determine the ICF's Medicaid rate and the calendar year the additions were completed.[45]

(9) Determine the sum of the weighted ages of the ICF's new beds resulting from additions that increase its Medicaid-certified capacity for the applicable cost report year and the immediately preceding 39 calendar years.[46] The weighted age, for a year, of such new beds is the product of the number by which those new beds increased the ICF's Medicaid-certified capacity that year and the difference of the calendar year in which occurs the last day of the period covered by the cost report being used to determine the facility's Medicaid rate and the calendar year the facility's Medicaid-certified capacity was so increased.[47]

(10) Determine the sum of the product determined under (6) and the sum of the sums determined under (7), (8), and (9).[48]

(11) Determine the quotient of the sum determined under (10) and the ICF's Medicaid-certified capacity on the last day of the applicable cost report year.[49]

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[43] R.C. 5124.17(C)(7)(b) and (c).

[44] R.C. 5124.17(C)(5)(h).

[45] R.C. 5124.17(C)(8)(c) and (d).

[46] R.C. 5124.17(C)(5)(i).

[47] R.C. 5124.17(C)(9)(b).

[48] R.C. 5124.17(C)(5)(j).

[49] R.C. 5124.17(C)(5)(k).

Age

An ICF's age is the lesser of the following:

(1) The difference of the calendar year in which occurs the last day of the period covered by the cost report being used to determine the facility's Medicaid rate and the calendar year in which the facility was initially constructed.

(2) 40.[50]

Value per square foot

An ICF's value per square foot is to be determined using the version of the RS Means Data that was most recently published at the time the determination is made. The data for assisted-senior living facility construction costs is to be used for ICFs in peer group 1-A or 2-A. The data for nursing home construction costs is to be used for ICFs in peer group 3-A, 4-A, or 5-A.[51] The RS Means Data has modifiers applicable to certain cities. The act requires that the following modifier be used in determining a facility's value per square foot:

(1) If located in Summit County, the modifier specified for Akron;

(2) If located in Athens County, the modifier for Athens;

(3) If located in Ashtabula, Geauga, Lake, Medina, Portage, Stark, Trumbull, or Wayne county, the modifier for Canton;

(4) If located in Ross County, the modifier for Chillicothe;

(5) If located in Hamilton County, the modifier for Cincinnati;

(6) If located in Cuyahoga County, the modifier specified for Cleveland;

(7) If located in Franklin County, the modifier for Columbus;

(8) If located in Montgomery County, the modifier for Dayton;

(9) If located in Brown, Butler, Clermont, Clinton, Champaign, Darke, Greene, Logan, Miami, Preble, Shelby, or Warren county, the modifier for Hamilton;

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[50] R.C. 5124.17(C)(6).

[51] R.C. 5124.17(C)(4)(a).

(10) If located in Allen, Auglaize, Defiance, Erie, Fulton, Hancock, Henry, Huron, Mercer, Paulding, Putnam, Ottawa, Sandusky, Seneca, Van Wert, Williams, or Wood county, the modifier for Lima;

(11) If located in Lorain County, the modifier for Lorain;

(12) If located in Ashland, Crawford, Delaware, Fairfield, Fayette, Hardin, Knox, Licking, Madison, Morrow, Pickaway, Richland, Union, or Wyandot county, the modifier for Mansfield;

(13) If located in Marion County, the modifier for Marion;

(14) If located in Clark County, the modifier for Springfield;

(15) If located in Jefferson County, the modifier for Steubenville;

(16) If located in Lucas County, the modifier for Toledo;

(17) If located in Mahoning County, the modifier for Youngstown;

(18) If located in Adams, Belmont, Carroll, Columbiana, Coshocton, Gallia, Guernsey, Harrison, Highland, Hocking, Holmes, Jackson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pike, Scioto, Tuscarawas, Vinton, or Washington county, the modifier for Zanesville.[52]

If the applicable RS means data ceases to specify a modifier for a city listed above, the ODODD Director must specify in rules a different modifier for the affected counties.[53]

Equipment per diem rate

An ICF's per diem equipment rate for a fiscal year is to be the lesser of the following:

(1) The quotient of the facility's costs for capital equipment for the applicable cost report year and the number of the facility's inpatient days for that year or the number of inpatient days the facility would have had during that year if its occupancy rate had been 92%, whichever is greater;

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[52] R.C. 5124.17(C)(4)(b).

[53] R.C. 5124.17(C)(4)(c).

(2) The following amount:

- $5 if the ICF is in peer group 1-A.
- $6 if the ICF is in peer group 2-A.
- $8 if the ICF is in peer group 3-A.
- $9 if the ICF is in peer group 4-A or 5-A.[54]

Secondary building per diem rate

A secondary building is a building or part of a building, other than an ICF, in which the owner of one or more ICFs has administrative work regarding the facilities performed or records regarding the facilities stored.[55] An ICF's per diem secondary building rate for a fiscal year is determined by dividing its secondary building value by the greater of (1) the number of its inpatient days for the applicable cost report year and (2) the number of inpatient days it would have had during that year if its occupancy rate had been 92%.[56]

Secondary building value

An ICF's secondary building value is the product of the sum of the depreciated current asset value of the facility's secondary buildings and the land values of those buildings and a rental rate of 11%.[57]

Depreciated current asset value of secondary building

The depreciated current asset value of an ICF's secondary building is the current asset value of the secondary building depreciated by the product of the age of the secondary building and 1.6%.[58]

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[54] R.C. 5124.17(D).

[55] R.C. 5124.01(ZZ).

[56] R.C. 5124.17(E).

[57] R.C. 5124.17(F)(1).

[58] R.C. 5124.17(F)(2).

Current asset value of secondary building

The current asset value of an ICF's secondary building is the product of the part of the secondary building's square footage that is allocated to the facility and the secondary building's value per square foot.[59]

Value per square foot of secondary building

The value per square foot of an ICF's secondary building is to be determined using the most recent national average commercial cost estimate for office/warehouse buildings according to information available at www.buildingjournal.com on the last day of the applicable cost report year. If that cost estimate ceases to be available at that website, the value per square foot is to be determined using the most recent comparable cost estimate that the ODODD Director is to specify in rules.[60]

Age of secondary building

The age of an ICF's secondary building is the lesser of the following:

(1) The difference of the calendar year in which occurs the last day of the period covered by the cost report being used to determine the facility's Medicaid rate and the calendar year the secondary building was initially constructed;

(2) 40.[61]

Land value of secondary building

The land value of an ICF's secondary building is the product of the current asset value of the ICF's secondary building and 10%.[62]

Limit on part of the capital component rate

The act requires ODODD to determine a limit on a part of the capital component rate for each ICF for each fiscal year. The part that is subject to the limit is the sum of a facility's per diem fair rental value rate, equipment rate, and secondary building rate. If that sum exceeds the limit determined for an ICF, the part of the facility's capital component rate that is subject to the limit must be reduced to the limit. The limit does

[59] R.C. 5124.17(F)(3).

[60] R.C. 5124.17(F)(4).

[61] R.C. 5124.17(F)(5).

[62] R.C. 5124.17(F)(6).

not affect the other part of a facility's capital component rate (the per diem nonextensive renovation rate). An ICF's limit for a fiscal year is to be the sum of three amounts.[63]

The first amount of an ICF's limit is the quotient of its desk-reviewed, actual, allowable capital costs for the applicable cost report year and the number of its inpatient days for that year or the number of inpatient days it would have had that year if its occupancy rate had been 92%, whichever is greater.[64]

The second amount of an ICF's limit is the following:

- $3 if the ICF is in peer group 1-A or 2-A.
- $5 if the ICF is in peer group 3-A, 4-A, or 5-A.[65]

The third amount of an ICF's limit is the greater of zero and 10% of the difference of the following:

- The sum of the first amount of the limit and the applicable amount of the second amount; and
- The sum of the ICF's per diem fair rental value rate, equipment rate, and secondary building rate.[66]

Direct care costs component under the new formula

An ICF's per Medicaid day rate for the direct care costs component of its total rate for a fiscal year under the new formula is to be determined as follows:

(1) Determine the product of the following:

- The lesser of the ICF's cost per case-mix unit for the applicable cost report year and the maximum cost per case-mix unit for the ICF's peer group for the fiscal year for which the rate is determined (see "**Cost per case-mix units**" below);

[63] R.C. 5124.17(G).

[64] R.C. 5124.17(G)(1).

[65] R.C. 5124.17(G)(2).

[66] R.C. 5124.17(G)(3).

- The ICF's quarterly case-mix score for the calendar quarter ending December 31, 2017 (in the case of the rate determined for FY 2019) or the calendar quarter ending on March 31 of the calendar year in which the fiscal year begins (in the case of the rate determined for subsequent fiscal years). (See "**Case-mix scores**" below.)[67] However, if ODODD accepts a cost report by a downsized ICF or partially converted ICF (see "**Important terms**" below) under a provision of continuing law that enables a facility's Medicaid rate to be revised sooner than it otherwise would, the facility's case-mix score in effect on the last day of the calendar quarter that ends during the period the cost report covers (or, if more than one calendar quarter ends during that period, the last of those calendar quarters) is to be used for this calculation.[68]

(2) Adjust the product determined under (1) by an estimated inflation rate. (See "**Estimated inflation rate**" below.)

Cost per case-mix units

ICF specific cost per case-mix unit

An ICF's cost per case-mix unit for a cost report year is to be determined by dividing the facility's desk-reviewed, actual, allowable, per diem direct care costs for that year by its annual average case-mix score for the fiscal year for which the rate is determined. (See "**Case-mix scores**" below.)[69]

Maximum cost per case-mix unit for each peer group

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:

(1) For peer group 1-A, 16%;

(2) For peer group 2-A, 14%;

(3) For peer group 3-A, 18%;

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[67] R.C. 5124.19(A).

[68] R.C. 5124.101(F)(1).

[69] R.C. 5124.19(B).

(4) For peer group 4-A, 22%.[70]

The maximum cost per case-mix unit for peer group 5-A for a fiscal year is the 95th percentile of all ICFs in that peer group for the applicable cost report year.[71]

In determining the maximum cost per case-mix unit for a peer group (other than peer group 5-A), ODODD is required to exclude from its determination the cost per case-mix unit of any ICF in the peer group that participated in Medicaid under the same provider for less than 12 months during the applicable cost report year. In determining the maximum cost per case-mix unit for a peer group (including peer group 5-A), ODODD must exclude from its determination the cost per case-mix unit of any ICF in the peer group that has a case-mix score that was assigned by ODODD.[72]

The act prohibits ODODD from resetting a peer group's maximum cost per case-mix unit for a fiscal year based on additional information it receives after it sets the maximum for that fiscal year. ODODD is required to reset a peer group's maximum cost per case-mix unit for a fiscal year only if it made an error in setting the maximum for that fiscal year based on information available to it at the time it originally sets the maximum for that fiscal year.[73]

Estimated inflation rate

For the inflation adjustment that is part of determining an ICF's rate for direct care costs, ODODD must estimate the inflation rate for the 18-month period beginning July 1 of the applicable cost report year and ending December 31 of the fiscal year for which the rate is determined. In estimating the inflation rate, ODODD must use Employment Cost Index for Total Compensation, Health Care and Social Assistance Component, published by the U.S. Bureau of Labor Statistics. However, if that index ceases to be published, ODODD is to use an index that the Bureau subsequently publishes that covers the staff costs of ICFs.[74]

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[70] R.C. 5124.19(C)(1).

[71] R.C. 5124.19(C)(2).

[72] R.C. 5124.19(C)(3) and (4).

[73] R.C. 5124.19(C)(5).

[74] R.C. 5124.19(D).

Case-mix scores

ICFs' case-mix scores

The act requires ODODD to determine a case-mix score for each ICF for each calendar quarter. A quarterly case-mix score is to be determined using (1) the most recent (as of the date the determination is made) resident assessment data compiled and revised for the ICF's residents (including residents on hospital or therapeutic leave) and (2) the case-mix scores of the ICF's residents. (See "**Residents' case-mix scores**" below.) ODODD also is required to determine an annual average case-mix score for each facility after the end of each calendar year. An ICF's quarterly case-mix scores for a calendar year are to be used to determine its annual average case-mix score.[75]

ODODD, for one or more months of a calendar quarter, may assign to an ICF a case-mix score that is 5% less than the ICF's case-mix score as of the date preceding the day on which the reduction takes effect if the facility does not timely revise assessment data used in determining a resident's case-mix score or attest that there are no changes in the resident's assessment data. (See "**Residents' case-mix scores**" below.) Before assigning a case-mix score to a facility, ODODD must permit the facility to revise the assessment data or make the attestation. ODODD is permitted to assign the case-mix score if the facility fails to do this not later than 45 days after the end of the calendar quarter for which the assessment data was to be revised or attestation was to be made or a later date the ODODD Director is authorized to specify in rules. When assigning a case-mix score, ODODD must follow the Director's rules. ODODD is prohibited from taking an action that affects Medicaid rates for prior payment periods except as authorized by continuing law governing redetermination of rates due to revised information and imposition of certain penalties.[76]

The Director must adopt rules as necessary to implement these provisions.[77]

Residents' case-mix scores

The act requires ODODD to assess each ICF resident (including each resident on hospital or therapeutic leave) regardless of payment source and compile complete assessment data on the residents. Assessments are to be performed in accordance with rules the ODODD Director is to adopt. ODODD must perform the initial assessment of

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[75] R.C. 5124.193(A).

[76] R.C. 5124.193(B).

[77] R.C. 5124.193(C).

an ICF resident and may perform a subsequent assessment of a resident under any of the following circumstances:

(1) The facility in which the resident resides or from which the resident is on hospital or therapeutic leave has submitted revised assessment data for the resident or an attestation of no changes in the resident's assessment data and ODODD has reason to believe that the revised assessment or attestation is inaccurate.

(2) ODODD has reason to believe that the resident's most recent assessment no longer accurately reflects the resident's condition.

(3) ODODD determines that the resident's most recent assessment should be updated because of the passage of time since that assessment was performed.[78]

If an ICF disagrees with the results of an assessment, it may request that ODODD reconsider the results in accordance with rules.[79]

Not later than 15 days after the end of each calendar quarter, an ICF must submit to ODODD (1) revised assessment data for each of its residents for whom there are changes in the resident's assessment data and (2) an attestation for each of its residents for whom there are no such changes. The revised assessment data and attestation must be submitted in a manner to be specified in rules.[80]

A resident assessment instrument to be specified in rules is to be used to compile or revise resident assessment data. The resident assessment instrument may be different from the resident assessment instrument used in determining ICFs' rates for direct care costs under the old formula.[81]

ODODD must establish six acuity groups for assigning case-mix scores to ICF residents. A resident's case-mix score is to be the score of the resident's acuity group as to be specified in rules.[82] ODODD must place each resident into one of the acuity groups. In determining which acuity group a resident is to be placed into, ODODD must:

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[78] R.C. 5124.191(A) and (B).

[79] R.C. 5124.191(C).

[80] R.C. 5124.191(D).

[81] R.C. 5124.191(E) and 5124.196.

[82] R.C. 5124.192(A).

(1) In accordance with rules to be adopted and using the most recent resident assessment data for the resident available to it, calculate for the resident an assessment score for each of the medical, behavioral, and adaptive skills domains on the resident assessment instrument used to compile or revise residents' assessment data;

(2) For each of the resident's domain assessment scores and using values to be specified in rules, assign the following points:

- If the resident's assessment score for the domain is more than one standard deviation above the mean assessment score for the domain for all residents as of December 31, 2017, one point.
- If the resident's assessment score is between one-half and one standard deviation above that mean, two points.
- If the resident's assessment score for the domain is between the mean and one-half standard deviation above the mean, three points.
- If the resident's assessment score for the domain is between the mean and one-half standard deviation below that mean, four points.
- If the resident's assessment score for the domain is between one-half and one standard deviation below the mean five points.
- If the resident's assessment score for the domain is more than one standard deviation below the mean, six points.

(3) Using the following weights, determine the weighted sum of the points assigned under (2) and round the weighted sum down to the nearest whole number:

- Points assigned to the resident's assessment score for the medical domain are to be weighted at 35%.
- Points assigned for the behavioral domain are to be weighted at 30%.
- Points assigned for the adaptive skills domain are to be weighted at 35%.

(4) Place the resident into the following acuity group based on the number of the resident's weighted sum determined under (3):

- For 5 or fewer points, group one.
- For 6 to 8 points, group two.

- For 9 or 10 points, group three.
- For 11 or 12 points, group four.
- For 13 to 15 points, group five.
- For 16 or more points, group six.[83]

The ODODD Director must adopt rules as necessary to implement the act's provisions regarding the acuity groups, including rules that (1) specify the case-mix scores for each acuity group, (2) prescribe a methodology for calculating assessment scores for the medical, behavioral, and adaptive skills domains on the resident assessment instrument used to compile and revise residents' assessment data, and (3) specify values to be used in assigning points to domain assessment scores. The case-mix scores specified for an acuity group must be based on relative resources used by residents who are placed in the group and were included in a time study of residents performed by ODODD.[84]

Rate reconsideration process

Continuing law requires the ODODD Director to establish a process under which ICFs may seek reconsideration of their Medicaid rates. The act provides that if a facility submits revised assessment data for a resident and the revised assessment data results in at least a 15% increase in the facility's case mix score, the facility may request that ODODD, through the rate reconsideration process, increase its rate for the direct care costs component to account for the increase. If ODODD determines that the revised assessment data so increases the facility's case-mix score, ODODD must grant the rate increase. The increase is to go into effect one month after the first day of the month after ODODD receives sufficient documentation to determine the amount of the increase.[85]

Conditions on making certain changes regarding case-mix scores

The act prohibits ODODD from making changes to either of the following unless certain conditions are met: (1) its instructions or guidelines for the resident assessment instrument to be used in compiling and revising assessment data of ICF residents and (2) the methodology for calculating assessment scores for the medical, behavioral, and

[83] R.C. 5124.192(B).

[84] R.C. 5124.192(C).

[85] R.C. 5124.38(E).

adaptive skills domains on the resident assessment instrument. The following are the conditions that must be met:

(1) The changes must be applied prospectively.

(2) ODODD must first notify all ICFs of the proposed changes.

(3) ODODD must first provide representatives of ICFs an opportunity to provide their concerns about, and suggestions to revise, the proposed changes.

(4) In the case of a change to the methodology for calculating assessment scores for the domains, ODODD must first determine that the proposed change is consistent with documentation of ICF staff time that was used to validate the methodology.[86]

Indirect care costs component under the new formula

An ICF's per Medicaid day rate for the indirect care costs component of its total rate for a fiscal year under the new formula is to be the lesser of an individual rate determined for the facility and the maximum rate determined for its peer group.[87]

An ICF's individual rate is to be the sum of (1) its desk-reviewed, actual, allowable, per diem indirect care costs for the applicable cost report year, adjusted for inflation and (2) an efficiency incentive equal to the difference between the amount of its per diem indirect care costs and the maximum rate for its peer group.[88] An ICF's efficiency incentive cannot exceed a certain percentage of the maximum rate for its peer group. If the ICF is in peer group 1-A, the percentage cap is 5%. If the ICF is in any other peer group, the percentage cap is 6%.[89] When adjusting the ICF's per diem indirect care costs for inflation, ODODD must estimate the rate of inflation for the 18-month period beginning July 1 of the applicable cost report year and ending on December 31 of the fiscal year for which the facility's rate is being determined. To estimate the rate of inflation, ODODD is to use the Consumer Price Index for all items for all urban consumers for the Midwest region, published by the U.S. Bureau of Labor Statistics.

[86] R.C. 5124.194.

[87] R.C. 5124.21(A).

[88] R.C. 5124.21(B).

[89] R.C. 5124.21(D).

However, if that index ceases to be published, ODODD is to use a comparable index that the Bureau publishes and ODODD determines is appropriate.[90]

The maximum rate for an ICF's peer group is to be a certain percentage above the peer group's median per diem indirect care costs for the applicable cost report year.

- If the ICF is in peer group 1-A, the percentage cap is 8%.
- If the ICF is in peer group 2-A or 3-A, 10%.
- If the ICF is in peer group 4-A or 5-A, 12%.

ODODD is prohibited from redetermining a peer group's maximum rate based on additional information it receives after the maximum rate is set. ODODD is to redetermine a peer group's maximum rate only if it made an error in computing the maximum rate based on information available to it at the time of the original calculation.[91]

Other protected costs component under the new formula

An ICF's per Medicaid day rate for the other protected costs component of its total rate for a fiscal year under the new formula is to be its desk-reviewed, actual, allowable, per diem other protected costs from the applicable cost report year, adjusted for inflation. The inflation adjustment is to be made using the Consumer Price Index for all urban consumers for nonprescription drugs and medical supplies published by the U.S. Bureau of Labor Statistics. However, if that index ceases to be published, ODODD is to use the index that is subsequently published by the Bureau that covers nonprescription drugs and medical supplies.[92]

Quality incentive payment under the new formula

Quality indicators

Beginning with FY 2021, ICFs may earn a quality incentive payment as part of their total Medicaid rate. To earn a quality incentive payment, a facility would have to be awarded by ODODD at least one point for meeting the following quality indicators:

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[90] R.C. 5124.21(E).

[91] R.C. 5124.21(C).

[92] R.C. 5124.23.

(1) The facility created and promoted diverse opportunities for its residents to participate in the broader community in the applicable cost report year.

(2) It offers multiple opportunities for off-site day programming activities, including resident-specific activities.

(3) All residents who are at least 18 years old and interested in employment have an identified place on ODODD's Path to Community Employment program.

(4) It has an active advocacy group that is driven by its residents or fosters its residents' participation in a community-wide group.

(5) Its bedrooms are designed and arranged to enhance privacy, promote personalization, and meet its residents' needs, and the facility encourages residents to bring their own home and room décor.

(6) It has and follows a policy specifying how it seeks direction from its residents.

(7) It has a policy for (a) evaluating each hospital emergency department visit by its residents to identify precipitating factors that led to the visit and (b) developing a plan to mitigate any identified precipitating factors.

(8) It has adopted the recommendations for resident health screening published on ODODD's website.

(9) Each month, it offers at least the number of wellness and fitness activities specified in rules by the ODODD Director.

(10) The number of its staff who were trained in positive behavior support strategies, trauma-informed care, and similar topics in the applicable cost report year is at least the number specified in rules by the Director.

(11) Members of its staff are involved in orienting and mentoring new staff.

(12) Its ratio of direct care staff to residents is at least the ratio specified in rules by the Director.

(13) Its direct care staff retention percentage is at least the percentage specified in rules by the Director.[93]

[93] R.C. 5124.24(A) and (B).

Amount of quality incentive payment

An ICF's per Medicaid day quality incentive payment for a fiscal year is to be the product of (1) the relative weight point value for the fiscal year and (2) the number of points the facility was awarded for meeting quality indicators for the fiscal year.[94] The relative weight point value for a fiscal year is to be determined as follows:

(1) For each ICF, determine the product of (a) the number of inpatient days the facility had for the applicable cost report year and (b) the number of points it was awarded for the fiscal year.

(2) Determine the sum of all of the products determined under (1) for the fiscal year.

(3) Determine 3.04% of the total desk-reviewed, actual, allowable direct care costs of all ICFs for the applicable cost report year.

(4) Divide the amount determined under (3) by the sum determined under (2).[95]

Rules

The act requires the ODODD Director to adopt rules as necessary to implement the quality incentive payments, including rules that specify or establish:

(1) The data needed for ODODD to determine whether an ICF meets the quality indicators and how and when a report of the data is to be submitted;

(2) Satisfactory evidence needed to determine that an ICF has met the quality indicators;

(3) The method by which ICFs are to be awarded points for meeting quality indicators and the number of points that each quality indicator is worth based on the indicator's relative importance compared to the other indicators.[96]

Pilot program

The act permits ODODD to establish a pilot program that (1) requires ICFs to submit data regarding their ability to meet proposed quality indicators during the last

[94] R.C. 5124.24(C).

[95] R.C. 5124.24(D).

[96] R.C. 5124.24(E).

six months of calendar year 2018 and (2) provides for ICFs that submit the data to receive an incentive payment in the form of an add-on to their total Medicaid rates for ICF services provided during FY 2020. An incentive payment add-on is not to be part of a facility's total per Medicaid day rate.[97]

Limits on compensation of ICF administrators

Continuing law permits ODODD to place limits on ICFs' reasonable costs for compensation paid to owners, relatives of owners, and facility administrators. Existing law, partly amended by the act, requires that costs limits for administrators of four or more facilities be the same as the limits for administrators of facilities with 150 or more beds. The act maintains this requirement for Medicaid rates determined under the old formula but does not apply it to the new formula.[98]

Elimination of adjustments to the rate determined under the new formula

The act repeals a requirement that ODODD adjust the FY 2019 Medicaid rate determined for ICFs under the new formula in certain circumstances. First, if the mean of the FY 2019 per Medicaid day total rate for ICFs was other than a target amount, ODODD was required to adjust the rate paid to ICFs by the percentage by which the mean was greater or less than the target amount. The target amount could not exceed $295.90. Second, ODODD also was required to reduce the amount it paid ICFs for FY 2019 if the federal government required that a franchise permit fee imposed on ICFs be reduced or eliminated. The rate reduction was to reflect the loss of the state and federal revenue generated from the franchise permit fee.[99]

Initial rate for new ICFs

There is a different process for determining the initial Medicaid rates for new ICFs (see "**Important terms**" below). Previously, the initial rate of a new ICF (other than one in peer group 3, renamed peer group 3-B) was determined using a combination of modifications to the old formula and certain median or maximum values determined for other ICFs under the old formula. The modification applies to the determination of the initial rate for capital costs; a new ICF's initial rate for capital costs was determined using its actual inpatient days or an imputed occupancy rate of 80%. The initial rate for a new ICF in peer group 3 was the sum of certain dollar amounts specified in prior law.

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[97] Section 10.

[98] R.C. 5124.29.

[99] Section 9 (repealing Section 261.169 of Am. Sub. H.B. 49 of the 132nd General Assembly).

Under the act, the initial rate for a new ICF is determined in much the same way, except that the new formula is to be used to determine the median and maximum values. A new ICF's initial capital component rate is to be the median capital component rate for its peer group. The initial rate for a new ICF in peer group 5-A is to be the sum of the same dollar amounts specified in prior law for peer group 3.[100]

Prior law required that certain modifications be made when determining a new ICF's initial Medicaid rate for FY 2019, other than a new ICF in peer group 3. For example, a new ICF's initial rate was to include a direct support personnel payment in an amount equal to the median direct support personnel payment made to other ICFs. The act eliminates the modifications.[101]

Reconsideration of new case-mix score following exception review

ODODD is permitted under continuing law to conduct an exception review of resident assessment data submitted by a facility as part of the process of determining the facility's Medicaid rate under the old formula. If an exception review is conducted before the effective date of an ICF's rate for direct care costs and the review results in findings that exceed tolerance levels, ODODD may use (1) the findings to redetermine individual case-mix scores, the facility's case-mix score for a quarter, and the facility's annual average case-mix score and (2) the redetermined case-mix scores to determine the facility's rate for direct care costs for the appropriate calendar quarter or quarters. The act permits an ICF, if it disagrees with a redetermination, to request ODODD to reconsider the redetermination in accordance with rules the ODODD Director is to adopt. If ODODD reconsiders the redetermination and revises the ICF's quarterly or annual average case-mix score, ODODD must use the revised score to determine the ICF's rate for direct care costs.[102]

The act does not provide for exception reviews to be conducted under the new formula. Therefore, this provision does not affect rates determined under the new formula and becomes obsolete on July 1, 2021.[103]

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[100] R.C. 5124.151.

[101] Sections 7 and 8 (amending Section 261.168 of Am. Sub. H.B. 49 of the 132nd General Assembly).

[102] R.C. 5124.198(B)(2).

[103] R.C. 5124.198(E).

Elimination of capped rate for ICF services to certain residents

The act eliminates a cap that prior law placed on the Medicaid rate for services that ICFs in peer group 1 (renamed peer group 1-B) provided to Medicaid recipients who were admitted on or after July 1, 2015, and placed in the chronic behaviors and typical adaptive needs classification or the typical adaptive needs and nonsignificant behaviors classification. Under the cap, the total per Medicaid day rate could not exceed $206.90 (for services provided to recipients in the chronic behaviors and typical adaptive needs classification) or $174.88 (for services provided to recipients in the typical adaptive needs and nonsignificant behaviors classification).[104]

Adjustments to rates determined under the old formula

Continuing law requires ODODD to make certain modifications to the old formula when determining FY 2019 Medicaid rates for ICFs in peer groups 1 and 2 (renamed peer groups 1-B and 2-B). For example, an ICF's efficiency incentive for capital costs must be reduced by 50% and, after all of the other modifications are made, an ICF's per Medicaid day total rate is to be increased by a direct support personnel payment equal to 3.04% of the facility's desk-reviewed, actual, allowable, per Medicaid day direct care costs from calendar year 2017. The act requires that these modifications also be made for FYs 2020 and 2021 (the last two years for which rate determinations are to be made using the old formula). A facility's direct support personnel payment for FYs 2020 and 2021 is to be based on its direct care costs from calendar years 2018 and 2019, respectively.[105]

In addition to the modifications to the old formula, continuing law requires ODODD to adjust, for FY 2019, the total per Medicaid day rate for all ICFs in peer groups 1 and 2 if the mean total rate for those facilities is other than a target amount. The target amount is $290.10 or, at ODODD's sole discretion, a larger amount. If an adjustment is to be made, it must equal the percentage by which the mean total per Medicaid day rate is greater or less than the target amount. The act applies this adjustment requirement to FYs 2020 and 2021 also.[106]

The act eliminates a requirement that ODODD reduce the amount it pays ICFs for FY 2019 if the federal government requires that a franchise permit fee imposed on

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[104] R.C. 5124.155 (repealed).

[105] R.C. 5124.15(C)(5) and Sections 7 and 8 (amending Section 261.168 of Am. Sub. H.B. 49 of the 132nd General Assembly).

[106] Sections 7 and 8 (amending Section 261.168(E) of Am. Sub. H.B. 49 of the 132nd General Assembly).

ICFs be reduced or eliminated. The reduction would have had to be an amount that reflects the loss of the state and federal revenue from the franchise permit fee.[107]

General Assembly's intent about the old formula

The act states the General Assembly's intent to enact legislation that goes into effect on or after July 1, 2021, and does both of the following:

(1) Repeals Revised Code sections that concern the old ICF rate formula, which the act makes obsolete on that date; and

(2) Amends other Revised Code sections as necessary to reflect the repeals.[108]

Effective date

The act's ICF-related changes take effect July 1, 2018.[109]

Important terms

Several terms are used repeatedly in the new and, in many cases, old formulas. The following explains what many of those terms mean.

Addition

An addition is an increase in an ICF's square footage.[110]

Cost report year

A cost report year is the calendar year preceding the calendar year in which a fiscal year for which a Medicaid rate determination is made begins. However, a cost report year is a shorter period for a downsized ICF, partially converted ICF, or new ICF for which ODODD accepts a cost report that covers, generally, three months. In that case, a cost report year is the period that the cost report covers.[111]

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[107] Sections 7 and 8 (amending Section 261.168(G) of Am. Sub. H.B. 49 of the 132nd General Assembly).

[108] Section 11.

[109] Section 12.

[110] R.C. 5124.01(A).

[111] R.C. 5124.01(H).

Desk-reviewed

An ICF's costs as reported on a cost report that undergoes a desk review by ODODD for a preliminary determination of whether the costs are allowable.[112]

Downsized ICF

A downsized ICF is one that permanently reduced its Medicaid-certified capacity pursuant to a plan approved by ODODD.[113]

Inpatient days

An ICF's inpatient days are the sum of (1) all days during which a resident, regardless of payment source, occupies a bed in the facility that is included in its Medicaid-certified capacity and (2) all days for which ODODD pays the facility to reserve a bed for a Medicaid recipient temporarily absent.[114]

Medicaid days

An ICF's Medicaid days are the sum of (1) all days during which a resident who is a Medicaid recipient eligible for ICF services occupies a bed that is included in the facility's Medicaid-certified capacity and (2) all days for which ODODD pays the facility to reserve a bed for a Medicaid recipient temporarily absent.[115]

New ICF

A new ICF is one that obtains an initial Medicaid provider agreement following the Director of Health's certification of the ICF, including such an ICF that replaces one or more ICFs for which the provider previously held a Medicaid provider agreement. Neither a downsized ICF nor a partially converted ICF is a new ICF. An ICF that undergoes a change of operator is not a new ICF.[116]

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[112] R.C. 5124.01(L).

[113] R.C. 5124.01(O).

[114] R.C. 5124.01(CC).

[115] R.C. 5124.01(HH).

[116] R.C. 5124.01(II).

Partially converted ICF

A partially converted ICF is one that converted some, but not all, of its beds to providing home and community-based services under the Individual Options Medicaid waiver program.[117]

NEOMED, Cleveland State, and OU Medical School partnership

The act permits the Ohio University Heritage College of Osteopathic Medicine to join the partnership between the Northeast Ohio Medical University (NEOMED) and Cleveland State University. It permits OU's Heritage College to admit and enroll a portion of the Cleveland State students provided for under the partnership.[118]

Under continuing law, NEOMED and Cleveland State University may establish a NEOMED campus at Cleveland State University whereby 50% or more of the medical curriculum taught to students under the partnership is based in Cleveland.[119]

Ohio State University land conveyance

The act authorizes the conveyance of real estate located in Franklin County under the jurisdiction of the Ohio State University, via purchase agreement at a price acceptable to the university's Board of Trustees. The real estate is located near the OSU Airport in the northwest area of Columbus. It may be sold to the City of Columbus until July 31, 2018. If the university and Columbus do not enter into a purchase agreement by that date, the real estate may be sold to one or more purchasers as an entire tract or in multiple tracts. The net proceeds must be deposited into university accounts for purposes determined by the Board of Trustees. The conveyance authority expires March 30, 2023.

The real estate must be conveyed in "as-is, where-is, with-all-faults" condition. The conveyance includes improvements situated on the real estate and is subject to all easements, covenants, conditions, and restrictions of record; all legal highways and public rights-of-way; zoning, building, and other laws, ordinances, restrictions, and regulations; and real estate taxes and assessments not yet due and payable. The deed may contain restrictions, exceptions, reservations, reversionary interests, and other terms and conditions specified in the purchase agreement or the resolution adopted by the Board of Trustees approving the sale.

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[117] R.C. 5124.01(NN).

[118] R.C. 3350.15(B).

[119] R.C. 3350.15(A).

Costs associated with the purchase, conveyance, and closing are to be paid pursuant to the purchase agreement. After the conveyance, the state or the university may release terms and conditions without further legislation. The deed must be executed by the Governor in the name of the state, countersigned by the Secretary of State, sealed with the Great Seal of the State, presented in the Office of the Auditor of State for recording, and delivered to the purchaser. The purchaser must present the deed for recording in the Office of the Franklin County Recorder.[120]

HISTORY

ACTION	DATE
Introduced	02-01-17
Reported, H. Ways & Means	06-20-17
Passed House (97-0)	10-11-17
Reported, S. Ways & Means	02-28-18
Recommitted, S. Ways & Means	03-13-18
Re-reported, S. Ways & Means	03-21-18
Passed Senate (33-0)	03-21-18
House concurred in Senate amendments (90-1)	03-21-18

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[120] Section 13.