February 21, 2025

To: Ohio Congressional Delegation

From: Ohio Developmental Disabilities Coalition

**RE: The Critical Role of Medicaid in Supporting Ohioans with Developmental Disabilities**

Dear Member of Ohio Congressional Delegation,

On behalf of the Ohio Developmental Disabilities Coalition, we write to urge your continued commitment to protecting and strengthening Medicaid for people with intellectual and developmental disabilities (I/DD) in Ohio. Medicaid is the foundation of our state's disability service system, providing essential supports across the lifespan—from respite care that helps families keep their children at home, to employment services that promote independence, to the comprehensive care provided in Intermediate Care Facilities (ICFs) for individuals with significant medical and behavioral needs.

The Ohio Developmental Disabilities Coalition is a broad partnership of organizations representing people with disabilities, their families, direct support professionals, providers, and county boards of developmental disabilities. Collectively, we serve and advocate for the more than **100,000 Ohioans with I/DD who rely on Medicaid-funded services every day.**

Medicaid is not just a healthcare program—it is a **lifeline** that makes inclusion, independence, and community participation possible. It funds vital supports such as:

- **Home and Community-Based Services (HCBS),** allowing individuals to live in their own homes rather than institutions.
- **Employment and day services,** helping people with disabilities find meaningful work and contribute to their communities.
- **Respite and family support services,** providing relief to caregivers so families can continue supporting their loved ones at home.
- **Intermediate Care Facilities (ICFs),** which provide comprehensive, 24-hour care for individuals with complex medical and behavioral support needs.

Any cuts or structural changes that reduce access to these critical supports would have **devastating consequences for individuals with disabilities, their families, and the workforce that supports them.**

We urge you to:

1. **Protect and strengthen Medicaid funding** to ensure continued access to essential services.
2. **Oppose any proposed cuts to Medicaid Long-term Services and Supports** and **Home- and Community-Based Services** for people with I/DD.
3. **Reject any efforts to cap, block grant, or reduce federal Medicaid funding,** which would shift costs to states and put services at risk.

Ohioans with disabilities and their families are counting on you. We welcome the opportunity to discuss how we can work together to sustain and improve these critical services. Please do not hesitate to reach out to any of the coalition members listed below.

Thank you for your leadership and support.

Sincerely,

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March 3, 2025

**The Honorable Jon Husted**
United States Senate
SR-198 Senate Office Building
Washington, DC 20510

**The Honorable Bernie Moreno**
United States Senate
SR-B33 Russell Senate Office Building
Washington, DC 20510

**Dear Senators Husted and Moreno,**

On behalf of the Ohio Provider Resource Association (OPRA) and our members across the state, I want to introduce you to Ohio's provider community and extend our willingness to work together in **strengthening and protecting Medicaid-funded services for Ohioans with intellectual and developmental disabilities** (I/DD).

OPRA is a statewide organization dedicated to supporting, strengthening, and advocating for Ohio's providers of I/DD services. For more than 50 years, we have worked alongside state and federal policymakers to build a high-quality, person-centered service system that helps individuals with disabilities live, work, and thrive in their communities. Today, OPRA represents **over 200 businesses** that **employ more than 30,000 Ohioans**, **serving over 40,000 individuals** in **all 88 counties**. The people we support depend on Medicaid-funded services to access employment, transportation, housing, healthcare, and community activities—allowing them to fully participate in the Ohio economy and society.

OPRA recognizes the importance of fiscal responsibility and supports efforts to improve efficiency and accountability within Medicaid. We are concerned that the House's Budget Blueprint could result in dramatic cuts to Medicaid. While intended to address fraud, waste, and abuse, these reductions could have **unintended consequences that impact the individuals and families who rely on these critical services**, as well as the providers working to deliver them. While we fully support efforts to improve program integrity, it is

essential that any changes do not disrupt essential care or create barriers to services that support independence and inclusion for Ohioans with disabilities.

OPRA and our members are committed to working with you and your colleagues to find ways to strengthen Medicaid by improving efficiency, reducing administrative burdens, and ensuring that dollars are spent effectively to provide the highest quality services. We believe there are opportunities to streamline regulations and address challenges that drive up costs without compromising care. We welcome the opportunity to be part of these conversations and to share insights from Ohio's provider community about what works—and what does not—in the current system.

We would greatly appreciate the opportunity to meet with you or your staff to discuss these issues further. **Our team will be in Washington, D.C., on March 24 and 25**, and we would love the chance to connect. Please feel free to reach out to Pete Moore, OPRA's President & CEO, at pmoore@opra.org or 614.398.8353 to coordinate a meeting or discuss how we can collaborate.

Thank you for your time and your commitment to serving the people of Ohio. We look forward to working with you to protect and strengthen Medicaid-funded services for Ohioans with disabilities and their families.

Sincerely,

Peter Moore, President & CEO
Ohio Provider Resource Association (OPRA)

Adam Guinther, Board ChairOhio Provider Resource Association (OPRA)

## Helping Children with Medical Complexity Transition from Hospitals to More Appropriate Care Settings

### The Challenge:

Right now, children who are medically ready to leave Ohio's children's hospitals are stuck—**not because they need to be in a hospital, but because there aren't enough nurses and respiratory therapists available to care for them at home**. Some of these children **do not have a family home to return to** and are in the custody of **Job and Family Services (JFS)**. These delays put children at **increased risk of hospital-acquired infections and medical complications** while driving up Medicaid costs unnecessarily.

For example, in 2022, Cincinnati Children's medically complex patients experienced a combined total of **3,952 avoidable inpatient days** due to the lack of access to home and community nursing services. These avoidable hospital stays cost Ohio Medicaid and other insurers an estimated **$22.5 million** for Cincinnati Children's patients alone in 2022.

### The Solution:

A more appropriate, **cost-effective** alternative exists: **step-down facilities, such as Intermediate Care Facilities (ICFs),** that can meet these children's ongoing medical needs, provide necessary therapies, and, in some cases, even **wean them off ventilators**.

While **long-term goals** should focus on **building the capacity of community-based nurses, respiratory therapists, trained family caregivers, and medical foster homes**, **we need a solution now** for children who are ready to leave the hospital today.

### Key Facts & Urgency:

- **The Cost to Medicaid:**
  - Children's hospital stay: **$6,000 per day**
  - Intermediate Care Facility: **$1,500 per day**
  - **Potential savings of $4,500 per day per child** while ensuring more appropriate care.
- **Health & Safety Risks:**
  - Hospitals are not designed for long-term stays—**prolonged hospitalization increases the risk of infections and medical decompensation**.
  - Hospitals also **need to free up beds** for children who require acute care.
- **Beds Are Available—They Just Need to Be Used:**
  - **Ohio already has ICF beds available, controlled by DODD**. These beds must be **released to providers** rather than kept "on the shelf."
  - **Capital funding may be needed** to expand capacity for children with medical complexities, including those beyond ventilator support.

## What's Needed Now:

- **Licenses.** DODD should **release ICF beds for immediate use** to Ohio's five providers who qualify for the ventilator add-on. This could be achieved through **budget language** to ensure more children can transition out of hospitals.
- **Capital Investment.** Targeted funding is needed to **expand medical step-down capacity** for children with complex needs. Ohio's five ICF providers estimate they could **serve 54 additional children statewide** if this investment were available.
- **Respite.** The **vent add-on must apply to respite** to support continuity of services. Current policy gaps limit providers' ability to care for children in respite situations – a service families need to support keeping their children at home.
- **Policy Alignment.** ICF rules should **reflect the realities of pediatric care.** For example, young children in hospitals routinely share rooms, but **ICF rules prevent a baby boy and baby girl on ventilators from rooming together**, leaving available beds empty.
- **Capacity Building.** While step-down facilities are an urgent solution, **long-term efforts must continue** to strengthen home and community-based care options so more children can safely return to family or foster homes.

## The Bottom Line:

Children's hospitals, providers, and families **all agree**—keeping children in hospitals when they don't need to be there **harms kids and drives up costs**. Ohio must take **action now** to ensure children with medical complexity get the right care in the right setting **without unnecessary delays**.

# House Bill 96: State Budget
# DD System Efficiency & Improvement Amendment (HC1236)

## What's the Issue?

Ohio's developmental disabilities providers face significant administrative burdens that increase costs without improving services, outcomes, or quality. A recent DODD survey found that, at the median**, providers had $700,000 in unreimbursed costs annually**, much of which is tied to outdated policies, excessive documentation, and redundant compliance requirements.

This amendment **streamlines processes** to **improve efficiency**, **reduce administrative waste**, and **focus resources on the people receiving services**.

## Why This Matters

Excessive Costs Without Benefit to People Served

- **Billing & Documentation Burdens:** Unnecessary 15-minute billing requirements force providers to spend thousands of hours on paperwork instead of direct support.
- **Misplaced Focus in Compliance:** By focusing on isolated, minor issues with providers already in good standing (e.g., those with national accreditation), resources are wasted on low-impact concerns, rather than addressing systemic issues or identifying real risks to quality and safety.
- **Employment & Community Access:**
    - Burdensome logging rules discourage providers from offering **transportation**, reducing routes and limiting access—despite transportation being the top barrier to employment and community life.
    - Outdated policies restrict **Group Employment Services** and limit people's ability to sell what they create, reducing independence.
    - Confusion over **provider-owned businesses** has unnecessarily blocked job training opportunities.

## What We're Asking For

This amendment provides **a cost-saving, common-sense solution** that:

- **Reduces unnecessary administrative costs**—freeing up Medicaid dollars for direct services.
- **Eliminates outdated rules that waste provider resources without improving care**.
- Improves **system efficiency** while maintaining accountability and service quality.
- **Ensures Medicaid dollars are spent where they belong—on people, not paperwork.**

**HC0387**

H. B. No. 96
As Introduced

_____ moved to amend as follows:

After line 84624, insert:

**"Sec. 5123.049.** The director of developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code governing the authorization and payment of home and community-based services and medicaid case management services. ~~The~~

(A) The rules shall provide for private providers of the services to receive one hundred per cent of the medicaid allowable payment amount and for government providers of the services to receive the federal share of the medicaid allowable payment, less the amount withheld as a fee under section 5123.0412 of the Revised Code. ~~The~~

(B) The rules shall —establish the process by which county boards of developmental disabilities shall certify and provide the nonfederal share of medicaid expenditures that the county board is required by sections 5126.059 and 5126.0510 of the Revised Code to pay. The process shall require a county board to certify that the county board has funding available at one time for two months costs for those expenditures. The process may permit a county board to certify that the county board has

funding available at one time for more than two months costs for those expenditures.

(C) The rules shall establish a mechanism to update provider rates for home and community-based services waiver programs administered by the department of developmental disabilities to reflect annual changes in the cost of providing services under those programs. In adopting rules under this division, the director shall consult with relevant stakeholders. Any rate updates established under rules adopted in accordance with this division shall be state funded and not subject to the funding mechanism established under rules adopted pursuant to division (B) of this section. The rules shall do all of the following:

(1) Specify a survey tool for collecting data on cost changes during the calendar year preceding the calendar year that precedes the calendar year in which a rate update takes effect. To the greatest extent practicable, the survey tool shall minimize the administrative burden on providers and the department by using a small number of defined cost categories that meet both of the following requirements:

(a) The categories are cost categories providers commonly track.

(b) The categories align with any federal requirements for reporting provider costs that apply to home and community-based services provided under waiver programs administered by the department.

(2) Prescribe a methodology for the department to select a representative sample of waiver program providers to complete the survey and the time and manner for selected providers to

complete the survey and submit it to the department;

(3) Provide a method for the department to analyze the data collected from the survey to determine the percentage change in costs during the calendar year covered by the survey;

(4) Specify that, beginning January 1, 2028, the uniform cost increase percentage the department determines in accordance with division (C)(3) of this section for the calendar year covered by the survey applies to rates for all home and community-based services provided under waiver programs administered by the department during the calendar year when the rate update takes effect."

In the table on line 104304, in row J, delete "$8,421,356" and insert "$8,571,356"

In the table on line 104304, in row K, delete "$1,127,127,000 $1,140,627,000" and insert "$1,151,372,743 $1,207,061,761"

In the table on line 104304, in row L, add $24,245,743 to fiscal year 2026 and add $66,584,761 to fiscal year 2027

In the table on line 104304, in row AC, delete "$3,385,530,510 $3,545,767,920" and insert "$3,428,634,053 $3,663,874,162"

In the table on line 104304, in row AD, delete "$97,000,000" and insert "$97,150,000"

In the table on line 104304, in row AF, add $43,103,543 to fiscal year 2026 and add $118,256,242 to fiscal year 2027

In the table on line 104304, in row AG, add $67,349,286 to fiscal year 2026 and add $184,841,003 to fiscal year 2027

After line 104505, insert:

**"Section 261.150.** LEGISLATIVE INTENT REGARDING HOME AND COMMUNITY-BASED SERVICES PROVIDER RATES

It is the intent of the General Assembly that the Department of Developmental Disabilities utilize the necessary portion of the foregoing appropriation items 653407, Medicaid Services, and 653654, Medicaid Services, to increase direct care provider rates for all Medicaid home and community-based services offered under waiver programs operated by the Department by the following percentages over the rates that are in effect on the day immediately preceding the day on which the rate increase takes effect:

(A) For rates beginning January 1, 2026, by 3.4%.

(B) For rates beginning January 1, 2027, by 2.3%."

After line 112962, insert:

"Section 5123.049 of the Revised Code as amended by both H.B. 1 and S.B. 79 of the 128th General Assembly."

Update the title, amend, enact, or repeal clauses accordingly

The motion was _____ agreed to.

SYNOPSIS

**Department of Developmental Disabilities**

**Section 261.10**

Increases the following appropriations: in GRF ALI 653321, Medicaid Program Support - State, by $150,000 in FY 2027; in GRF ALI 653407, Medicaid Services, by $24,245,743 in FY 2026 and by

$66,434,761 in FY 2027; in FED Fund 3A40 ALI 653654, Medicaid Services, by $43,103,543 in FY 2026 and by $118,106,242 in FY 2027; and FED Fund 3A40 ALI 653655, Medicaid Support, by $150,000 in FY 2027; for a total increase of $67,349,286 in FY 2026 and $184,841,003 in FY 2027.

**Provider rates for DD-administered home and community-based services**

**R.C. 5123.049 and Section 261.150**

Requires the Director of Developmental Disabilities to adopt rules establishing a mechanism to update provider rates for home and community-based services (HCBS) provided under waiver programs administered by the Department.

Declares that it is the intent of the General Assembly that the Department increase HCBS provider rates for services provided under waiver programs administered by the Department as follows:

- For rates beginning January 1, 2026, by 3.4%.

- For rates beginning January 1, 2027, by 2.3%.

**HC1236**

H. B. No. 96
As Introduced

_____ moved to amend as follows:

After line 84624, insert:

**"Sec. 5123.049.** The director of developmental disabilities shall adopt rules in accordance with Chapter 119. of the Revised Code governing the authorization and payment of home and community-based services and medicaid case management services. The rules shall provide for private providers of the services to receive one hundred per cent of the medicaid allowable payment amount and for government providers of the services to receive the federal share of the medicaid allowable payment, less the amount withheld as a fee under section 5123.0412 of the Revised Code. The rules shall establish the process by which county boards of developmental disabilities shall certify and provide the nonfederal share of medicaid expenditures that the county board is required by sections 5126.059 and 5126.0510 of the Revised Code to pay. The process shall require a county board to certify that the county board has funding available at one time for two months costs for those expenditures. The process may permit a county board to certify that the county board has funding available at one time for more than two months costs for those expenditures.



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The rules shall specify that for purposes of provider payment rates for homemaker and personal care services under the individual options waiver, "site" means a single physical location in which two or more individuals share homemaker and personal care services of the same agency provider. "Site" may include multiple-unit dwellings if all units are licensed and all residents share homemaker and personal care services from the same agency provider."

After line 85014, insert:

**"Sec. 5123.162.** (A) The director of developmental disabilities may conduct surveys of persons and government entities that seek a supported living certificate to determine whether the persons and government entities meet the initial certification standards. ~~The~~

(B) The director may also conduct surveys of providers to determine whether the providers continue to meet the certification standards. All of the following apply to the surveys:

(1) The director shall use a risk-based approach to compliance monitoring, prioritizing reviews based on patterns of noncompliance, complaints, or significant operational changes, rather than conducting repetitive reviews of historically compliant providers.

(2) The director shall adjust compliance review frequency and scope based on provider compliance history, with reduced review requirements for providers that demonstrate consistent compliance.

(3) The director shall conduct abbreviated surveys when a provider holds an accreditation, issued by a national

accrediting entity, for certifiable services and supports when national accreditation exists for such services and supports or equivalent services and supports. The abbreviated survey shall rely on a smaller sample of staff and individuals served, examine fewer policies, and focus on areas that are not reviewed by the national accrediting entity.

(4) The director shall not create new review standards that exceed state and federal requirements applicable to the provider's certifiable services and supports.

(5) The director shall not require reviews of provider policies and procedures at multiple service locations operated by the provider when the policies and procedures are uniform across all locations operated by the provider.

(C) The director may assign to a county board of developmental disabilities the responsibility to conduct either type of survey. Each survey shall be conducted in accordance with rules adopted under section 5123.1611 of the Revised Code.

~~(B)~~ (D)(1) Following each survey of a provider, the director shall issue a report listing the date of the survey, any citations issued as a result of the survey, and the statutes or rules that purportedly have been violated and are the bases of the citations. The director shall also do both of the following:

~~(1)~~ (a) Specify a date by which the provider may appeal any of the citations;

~~(2)~~ (b) When appropriate, specify a timetable within which the provider must submit a plan of correction describing how the problems specified in the citations will be corrected and the date by which the provider anticipates the problems will be

corrected. The director shall ensure that corrective action plans focus on systemic issues and not isolated deficiencies that were corrected immediately.

(2) The department shall establish a streamlined process for resolving disputed deficiencies identified in the survey report issued under division (D)(1) of this section, allowing providers to submit clarifications or documentation within a reasonable time frame before citations are issued. Formal appeals shall be required only when a provider disputes a deficiency finding that has not been resolved through the streamlined review process.

(E) When noncompliance is identified during a survey and the deficiency can be immediately remedied, a provider shall be given the opportunity to correct the deficiency at the time of the survey. If the provider corrects the deficiency during the survey, no formal citation, plan of correction, or appeal is required. The department shall document the correction in the final report issued under division (D) of this section.

~~(C)~~ (F) If the director initiates a proceeding to revoke a provider's certification, the director shall include the report required by division ~~(B)~~ (D) of this section with the notice of the proposed revocation the director sends to the provider. In this circumstance, the provider may not submit a plan of correction.

~~(D)~~ (G) After a plan of correction is submitted, the director shall approve or disapprove the plan. If the plan of correction is approved, a copy of the approved plan shall be provided, not later than five business days after it is approved, to any person or government entity that requests it and made available on the internet web site maintained by the

department of developmental disabilities. If the plan of correction is not approved and the director initiates a proceeding to revoke the provider's certification, a copy of the survey report shall be provided to any person or government entity that requests it and shall be made available on the internet web site maintained by the department.

~~(E)~~ (H) In addition to survey reports described in this section, all other records associated with surveys conducted under this section are public records for the purpose of section 149.43 of the Revised Code and shall be made available on the request of any person or government entity."

After line 86426, insert:

**"Sec. 5123.621.** It is the intent of the general assembly that ~~all~~ :

(A) All individuals being served on ~~the effective date of this section~~ September 29, 2015, through the array of adult day services that exists on that date, including services delivered in a sheltered workshop, be fully informed of any new home and community-based services and their option to receive those services. It is also the intent of the general assembly that those individuals be permitted to continue receiving services in a variety of settings as long as those settings offer opportunities for community integration as described in their individual service plans.

(B) The department of developmental disabilities will expand opportunities for adult day service providers and individuals receiving home and community-based services by allowing all of the following:

(1) Individuals receiving home and community-based

services to sell or profit from items they make or create while receiving the service;

(2) Agency providers of transportation services under home and community-based services to bill the agency provider's usual and customary rate;

(3) Agency providers of home and community-based services to own or operate businesses that create employment or training opportunities for people with disabilities receiving home and community-based services by those providers."

After line 112711, insert:

**"Section 751.00.01.** Not later than January 1, 2026, the Department of Developmental Disabilities shall submit a waiver to the United States Centers for Medicare and Medicaid Services, updating group employment supports definitions and rates to incentivize and support small group employment models, as recommended by the Department's Blueprint for Adult Day and Employment Services Work Group, to expand meaningful work opportunities for people with disabilities in accordance with division (B) of section 5123.621 of the Revised Code."

After line 112964, insert:

"Section 5123.049 of the Revised Code as amended by both H.B. 1 and S.B. 79 of the 128th General Assembly."

Update the title, amend, enact, or repeal clauses accordingly

The motion was _____ agreed to.

SYNOPSIS

**Department of Developmental Disabilities provider surveys; waiver request**

**R.C. 5123.162**

Requires the Director of Developmental Disabilities, when conducting surveys of supported living certificate holders, to do the following:

-- Use a risk-based approach to compliance monitoring, adjusts compliance review frequency and scope based on provider performance history, and conduct an abbreviated performance review when the provider is accredited by a national accrediting entity.

-- Allow, where possible, for immediate correction of noncompliance deficiencies found during the survey without penalty to the provider.

-- Establish a streamlined process for resolving disputed findings.

**HCBS homemaker and personal care services rules**

**R.C. 5123.049**

Defines "site" for purposes of billing for homemaker and personal care services under the Individual Options home and community-based services waiver.

**Intent to expand opportunities for individuals with disabilities**

**R.C. 5123.621**

States the General Assembly's intent that the Department

expand opportunities for adult day services providers and individuals receiving such services.

**Waiver request**

**Section 751.00.01**

Requires the Department to submit a waiver to CMS, updating the group employment support definitions and rates to expand work opportunities for people with disabilities.

**HC0406**

H. B. No. 96
As Introduced

_____ moved to amend as follows:

After line 86640, insert:

**"Sec. 5124.17.** (A) For each fiscal year, the department of developmental disabilities shall determine each ICF/IID's per medicaid day capital component rate. An ICF/IID's rate for a fiscal year shall equal the sum of the following:

(1) The lesser of the following:

(a) The sum of all of the following:

(i) The ICF/IID's per diem fair rental value rate for the fiscal year as determined under division (B) of this section;

(ii) The ICF/IID's per diem equipment rate for the fiscal year as determined under division (D) of this section;

(iii) The ICF/IID's per diem secondary building rate for the fiscal year as determined under division (E) of this section.

(b) The sum determined for the fiscal year under division (G) of this section.

(2) The ICF/IID's per diem nonextensive renovation rate



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for the fiscal year as determined under division (H) of this section.

(B) An ICF/IID's per diem fair rental value rate for a fiscal year is the quotient of the following:

(1) The ICF/IID's fair rental value as determined under division (C) of this section;

(2) The greater of the following:

(a) The number of the ICF/IID's inpatient days for the applicable cost report year;

(b) The number of inpatient days the ICF/IID would have had during the applicable cost report year if its occupancy rate had been ninety-two per cent that year.

(C)(1) An ICF/IID's fair rental value is the product of the following:

(a) The sum of the following:

(i) The ICF/IID's depreciated current asset value as determined under division (C)(2) of this section;

(ii) The ICF/IID's land value as determined under division (C)(10) of this section.

(b) Eleven per cent.

(2) An ICF/IID's depreciated current asset value is its current asset value, as determined under division (C)(3) of this section, depreciated by the product of the following:

(a) The ICF/IID's effective age as determined under division (C)(5) of this section;

(b) One and six-tenths per cent.

(3) An ICF/IID's current asset value is the product of the following:

(a) The ICF/IID's value per square foot as determined under division (C)(4) of this section;

(b) The lesser of the ICF/IID's square footage and the following:

(i) If the ICF/IID is in peer group 1 and is a downsized ICF/IID, its medicaid-certified capacity on the last day of the applicable cost report year multiplied by one thousand;

(ii) If the ICF/IID is in peer group 1 and is not a downsized ICF/IID, its medicaid-certified capacity on the last day of the applicable cost report year multiplied by five hundred fifty;

(iii) If the ICF/IID is in peer group 2 and is a downsized ICF/IID, its medicaid-certified capacity on the last day of the applicable cost report year multiplied by one thousand;

(iv) If the ICF/IID is in peer group 2 and is not a downsized ICF/IID, its medicaid-certified capacity on the last day of the applicable cost report year multiplied by seven hundred fifty;

(v) If the ICF/IID is in peer group 3, its medicaid-certified capacity on the last day of the applicable cost report year multiplied by eight hundred fifty;

(vi) If the ICF/IID is in peer group 4 or peer group 5, its medicaid-certified capacity on the last day of the applicable cost report year multiplied by nine hundred.

(4)(a) An ICF/IID's value per square foot shall be determined by using the version of the following RS means data

that was most recently published at the time the determination is made:

(i) If the ICF/IID is in peer group 1 or peer group 2, the RS means data for assisted-senior living facility construction costs;

(ii) If the ICF/IID is in peer group 3, peer group 4, or peer group 5, the RS means data for nursing home construction costs.

(b) Except as provided in division (C)(4)(c) of this section, in determining an ICF/IID's value per square foot, the following modifier shall be used:

(i) If the ICF/IID is located in Summit county, the modifier specified in the applicable RS means data for Akron;

(ii) If the ICF/IID is located in Athens county, the modifier specified in the applicable RS means data for Athens;

(iii) If the ICF/IID is located in Ashtabula, Geauga, Lake, Medina, Portage, Stark, Trumbull, or Wayne county, the modifier specified in the applicable RS means data for Canton;

(iv) If the ICF/IID is located in Ross county, the modifier specified in the applicable RS means data for Chillicothe;

(v) If the ICF/IID is located in Hamilton county, the modifier specified in the applicable RS means data for Cincinnati;

(vi) If the ICF/IID is located in Cuyahoga county, the modifier specified in the applicable RS means data for Cleveland;

(vii) If the ICF/IID is located in Franklin county, the modifier specified in the applicable RS means data for Columbus;

(viii) If the ICF/IID is located in Montgomery county, the modifier specified in the applicable RS means data for Dayton;

(ix) If the ICF/IID is located in Brown, Butler, Clermont, Clinton, Champaign, Darke, Greene, Logan, Miami, Preble, Shelby, or Warren county, the modifier specified in the applicable RS means data for Hamilton;

(x) If the ICF/IID is located in Allen, Auglaize, Defiance, Erie, Fulton, Hancock, Henry, Huron, Mercer, Paulding, Putnam, Ottawa, Sandusky, Seneca, Van Wert, Williams, or Wood county, the modifier specified in the applicable RS means data for Lima;

(xi) If the ICF/IID is located in Lorain county, the modifier specified in the applicable RS means data for Lorain;

(xii) If the ICF/IID is located in Ashland, Crawford, Delaware, Fairfield, Fayette, Hardin, Knox, Licking, Madison, Morrow, Pickaway, Richland, Union, or Wyandot county, the modifier specified in the applicable RS means data for Mansfield;

(xiii) If the ICF/IID is located in Marion county, the modifier specified in the applicable RS means data for Marion;

(xiv) If the ICF/IID is located in Clark county, the modifier specified in the applicable RS means data for Springfield;

(xv) If the ICF/IID is located in Jefferson county, the modifier specified in the applicable RS means data for Steubenville;

(xvi) If the ICF/IID is located in Lucas county, the modifier specified in the applicable RS means data for Toledo;

(xvii) If the ICF/IID is located in Mahoning county, the modifier specified in the applicable RS means data for Youngstown;

(xviii) If the ICF/IID is 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 specified in the applicable RS means data for Zanesville.

(c) If a modifier ceases to be specified in the applicable RS means data for a city listed in division (C)(4)(b) of this section, the director of developmental disabilities shall specify in rules adopted under section 5124.03 of the Revised Code a different modifier for the counties that are affected by the change.

(5) An ICF/IID's effective age shall be determined as follows:

(a) Determine the sum of the numbers of the ICF/IID's new bed equivalents for renovations for the applicable cost report year and the immediately preceding thirty-nine calendar years as determined for each of those years under division (C)(7)(a) of this section;

(b) Determine the sum of the numbers of the ICF/IID's new bed equivalents for additions that do not increase the ICF/IID's medicaid-certified capacity for the applicable cost report year and the immediately preceding thirty-nine calendar years as determined for each of those years under division (C)(8)(a) of

this section;

(c) Determine the sum of the numbers of the ICF/IID's new beds resulting from additions that increase the ICF/IID's medicaid-certified capacity for the applicable cost report year and the immediately preceding thirty-nine calendar years as determined for each of those years under division (C)(9)(a) of this section;

(d) Determine the sum of the sums determined under divisions (C)(5)(a), (b), and (c) of this section;

(e) Determine the difference of the following:

(i) The ICF/IID's medicaid-certified capacity on the last day of the applicable cost report year;

(ii) The lesser of the amount specified in division (C)(5)(e)(i) of this section and the sum determined under division (C)(5)(d) of this section.

(f) For the purpose of determining the weighted age of the ICF/IID's original beds, determine the product of the following:

(i) The difference determined under division (C)(5)(e) of this section;

(ii) The ICF/IID's age as determined under division (C)(6) of this section.

(g) Determine the sum of the weighted ages of the ICF/IID's new bed equivalents for renovations for the applicable cost report year and the immediately preceding thirty-nine calendar years as determined for each of those years under division (C)(7)(c) of this section;

(h) Determine the sum of the weighted ages of the

ICF/IID's new bed equivalents for additions that do not increase its medicaid-certified capacity for the applicable cost report year and the immediately preceding thirty-nine calendar years as determined for each of those years under division (C)(8)(d) of this section;

(i) Determine the sum of the weighted ages of the ICF/IID's new beds resulting from additions that increase its medicaid-certified capacity for the applicable cost report year and the immediately preceding thirty-nine calendar years as determined for that period and each of those years under division (C)(9)(b) of this section;

(j) Determine the sum of the following:

(i) The product determined under division (C)(5)(f) of this section;

(ii) The sum of the sums determined under divisions (C)(5)(g), (h), and (i) of this section.

(k) Determine the quotient of the following:

(i) The sum determined under division (C)(5)(j) of this section;

(ii) The ICF/IID's medicaid-certified capacity on the last day of the applicable cost report year.

(6) An ICF/IID's age is the lesser of the following:

(a) The difference between the following:

(i) The calendar year in which occurs the last day of the period covered by the cost report being used to determine the ICF/IID's rate under this section;

(ii) The calendar year in which the ICF/IID was initially

constructed.

(b) Forty.

(7)(a) The number, for a year, of an ICF/IID's new bed equivalents for renovations is the quotient of the following:

(i) The ICF/IID's desk-reviewed, actual, allowable renovation costs for the year;

(ii) Seventy thousand dollars.

(b) The age of an ICF/IID's new bed equivalents for renovations is the difference of the following:

(i) The calendar year in which occurs the last day of the period covered by the cost report being used to determine the ICF/IID's rate under this section;

(ii) The calendar year the renovations were completed.

(c) The weighted age, for a year, of an ICF/IID's new bed equivalents for renovations is the product of the following:

(i) The number, for that year, of the ICF/IID's new bed equivalents for renovations as determined under division (C)(7)(a) of this section;

(ii) The age of those new bed equivalents as determined under division (C)(7)(b) of this section.

(8)(a) The number, for a year, of an ICF/IID's new bed equivalents for additions that do not increase its medicaid-certified capacity is the quotient of the following:

(i) The value of such additions made to the ICF/IID that year as determined under division (C)(8)(b) of this section;

(ii) Seventy thousand dollars.

(b) The value of additions that do not increase an ICF/IID's medicaid-certified capacity is the product of the following:

(i) The total square footage of the additions;

(ii) The ICF/IID's value per square foot as determined under division (C)(4) of this section.

(c) The age of an ICF/IID's new bed equivalents for additions that do not increase its medicaid-certified capacity is the difference of the following:

(i) The calendar year in which occurs the last day of the period covered by the cost report being used to determine the ICF/IID's rate under this section;

(ii) The calendar year the additions were completed.

(d) The weighted age, for a year, of an ICF/IID's new bed equivalents for additions that do not increase its medicaid-certified capacity is the product of the following:

(i) The number, for that year, of the ICF/IID's new bed equivalents for such additions as determined under division (C)(8)(a) of this section;

(ii) The age of those new bed equivalents as determined under division (C)(8)(c) of this section.

(9)(a) The number, for a year, of new beds resulting from additions that increase an ICF/IID's medicaid-certified capacity is the number by which the new beds increased the ICF/IID's medicaid-certified capacity that year.

(b) The weighted age, for a year, of new beds resulting from additions that increase an ICF/IID's medicaid-certified

capacity is the product of the following:

(i) The number by which those new beds increased the ICF/IID's medicaid-certified capacity that year;

(ii) 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/IID's rate under this section and the calendar year the ICF/IID's medicaid-certified capacity was so increased.

(10) An ICF/IID's land value is the product of the following:

(a) The ICF/IID's current asset value as determined under division (C)(3) of this section;

(b) Ten per cent.

(D) An ICF/IID's per diem equipment rate for a fiscal year shall be the lesser of the following:

(1) The quotient of the following:

(a) The ICF/IID's costs for capital equipment for the applicable cost report year;

(b) The greater of the following:

(i) The number of the ICF/IID's inpatient days for the applicable cost report year;

(ii) The number of inpatient days the ICF/IID would have had during the applicable cost report year if its occupancy rate had been ninety-two per cent that year.

(2) The following amount:

(a) If the ICF/IID is in peer group 1, ~~five~~ eight dollars_

and fifty cents;

(b) If the ICF/IID is in peer group 2, ~~six~~ eleven dollars and ~~fifty~~ five cents;

(c) If the ICF/IID is in peer group 3, ~~eight~~ thirteen dollars and sixty cents;

(d) If the ICF/IID is in peer group 4 or peer group 5, ~~nine~~ fifteen dollars and thirty cents.

(E) An ICF/IID's per diem secondary building rate for a fiscal year is the quotient of the following:

(1) The ICF/IID's secondary building value as determined under division (F) of this section;

(2) The greater of the following:

(a) The number of the ICF/IID's inpatient days for the applicable cost report year;

(b) The number of inpatient days the ICF/IID would have had during the applicable cost report year if its occupancy rate had been ninety-two per cent that year.

(F)(1) An ICF/IID's secondary building value is the product of the following:

(a) The sum of the following:

(i) The sum of the depreciated current asset values of the ICF/IID's secondary buildings as determined under division (F)(2) of this section;

(ii) The sum of the land values of the ICF/IID's secondary buildings as determined under division (F)(6) of this section.

(b) A rental rate of eleven per cent.

(2) The depreciated current asset value of an ICF/IID's secondary building is the current asset value of the secondary building, as determined under division (F)(3) of this section, depreciated by the product of the following:

(a) The age of the secondary building as determined under division (F)(5) of this section;

(b) One and six-tenths per cent.

(3) The current asset value of an ICF/IID's secondary building is the product of the following:

(a) The part of the secondary building's square footage that is allocated to the ICF/IID;

(b) The secondary building's value per square foot as determined under division (F)(4) of this section.

(4) The value per square foot of an ICF/IID's secondary building shall be determined by using the following:

(a) Except as provided in division (F)(4)(b) of this section, the most recent national average commercial cost estimate for office/warehouse buildings according to information available at buildingjournal.com on the last day of the applicable cost report year;

(b) If the national average commercial cost estimate for office/warehouse buildings ceases to be available at buildingjournal.com, the most recent comparable cost estimate as specified in rules the director of developmental disabilities shall adopt under section 5124.03 of the Revised Code.

(5) The age of an ICF/IID's secondary building is the lesser of the following:

(a) The difference of the following:

(i) The calendar year in which occurs the last day of the period covered by the cost report being used to determine the ICF/IID's rate under this section;

(ii) The calendar year the secondary building was initially constructed.

(b) Forty.

(6) The land value of an ICF/IID's secondary building is the product of the following:

(a) The current asset value of the ICF/IID's secondary building as determined under division (F)(3) of this section;

(b) Ten per cent.

(G) For the purposes of divisions (A)(1)(b) and (H)(1)(b)(ii) of this section, the department shall determine the sum of the following for each ICF/IID for each fiscal year:

(1) The quotient of the following:

(a) The ICF/IID's desk-reviewed, actual, allowable capital costs for the applicable cost report year;

(b) The greater of the following:

(i) The number of the ICF/IID's inpatient days for the applicable cost report year;

(ii) The number of inpatient days the ICF/IID would have had during the applicable cost report year if its occupancy rate had been ninety-two per cent that year.

(2) The following amount:

(a) If the ICF/IID is in peer group 1 or peer group 2, three dollars;

(b) If the ICF/IID is in peer group 3, peer group 4, or peer group 5, five dollars.

(3) The greater of the following:

(a) Ten per cent of the difference of the following:

(i) The sum of the quotient determined for the fiscal year under division (G)(1) of this section and the applicable amount specified in division (G)(2) of this section;

(ii) The sum determined for the fiscal year under division (A)(1)(a) of this section.

(b) Zero.

(H) An ICF/IID's per diem nonextensive renovation rate for a fiscal year is the following:

(1) If the sum of the ICF/IID's per diem costs of nonextensive renovations for the applicable cost report year as determined under division (I) of this section and the ICF/IID's per diem costs of ownership for the applicable cost report year as determined under division (J) of this section is greater than the sum determined for the ICF/IID for the fiscal year under division (G) of this section, the lesser of the following:

(a) The ICF/IID's per diem costs of nonextensive renovations for the applicable cost report year as determined under division (I) of this section;

(b) The difference of the following:

(i) The sum of the ICF/IID's per diem costs of nonextensive renovation for the applicable cost report year as

determined under division (I) of this section and the ICF/IID's per diem costs of ownership for the applicable cost report year as determined under division (J) of this section;

(ii) The sum determined for the ICF/IID for the fiscal year under division (G) of this section.

(2) If the sum of the ICF/IID's per diem costs of nonextensive renovation for the applicable cost report year as determined under division (I) of this section and the ICF/IID's per diem costs of ownership for the applicable cost report year as determined under division (J) of this section is less than or equal to the sum determined for the ICF/IID for the fiscal year under division (G) of this section, zero.

(I) An ICF/IID's per diem costs of nonextensive renovations for an applicable cost report year are the quotient of the following:

(1) The ICF/IID's desk-reviewed, actual, allowable costs of nonextensive renovations for the applicable cost report year;

(2) The greater of the following:

(a) The number of the ICF/IID's inpatient days for the applicable cost report year;

(b) The number of inpatient days the ICF/IID would have had during the applicable cost report year if its occupancy rate had been ninety-two per cent that year.

(J) An ICF/IID's per diem costs of ownership for an applicable cost report year are the quotient of the following:

(1) The ICF/IID's desk-reviewed, actual, allowable costs of ownership for the applicable cost report year;

(2) The greater of the following:

(a) The number of the ICF/IID's inpatient days for the applicable cost report year;

(b) The number of inpatient days the ICF/IID would have had during the applicable cost report year if its occupancy rate had been ninety-two per cent that year.

(K) Beginning July 1, 2026, and annually thereafter, the department shall adjust the amounts specified in division (D)(2) of this section for inflation, using the following:

(1) Subject to division (K)(2) of this section, the consumer price index for all items for all urban consumers for the midwest region, published by the United States bureau of labor statistics;

(2) If the United States bureau of labor statistics ceases to publish the index specified in division (K)(1) of this section, a comparable index that the bureau publishes and the department determines is appropriate."

Update the title, amend, enact, or repeal clauses accordingly

The motion was _____ agreed to.

SYNOPSIS

**Per Medicaid day payment rate for ICFs/IID - per diem equipment rate**

**R.C. 5124.17**

Modifies the per diem equipment rate element of an

ICF/IID's per Medicaid day capital component rate as follows:

- Increases specified dollar amounts used when determining the equipment rate as follows: for ICFs/IID in peer group one, $8.50 (from $5), for ICFs/IID in peer group two, $11.05 (from $6.50), for ICFs/IID in peer group three, $13.60 (from $8), and for ICFs/IID in peer group four or five, $15.30 (from $9).

Beginning July 1, 2026, requires the Department of Developmental Disabilities to adjust the specified dollar amounts annually for inflation.