In line 129409, delete "AND FISCAL YEAR 2019"

In line 129423, delete "or" and insert a period

Delete line 129424

In line 129426, delete "or fiscal year 2019"

In line 129430, delete "or" and insert a period

Delete line 129431

In line 129433, delete "or" and insert a period

Delete line 129434

In lines 129439, 129445, and 129449, delete "and fiscal year 2019"

In line 129452, delete "years" and insert "year"

In line 129487, delete "the following"

In line 129488, after "year" insert "2016"; delete the colon and insert a period

Delete lines 129489 and 129490

In line 129493, after "by" insert "a direct support personnel payment equal to"; delete "to reflect" and insert "of the ICF/IID's per diem, desk-reviewed, actual, allowable direct care costs."

Delete line 129494

In line 129495, delete "and fiscal year 2019"

In line 129516, delete "(in" and insert a semicolon

Delete lines 129517 and 129518

In line 129534, after "by" insert "the median ~~a~~ direct support personnel payment determined for ICF/IID’s under division (C) (2) (h) of this section. ~~equal to~~"; delete "to” ~~reflect" and insert "the ICF/IID's per diem, desk-reviewed, actual, allowable direct care costs."~~

Delete line 129535

In line 129537, delete "or fiscal year 2019"

In line 129541, delete "or fiscal year"

In line 129542, delete "2019"

In line 129554, delete "in the case of the fiscal year 2018 rate and as" and insert a period

Delete lines 129555 and 129556

Between lines 129600 and 129601, insert:

"Section 261.166. FISCAL YEAR 2019 MEDICAID PAYMENT RATES FOR ICFs/IID IN PEER GROUPS 1 AND 2

(A) As used in this section:

(1) "Change of operator," "entering operator," "exiting operator," "ICF/IID," "ICF/IID services," "Medicaid days," "provider," and "provider agreement" have the same meanings as in section 5124.01 of the Revised Code.

(2) "Franchise permit fee" means the fee imposed by sections 5168.60 to 5168.71 of the Revised Code.

(B)(1) This section applies to each ICF/IID to which any of the following applies:

(a) The provider of the ICF/IID has a valid Medicaid provider agreement for the ICF/IID on June 30, 2018, and a valid Medicaid provider agreement for the ICF/IID during fiscal year 2019.

(b) The ICF/IID undergoes a change of operator that takes effect during fiscal year 2019, the exiting operator has a valid Medicaid provider agreement for the ICF/IID on the day immediately preceding the effective date of the change of operator, and the entering operator has a valid Medicaid provider agreement for the ICF/IID during fiscal year 2019.

(c) The ICF/IID is a new ICF/IID for which the provider obtains an initial provider agreement during fiscal year 2019.

(2) This section does not apply to an ICF/IID currently in Peer Group 3.

(C)(1) The Department of Developmental Disabilities shall work in conjunction with the Ohio Association of County Boards, the Ohio Health Care Association, the Ohio Provider Resource Association, the Values and Faith Alliance, and the Academy of Senior Health Services to finalize a new ICF/IID Medicaid payment methodology that will take effect for fiscal year 2019. The Department shall not propose a new payment methodology to the General Assembly without agreement of the associations. It is the intent of the General Assembly to specify in statute, effective no sooner than July 1, 2018, and no later than January 1, 2019, the new ICF/IID Medicaid payment methodology.

(2) The new ICF/IID Medicaid payment methodology developed under division (C)(1) of this section will include all the following elements:

(a) The Ohio Developmental Disabilities Profile as the assessment instrument used to determine ICF/IID case-mix scores for calculation of the direct care rate component;

(b) A methodology to determine rates for the capital rate component using a calculation of the facility’s current asset value and a rate of return. The calculation of current asset value shall include all the following components:

(i) The age of the facility;

(ii) The date and cost of capital improvements made to the facility;

(iii) The current number of beds in the facility;

(iv) Use of an RS Means Construction Cost Index;

(v) A rate of depreciation;

(vi) An estimation for equipment value;

(vii) An estimation for land value.

(c) A quality incentive rate component to take effect July 1, 2019, and a requirement that DODD begin collecting the data needed for the calculation no later than January 1, 2018.

(d) A new peer group structure that differentiates ICF/IID providers by bed capacity.

(e) Consideration of the changing acuity of individuals served in ICFs/IID, including individuals with intensive behavioral and intensive medical needs.

(f) A method of transitioning providers to the rates established under the new payment methodology. The method of transitioning providers shall specify all of the following:

(i) For ~~at least~~ thirty-six months after the effective date of the new payment methodology, the Department will compare each provider's rate calculated using the new payment methodology with the provider's rate calculated using the previous payment methodology in effect on June 30, 2018.

(ii) If the provider's rate calculated using the new payment methodology is less than the provider's rate calculated using the previous payment methodology, the provider's rate will be the rate calculated using the previous payment methodology.

(iii) Subject to the limitation in division (C)(2)(f)(iii) (iv) of this section, if the provider's rate calculated using the new payment methodology is greater than the provider's rate calculated using the previous payment methodology, the provider's rate will be the rate calculated using the new payment methodology.

~~(iii)~~ (iv) The Department may establish a maximum percentage by which a provider's rate as calculated using the new payment methodology may exceed the provider's rate as calculated using the previous payment methodology. In establishing the maximum percentage, the Department shall strive to the greatest extent possible to ensure that the mean total per Medicaid day rate for all ICFs/IID to which this section applies equals the amount specified in division (C)(4) of this section.

(3) Subject to the transition method specified in division (C)(2)(f) of this section, the provider of an ICF/IID to which this section applies shall be paid, for ICF/IID services the ICF/IID provides during the portion of fiscal year 2019 after the new payment methodology takes effect, the total per Medicaid day rate determined under the new payment methodology.

(4) The mean total per Medicaid day rate for all ICFs/IID for which a rate is determined under division (C)(3) of this section, weighted by May 2018 Medicaid days, shall not exceed $295.90. The Department, in its sole discretion, may use a larger amount for the purpose of that division. In determining whether to use a larger amount, the Department may consider any of the following:

(i) The reduction in the total Medicaid-certified capacity of all ICFs/IID that occurs in the preceding fiscal year, and the reduction that is projected to occur in the fiscal year for which the rate is paid, as a result of either of the following:

(a) A downsizing pursuant to a plan approved by the Department under section 5123.042 of the Revised Code;

(b) A conversion of beds to providing home and community-based services under the Individual Options waiver pursuant to section 5124.60 or 5124.61 of the Revised Code.

(ii) The increase in Medicaid payments made for ICF/IID services provided during the preceding fiscal year, and the increase that is projected to occur in the fiscal year for which the rate is paid, as a result of the modifications to the payment rates made under section 5124.101 of the Revised Code;

(iii) The total reduction in the number of ICF/IID beds that occurs pursuant to section 5124.67 of the Revised Code;

(iv) Other factors the Department determines to be relevant.

(D) If the new ICF/IID Medicaid payment methodology is implemented after July 1, 2018, the provider of each ICF/IID to which this section applies shall be paid a rate determined under division (E) of this section for the period beginning July 1, 2018, and ending on the day before the date the new payment methodology takes effect.

(E)(1) Under the circumstances specified in division (D) of this section for fiscal year 2019, this division applies to each ICF/IID that is in peer group 1 or peer group 2 and to which any of the following applies:

(a) The provider of the ICF/IID has a valid Medicaid provider agreement for the ICF/IID on June 30, 2018, and a valid Medicaid provider agreement for the ICF/IID during fiscal year 2019.

(b) The ICF/IID undergoes a change of operator that takes effect during fiscal year 2019, the exiting operator has a valid Medicaid provider agreement for the ICF/IID on the day immediately preceding the effective date of the change of operator, and the entering operator has a valid

Medicaid provider agreement for the ICF/IID during fiscal year 2019.

(c) The ICF/IID is a new ICF/IID for which the provider obtains an initial provider agreement during fiscal year 2019.

(2) This division does not apply to an ICF/IID in peer group 3.

(3) The Department shall follow this division in determining the rate to be paid for ICF/IID services provided during fiscal year 2019 by ICFs/IID subject to this division notwithstanding anything to the contrary in Chapter 5124. of the Revised Code.

(4) Except as otherwise provided in division (E)(9) of this section, the provider of an ICF/IID to which this section applies shall be paid, for ICF/IID services the ICF/IID provides during fiscal year 2019, the total per Medicaid day rate determined for the ICF/IID under division (E)(5) or (6) of this section.

(5) Except in the case of a new ICF/IID, the fiscal year 2019 total per Medicaid day rate for an ICF/IID to which this section applies shall be the ICF/IID's total per Medicaid day rate determined for the ICF/IID in accordance with Chapter 5124. of the Revised Code for fiscal year 2019 with the following modifications:

(a) The ICF/IID's efficiency incentive for capital costs, as determined under division (F) of section 5124.17 of the Revised Code, shall be reduced by 50 per cent.

(b) In place of the maximum cost per case-mix unit established for the ICF/IID's peer group under division (C) of section 5124.19 of the Revised Code, the ICF/IID's maximum costs per case-mix unit shall be the amount the Department determined for the ICF/IID's peer group for fiscal year 2016 in accordance with division (E) of Section 259.160 of Am. Sub. H.B. 64 of the 131st General Assembly.

(c) In place of the inflation adjustment otherwise calculated under division (D) of section 5124.19 of the Revised Code for the purpose of division (A)(1)(b) of that section, an inflation adjustment of 1.014 shall be used.

(d) In place of the efficiency incentive otherwise calculated under division (B)(2) of section 5124.21 of the Revised Code, the ICF/IID's efficiency incentive for indirect care costs shall be the following:

(i) In the case of an ICF/IID in peer group 1, $3.69;

(ii) In the case of an ICF/IID in peer group 2, $3.19.

(e) In place of the maximum rate for indirect care costs established for the ICF/IID's peer group under division (C) of section 5124.21 of the Revised Code, the Department shall calculate the maximum rate by striving to the greatest extent possible, to do both of the following:

(i) Avoid rate reductions under division (E)(9)(a) of this section;

(ii) Have the amount so determined result in payment of all desk-reviewed, actual, allowable indirect care costs for the same percentage of Medicaid days for ICF’s/IID in peer group 1 as for ICF’s/IID in peer group 2 as of July 1, 2018, based on May 2018 Medicaid days.

(f) In place of the inflation adjustment otherwise calculated under division (D)(1) of section 5124.21 of the Revised Code for the purpose of division (B)(1) of that section only, an inflation adjustment of 1.014 shall be used.

(g) In place of the inflation adjustment otherwise made under section 5124.23 of the Revised Code, the ICF/IID's desk-reviewed, actual, allowable, per Medicaid day other protected costs, excluding the franchise permit fee, from calendar year 2017 shall be multiplied by 1.014.

(h) After all the modifications specified in divisions (E)(5)(a) to (g) of this section have been made, the ICF/IID's total per Medicaid day rate shall be increased by the direct support personnel payment determined in accordance with division (E)(7) of this section.

(6) The fiscal year 2019 initial total per Medicaid day rate for a new ICF/IID to which this section applies shall be the ICF/IID's initial total per Medicaid day rate determined for the ICF/IID in accordance with section 5124.151 of the Revised Code for fiscal year 2019 with the following modifications:

(a) In place of the amount determined under division (B)(2)(a) of section 5124.151 of the Revised Code, if there are no cost or resident assessment data for the new ICF/IID, the new ICF/IID's initial per Medicaid day rate for direct care costs shall be determined as follows:

(i) Determine the median of the costs per case-mix units of each peer group;

(ii) Multiply the median determined under division (E)(5)(a)(i) of this section by the median annual average case-mix score for the new ICF/IID's peer group for calendar year 2017;

(iii) Multiply the product determined under division (E)(5)(a)(ii) of this section by 1.014.

(b) In place of the amount determined under division (B)(3) of section 5124.151 of the Revised Code, the new ICF/IID's initial per Medicaid day rate for indirect care costs shall be the following:

(i) If the new ICF/IID is in peer group 1, as determined in section (E)(5)(e) of this section;

(ii) If the new ICF/IID is in peer group 2, as determined in section (E)(5)(e) of this section.

(c) In place of the amount determined under division (B)(4) of section 5124.151 of the Revised Code, the new ICF/IID's initial per Medicaid day rate for other protected costs shall be 115 per cent of the median rate for ICFs/IID determined under section 5124.23 of the Revised Code with the modification made under division (E)(5)(g) of this section.

(d) In place of the amount determined under division (B)(1) of section 5124.151 of the Revised Code, the new ICF/IID’s initial per Medicaid day rate for capital costs shall be the median rate for all ICFs/IID determined under section 5124.17 of the Revised Code with the modification made under division (E)(5)(a) of this section.

(e) After all the modifications specified in divisions (E)(6)(a) to (d) of this section have been made, the new ICF/IID's initial total per Medicaid day rate shall be increased by the median direct support personnel payment determined under division (E)(7) of this section for all ICFs/IID to which this section applies.

(7) An ICF/IID's direct support personnel payment, for the purpose of divisions (E)(5)(h) and (E)(6)(e) of this section, shall be 3.04% of the ICF/IID's per diem, desk-reviewed, actual, allowable direct care costs.

(8) A new ICF/IID's initial total modified per Medicaid day rate for fiscal year 2019 as determined under division (E)(6) of this section shall be adjusted at the applicable time specified in division (D) of section 5124.151 of the Revised Code. If the adjustment affects the ICF/IID's rate for ICF/IID services provided during fiscal year 2019, the modifications specified in division (E)(5) of this section apply to the adjustment.

(9)(a) If the mean total per Medicaid day rate for all ICFs/IID to which division (E) of this section applies, weighted by May 2018 Medicaid days and determined under division (E) of this section as of July 1, 2018, is other than the amount determined under division (E)(9)(b) of this section, the Department shall adjust, for fiscal year 2019, the total per Medicaid day rate for each ICF/IID to which this section applies by a percentage that is equal to the percentage by which the mean total per Medicaid day rate is greater or less than the amount determined under division (E)(9)(b) of this section.

(b) The amount to be used for the purpose of division (E)(9)(a) of this section shall be not less than $290.10. The Department, in its sole discretion, may use a larger amount for the purpose of that division. In determining whether to use a larger amount, the Department may consider any of the following:

(i) The reduction in the total Medicaid-certified capacity of all ICFs/IID that occurs in fiscal year 2018, and the reduction that is projected to occur in fiscal year 2019, as a result of either of the following:

(a) A downsizing pursuant to a plan approved by the Department under section 5123.042 of the Revised Code;

(b) A conversion of beds to providing home and community-based services under the Individual Options waiver pursuant to section 5124.60 or 5124.61 of the Revised Code.

(ii) The increase in Medicaid payments made for ICF/IID services provided during fiscal year 2018, and the increase that is projected to occur in fiscal year 2019, as a result of the modifications to the payment rates made under section 5124.101 of the Revised Code;

(iii) The total reduction in the number of ICF/IID beds that occurs pursuant to section 5124.67 of the Revised Code;

(iv) Other factors the Department determines to be relevant.

(F) If the United States Centers for Medicare and Medicaid Services requires that the franchise permit fee be reduced or eliminated, the Department shall reduce the amount it pays ICF/IID providers under this section as necessary to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee."