



## Ohio Administrative Code

### Rule 5160-3-99 Payment methodology for state-operated intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).

Effective: July 3, 2025

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This rule describes the methodology for calculating payment rates for state-operated intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) operated by the Ohio department of developmental disabilities (DODD) and is effective for periods on or after July 1, 2024.

#### (A) Definitions.

(1) "Ancillary care costs" are costs for services other than direct care, incurred by the state-operated intermediate care facility for individuals with intellectual disabilities that are reasonable and provided to ICF/IID residents through an ICF/IID employee or through a contractual arrangement with the ICF/IID. For the purpose of the ICF/IID cost reporting and rate calculation, ancillary care costs include pharmacy, radiology, and laboratory, clinic care, and physician service costs.

(2) "Base rate year" means the period used to establish the interim payment rate for each ICF/IID.

(3) "Base year cost report" means the cost report used to establish the interim payment rate.

(4) "Capital costs" as in section 5124.01 of the Revised Code.

(5)

(6) "Cost report" means an ODM approved, electronically filed, cost report format, including its supplements and attachments, used to report cost and statistical data for the operation of an ICF/IID.

(7) "Covered services" are medicaid reimbursable services provided to a resident of an ICF/IID by an ICF/IID employee or through a contractual arrangement with an ICF/IID. Covered services include ancillary care and direct care services.



- (8) "Direct care costs" are costs which can be directly assigned to one program or cost center for services delivered to a resident of an ICF/IID through an ICF/IID employee or contractual arrangement with an ICF/IID. Direct care costs include wages, taxes, staff development, contracting and consulting services. Direct care costs exclude ancillary care costs.
- (9) "Federal financial participation (FFP)" means the federal government's share of a state's expenditures under the medicaid program.
- (10) "Final payment rate" means the rate of payment calculated using the audited rate year cost report data.
- (11) "Final settlement" is the process where allowable and reasonable costs included in the audited rate year cost report are used to establish a final payment rate that is reconciled to the interim payment rate.
- (12) "Interim payment rate" means the rate of payment calculated using the desk reviewed base year cost report data until the final payment rate is determined.
- (13) "Medicaid days" are days an individual is eligible to receive medicaid covered services.
- (14) "Medicaid paid days" are days that an ICF/IID is paid by the Ohio department of medicaid (ODM) for a medicaid eligible resident residing in an ICF/IID.
- (15) "Non-medicaid days" are days an individual is not covered by medicaid and are, therefore, not billable.
- (16) "Per diem" means the payment made to an ICF/IID covering all costs (direct care, ancillary care, and capital) related to the services furnished to medicaid recipients.
- (17) "Rate year" means the period where calculated interim rates are paid to the ICF/ IID using the base year cost report data.
- (18) "Rate year cost report" means the cost report used to establish the final payment rate.



(19) "Reasonable and allowable costs" means costs established in accordance with the centers for medicare and medicaid services (CMS) publications 15-1 ("The Provider Reimbursement Manual - Part 1") and 15-2 ("The Provider Reimbursement Manual - Part 2") as in effect October 1, 2023, available at <https://www.cms.gov/> and 45 C.F.R. part 92 in effect as of October 1, 2023.

(20) "State-operated intermediate care facility for individuals with intellectual disabilities" means an institution as defined in section 1905(d) of the Social Security Act 42 U.S.C. 1396d(d) (October 1, 2023) and operated by DODD under a medicaid provider agreement with ODM.

(21) "Total inpatient days" means the sum of all days during which a resident, regardless of payment source, occupies a bed in an ICF/IID that is included in the ICF/IID certified capacity under Title XIX of the Social Security Act, 49 stat. 620, 42 U.S.C.A. 301 in effect as of October 1, 2023. Therapeutic and hospital leave days for which payment is made under section 5124.34 of the Revised Code are considered inpatient days.

(B) Source data for calculations.

(1) The cost report covers the period of July first to June thirtieth. All cost reports will be submitted to ODM in an electronic format provided by ODM. DODD will maintain, on the DODD website (<http://dodd.ohio.gov/Pages/default.aspx>), an electronic version of the cost report for each cost report period.

(2) The calculations described in this rule will be based on the most recent desk reviewed base year cost report data submitted to ODM. The ICF/IID cost report will:

(a) Be prepared in accordance with medicare principles governing reasonable and allowable cost reimbursement. The method used to allocate supporting cost centers will be the step-down method described in CMS publication 15-1, section 2306. The statistics on the approved cost reporting form, will be used for cost allocation purposes; and

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



(c) Include a cost report certification executed by DODD attesting to the accuracy of the cost report, and compliance with applicable federal and state rules and regulations. In addition, all subsequent revisions to the cost report will include an executed certification; and

(d) Include costs for all covered services, provided directly by ICF/IID employees or through a contractual arrangement with the ICF/IID, that are generally available to medicaid recipients and provided to a resident of an ICF/IID by the ICF/IID, and will be reimbursed only to ICF/IID. These costs are subject to all otherwise applicable audit guidelines and tests of reasonableness; and

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

(f) Not include the cost of any goods or services that are otherwise reimbursed to a provider other than the ICF/IID regardless of the type of service.

(3) A desk review will be performed by ODM on all base year cost reports for the purpose of determining interim payment rates, all of which are subject to final settlement under paragraph (E) of this rule. Desk review procedures will take into consideration the relationship between the prior year's audited costs and the current year's reported costs. Adjustments may be made to the cost report by ODM as necessary to determine reasonable and accurate interim payment rates. Adjustments made by ODM do not preclude findings of additional cost exceptions issued as the result of an audit.

(4) An ICF/IID certified cost report will be filed with ODM within one hundred eighty days of the end of the fiscal year. If the cost report is not received within one hundred eighty days of the end of the fiscal year the rate paid will be the lower of ninety per cent of the state wide average rate or the interim payment rate.

(5) DODD may request an extension in writing and ODM may grant one extension of up to thirty calendar days for filing a cost report. ODM will designate the individual to receive the request within ODMs financial management, planning and rate setting section. The extension request will be submitted to ODM no later than one hundred fifty days after the end of the fiscal year. ODM will respond to DODD within fifteen calendar days of receipt of the extension request.



(C) Calculation of interim payment rates.

(1) Interim payment rates for each ICF/IID will be based upon the source data described in paragraph (B) of this rule.

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

(a) Calculation of direct care cost per diem rate.

(i) Calculate the direct care cost per diem for each ICF/IID by dividing direct care costs by total inpatient days.

(ii) For each ICF/IID multiply the ICF/IID's direct care cost per diem by the ICF/IID's total inpatient days. Sum results for all ICFs/IID and divide by the sum of the ICF/IID total inpatient days for all ICFs/IID.

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

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

(b) Calculate the ancillary care cost per diem rate for each ICF/IID by dividing ancillary care costs by total inpatient days.

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

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



basket consumer price index as determined by the United States bureau of labor statistics..

(D) Audit.

(1) ODM will perform field audits either directly or through arrangement of the most current cost report for each ICF/IID at least once every three years or more often as determined by ODM. Cost reports for other periods may also be audited within three years from the fiscal year end, unless justified from previous audit findings. ODM will use a full or limited scope audit. The audits will be performed in accordance with auditing standards adopted by ODM. ODM will develop a risk-based methodology to determine which ICFs/IID are subject to audit.

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

(3) DODD will maintain documentation to support all transactions, to permit the reconstruction of all transactions and the proper completion of all reports required by state and federal laws and regulations, and to substantiate compliance with all applicable federal laws and regulations, state laws and administrative rules. This documentation will be maintained for the greater of seven years after the cost report is filed or, if ODM issues an audit report, six years after all appeal rights relating to the audit report are exhausted. Documentation will include sufficient detail to disclose:

(a) Services provided; and

(b) Administrative costs of services provided; and

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

(d) Total inpatient days, medicaid days, and non-medicaid days; and

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



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

(g) Costs reported to ODM represent actual incurred, reasonable, and allowable costs in accordance with provisions of the CMS provider manual 15-1, Chapter 5160-3 of the Administrative Code as applicable, and 45 C.F.R. 92.

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

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

(b) Related to non-reimbursable costs.

(5) DODD will maintain adequate systems of internal control (e.g. preventive, detective, and compensating controls) as related to federal funding to ensure:

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

(b) Efficient and effective use of resources; and

(c) Compliance with pertinent laws and regulations.

(E) Final settlement.

(1) Final settlement will include adjustments to the base rate year cost report included in paragraphs

(B) (2) and (D) (1) to (D) (5) of this rule.

(2) The final payment rate will be calculated as follows:

(a) Calculation of direct care cost per diem rate.

(i) Calculate the direct care cost per diem rate for each ICF/IID by dividing direct care costs by total inpatient days.



(ii) For each ICF/IID, multiply the ICF/IID's direct care cost per diem rate as calculated in paragraph (E)(2)(a)(ii) of this rule by the ICF/IID's total inpatient days. Sum results for all ICFs/IID and divide by the sum of total inpatient days for all ICFs/IID.

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

(iv) The final ICF/IID direct care cost per diem rate will be the lower of the amount calculated in paragraph (E)(2)(a)(i) of this rule or the direct care per diem ceiling as calculated in paragraph (E)(2)(a)(iii) of this rule.

(b) Calculate the ancillary care cost per diem rate for each ICF/IID by dividing ancillary care costs by total inpatient days.

(c) Calculate the capital cost per diem rate for each ICF/IID by dividing capital costs by total inpatient days. The final rate for each ICF/IID will be the sum of the amounts calculated in paragraphs (E)(2)(a)(iv), (E)(2)(b) and (E)(2)(c) of this rule.

(3) The final payment rate calculated in paragraph (E)(2) of this rule is subtracted from the interim payment rate calculated in paragraph (C)(2) of this rule. The result is multiplied by the medicaid paid days and applicable FFP rate. The result of this calculation is the final settlement amount. Where the interim payment rate exceeds the final payment rate, the excess payment will be remitted to ODM. If the final payment rate exceeds the interim payment rate, ODM will remit the amount to DODD.

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

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

(F) Upper payment limit assurance.





Payments made to ICFs/IID in accordance with this rule under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts which would have been recognized under Title XVIII of the Social Security Act, 42 U.S.C. 1395 for comparable services in accordance with 42 C.F.R 447.272, in effect as of October 1, 2023.

(G) Dispute resolution.

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

(H) Rule exclusion.

Excluding those rules referring to reasonableness ceilings, cost limitations, cost reimbursement, occupancy levels, disallowance of costs, payment calculations, payment methodology, and appeals, all other rules which govern the operation of medicaid-certified ICFs/IID under Chapters 5160-1, 5160-3, and 5123-7 of the Administrative Code will apply to ICFs/IID. The payment methodology specified in this rule will govern the reimbursement of medicaid costs for ICFs/IID.

(I) Claim submission, payment and adjustment process.

All ICFs/IID will comply with claim submission, payment, and adjustment requirements in accordance with rule 5123-7-15 of the Administrative Code.