UNDERSTANDING THE NEW BUDGET

Identifying Challenges & Opportunities

Provisions effective September 29, 2011 in highlight

Rolf | Healthcare Counsel

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These appendices may be downloaded from our website at www.RolfLaw.com/Budget.

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Purpose

We created this document in response to the enactment of Amended Substitute House Bill 153 ("H.B. 153" or "the budget bill") and as a value-added service to our clients.

Within Ohio's skilled nursing facility ("SNF") community, H.B. 153 has received (and will likely continue to receive) much well-deserved criticism. For the time being, however, H.B. 153 is in effect and our clients need to know and understand the bill's provisions.

Our firm has developed this document not only to summarize the changes relevant to the SNF community that were enacted by the budget bill, but to provide a broader framework regarding the challenges and opportunities provided by H.B. 153. To that end, we have divided this document into the following sections:

Perspective A short discussion of the potential reactions of the SNF community to the legislation with an emphasis on a success-driven mindset.

Keys to Success A listing of approaches that our firm believes are critical to SNF providers that will thrive into the future.

Summary A detailed summary of the SNF provisions enacted by H.B. 153.

This foundational document is designed to be the basis for a meeting, and is purposefully not complete unto itself. There is no "one solution" that is appropriate or even feasible for all providers. Rather, this document is intended to spark a broader conversation on the future of long-term care and to provide jump off point for productive discussion and brainstorming.

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Perspective

It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change.

- Charles Darwin

The opening up of new markets, foreign or domestic, and the organizational development from the craft shop to such concerns as U.S. Steel illustrate the same process of industrial mutation—if I may use that biological term—that incessantly revolutionizes the economic structure from within, incessantly destroying the old one, incessantly creating a new one. This process of Creative Destruction is the essential fact about capitalism. It is what capitalism consists in and what every capitalist concern has got to live in.

Every piece of business strategy acquires its true significance only against the background of that process and within the situation created by it. It must be seen in its role in the perennial gale of creative destruction; it cannot be understood irrespective of it or, in fact, on the hypothesis that there is a perennial lull.

- Joseph Schumpeter

H.B. 153 has been called "transformational" by the Kasich Administration, and, indeed, it will in all likelihood significantly *accelerate* the transformation of the nursing facility profession. However, it is not the *cause* of that evolution. It is merely the latest step in the predictable progression towards tomorrow's long-term care.

Sophisticated providers for some time have understood that the realities of exponentially advancing technology and medical science, demographic changes, government deficit spending, and contemporary cultural expectations (to name just a few), are driving inevitable change in the long-term care business.

In response to these realities, many have been considering, or taking actual steps towards, transforming their businesses (and the way that they conceive of their businesses). H.B. 153 provides an opportunity for businesses to position themselves for better market dominance in a field that will most certainly be vital in the future.

It is true that nursing facility owners must face the future with eyes wide open. And, it is true that H.B. 153 enacts a tremendous cut in reimbursement for Ohio's nursing facilities. But like any time of significant turbulence, there will be those who do not endure the creative destruction of change, and those who learn to prosper in the new environment.

Like many other "structural changes" that nursing facilities have faced in the past, the current budget bill provides significant challenges, but also opportunities. How an organization responds will define its future success.

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Keys to Success

Our firm believes the strategic approach of successful providers will include some or all of the following approaches:

- **Diversify Service Lines**

  For over 20 years, Ohio has attempted to shift SNF residents to settings that are perceived (on a per diem basis) to be less-expensive, such as residential care facilities ("RCFs") and HCBS. This shift has been accomplished through a variety of legislative initiatives, from expanding payor sources and the type and amount of care provided in these settings to loosening Medicaid eligibility requirements. We believe this trend will continue into the foreseeable future. We also believe that SNF owners and operators possess the financial and operational resources, as well as access to potential clients, to compete and succeed in other service areas.

  We believe that the successful businesses of the future will be those whose self-identity evolves away from a particular model of care delivery, and rather focuses on a commitment to the end-user of their services. Thus, a SNF operator is not necessarily in the "nursing facility business", but in the business of caring for the elderly and those in need of short-term rehabilitation. As technology, demography and expectations evolve, so will those who provide services to that growing segment of our population. Many will achieve future success by adopting an approach similar to that adopted by hospitals many years ago when they became "health systems" – i.e., integrated care delivery systems with the hospital as the nucleus. We believe that similar strength can be achieved in the long-term care and community-based care environment.

  Such diversification will allow not only for revenue enhancement and risk spreading, but allow providers to more fully and holistically care for those to whom they have dedicated their professional lives.

- **Monitor High-Cost Ancillary Services**

  Historical "relationship-based" ancillary relationships (in many ways unfortunately) must give way to models based on a recurrent examination of the cost, efficiency and quality of the services provided. Many of our clients have realized significant cost-savings by periodically competitively bidding high-cost ancillary services, such as therapy and pharmacy. Other clients have started their own ancillary service businesses, or entered into joint ventures with existing ancillary service providers to increase revenue and/or reduce costs. Still, other clients have "out-sourced" certain services to shift risk and/or enhance revenue.

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- **Ensure That Contracts Anticipate Future Contingencies**

  Coupled with the focus on ancillary cost, efficiency and quality is the necessity of adopting systems to ensure that favorable contract terms are achieved by the SNF. Historically, this has been a lax area for most facilities, and the most common approach is still to sign (with very little revision) the contracts proposed by outside vendors. Most SNFs focus only on price and the ability to quickly terminate. While those terms are important, such an approach can leave an organization very exposed. For example, in the last year, our law firm has seen a large number of audits by third-party contractors that have resulted in payment obligations well over $500,000 based primarily on the services provided by ancillary providers. Unfortunately, most vendor-drafted contracts significantly limit a SNF's recoupment options in these situations.

- **Tighten Up Accounts Receivable Practices**

  Perhaps the only thing worse than an empty SNF bed is an occupied SNF bed (for which costs are being incurred) for which the SNF provider is not being paid. The days are long gone in which the SNF provider can afford to incur bad debt of any significant amount. We believe that successful providers will adopt a comprehensive approach to collections that includes implementation of an aggressive accounts receivable policy, use of effective admission materials, application of proper discharge procedures, working with residents and their families to obtain payment voluntarily, and, when necessary, instituting legal action. We are pleased that H.B. 153 has enacted changes to this critical area.

- **Implement & Integrate Quality Tracking Mechanisms**

  Because there are greater monetary rewards for high quality and greater monetary disincentives for low quality, the successful SNF provider will continue to improve its quality tracking mechanisms. With the advent of accountable care organizations and payment penalties for re-hospitalizations, hospitals are choosing (or will choose) partner providers based on quality. Additionally, while the existing quality points will be used in Fiscal Year 2012, a significant expansion of those points is likely to occur for Fiscal Year 2013, with an emphasis on person-centered care and other factors to be determined.

- **Continue Vigorous Focus on Efficient Operation**

  Since 2005 and the effective demise of cost-based reimbursement, SNF providers have focused and improved upon efficiencies through a variety of different techniques while maintaining quality of services. Examples include but are not limited to monitoring and adjusting staffing levels and ratios, wage increases (union

and non-union), employee benefit levels and structures (including self-insurance for health, liability, and workers compensation), cost of capital, and real estate taxes. Successful SNF providers will continue to focus on and maximize the efficiencies to be obtained in these and other areas.

- **Look for Strategic Acquisitions & Dispose of Underperforming Assets**

More opportunities will be created to buy, sell or lease underperforming SNFs. This is especially true after the enactment of Ohio's biennial budget, after which many SNF owners and operators will be less bullish about their business. We will likely see continued consolidation as the cost of compliance and the complexity of the business makes it more difficult for small providers to compete.

Similarly, Ohio's continued reliance upon high FPFs to fund the Medicaid program means that the cost (in FPF alone) to operate a 100 beds SNF bed is in excess of $415,000 per year. H.B. 153 provides new opportunities to buy nursing home beds at lower prices or for an operator to reduce the annual FPF liability imposed upon Ohio SNFs.

- **Differentiate from the Market**

In today's competitive SNF environment, differentiation from the market is critical. For example, providers can differentiate themselves in the market by offering services that competitors do not offer. Also, a well-maintained physical plant can make a significant difference in admissions and occupancy rates. From smaller exterior renovations to entire replacement facilities, "curb appeal" is just as critical for SNFs as it is for residential housing. Interior renovations can also play an important role in differentiating SNFs from their competitors, whether private rooms are being created by the removal of unused beds or whether a wing is being renovated to improve person-centered care.

- **Continue to be Creative**

SNF providers have a long history of "thinking outside of the box", and we believe successful operators will continue to think and act creatively, whether through developing dedicated units for the treatment of low resource utilization residents, participating in pilot projects on the Federal or State level, or seeking new funding mechanisms to supplement "traditional" payer sources.

History has indicated, and our firm strongly believes, that Ohio's SNF owners and operators are resilient and able to adapt to change. The key to continued success for Ohio's SNF owners and operators will be (as it has in the past) to understand and utilize the opportunities provided by H.B. 153, and to review and challenge existing beliefs and practices (even if long-held) to see if they should be changed going into the future.

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Summary

A. Certificate of Need ("CON")

1. *Change of Project Site*

a. Prior Law: Prohibited changing the site of a proposed SNF project without filing a new CON application.

b. H.B. 153: Permits a CON applicant to change the site of the proposed SNF project if the application is not deemed complete or subject to comparative review, and upon payment of a non-refundable fee equal to 25% of the fee charged for the original application.[1]

2. *Bathtub and Shower Requirement*

a. Prior Law: Ohio Administrative Code ("OAC") Rule 3701-17-21 currently requires (subject to waiver) all newly-constructed nursing home rooms to have a shower or bathtub located in a toilet room "directly accessible from and exclusively for each resident sleeping room."

b. H.B. 153: Prohibits rules requiring bathtubs and showers for each resident room (or a percentage thereof) and instead requires rules that bathing (including transportation to bathing facilities) be conducted in a manner that upholds patient dignity and privacy.[2]

B. Medicaid (NF Reimbursement)[3]

1. *General Reimbursement Provisions*

a. Fully implements pricing, except that for Fiscal Year (FY) 2012 only a stop loss provision will limit a SNF's rate reduction to 10% plus half of any amount above 10% that it otherwise would have been reduced. There will be no stop gain.

b. The case-mix scores used to calculate each SNF's July 1, 2011, direct care rate will be the same score used for the January 1, 2011, rate (that is, the average of the June and September 2010 scores). This is a "one-time deal" to avoid an additional $45 million in cuts.

c. The direct care price will be the 25th percentile plus 2%. The consolidated services "add-on" has been moved to the direct care cost center, and the price per case mix unit has been increased by $1.88 to account for these services (down from $3.91).

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[1] *ORC §§ 3702.52, 3702.523, and 3702.57; effective September 29, 2011.*

[2] *ORC §§ 3721.04; effective September 29, 2011.*

[3] *Various Sections of ORC Chapter 5111 and uncodified law of H.B. 153, effective July 1, 2011.*

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d. The capital and ancillary/support prices will be the 25th percentile.

e. A subcommittee of the Unified Long-Term Care System ("ULTCS") Work Group will review the overall SNF reimbursement system and make recommendations by the end of 2012. Peer groups and capital are two of the issues to be considered.

2. ***Franchise Permit Fees***

a. Reduces the franchise permit fee to a base of $11.47 for FY 2012 and $11.67 for FY 2013 (subject to recalibration).

b. Reimbursement for the bed tax will be $11.47 in FY 2012 only, and zero in FY 2013 (moved to quality incentive payment).

c. Requires the franchise permit fee to be re-determined if beds are surrendered between May 1 and January 1.

d. Allocates the franchise permit fee between sellers and buyers upon a change of ownership.

e. County homes are still not subject to the bed tax (but will receive quality incentive payments), although the issue will be studied by a legislative study committee.

3. ***Quality Incentive Payments***

a. The quality incentive payment structure and average amount will be unchanged for FY 2012, except there will be two additional points for above average Medicaid utilization.

b. New quality measures and a new structure for awarding points will be developed by September 1, 2011, by another subcommittee of the ULTCS Work Group. The new structure and measures will be placed in statute, not rule, by December 31, 2011, and the provision for no quality payment if rules are not adopted has been eliminated.

c. The new system will establish a maximum quality payment of $16.44 per day instead of an average (currently $3.03).

d. There will be multiple paths for SNFs to earn quality points and the maximum reimbursement level.

e. However, if the total dollars allocated for quality (defined using the maximum payment) are not awarded, the remaining money will be distributed at the end of FY 2013 as a "quality bonus" to SNFs in a manner to be determined.

4. *Miscellaneous Reimbursement Provisions*

a. Starting in FY 2013 (July 1, 2012), the rate for patients grouping as PA1s and PA2s will be $130. These patients also will be excluded from the SNF's case mix score. There is no change for FY 2012.

b. Leave days will stay at 30 per calendar year, but reimbursement will be cut to 18% of the per diem unless the SNF had better than 95% occupancy in the previous year, in which case reimbursement will be 50%. This change will take effect January 1, 2012.

c. Behavioral and mental health services are being added to the direct care cost center.

d. SNFs will be paid not more than 100% (as opposed to 109% under prior law) of their Medicaid rate for services provided on and after January 1, 2012, for dual-eligible individuals. This will effectively eliminate all Part A crossover payments from Medicaid.

C. Regulatory Relief

1. *Staffing Requirements*

a. Prior Law: OAC Rule 3701-17-08 currently requires each SNF to provide 2.75 hours of "direct care and services per resident per day as follows the "Sub-Ratios"):

   i. A minimum daily average of 2 hours per resident per day to be provided by nurse aides, with the ratio of nurse aides to residents not exceeding 1 nurse aide for every 15 residents or major part thereof.

   ii. A minimum daily average of 2/10 of an hour per resident per day to be provided by registered nurses.

   iii. The remainder of the hours may be provided by nurses, nurse aides, activities aides, occupational therapists, physical therapists, dietitians, and social service workers who provide direct care and services to the residents.

b. H.B. 153: Eliminates the "Sub-Ratios" in OAC Rule 3701-17-08 and reduces the overall staffing ratio to 2.5 hours per patient day. However, only nurses and nurse aides will count against this ratio. Administrative and supervisory nurses are counted.[4]

[4] *ORC § 2117.25; effective September 29, 2011.*

2. *Second Level of Informal Dispute Resolution ("IDR") Hearing*

a. Prior Law: Provided for a two-level IDR process. However, both levels of review were conducted by employees of the Ohio Department of Health, and was a "paper-review" process only.

b. H.B. 153: Allows the second level of IDR to be conducted by a hearing officer upon payment of a fee.[5]

3. *Resident Discharge*

a. Prior Law: Current law requires a discharge notice to specify a proposed location to which the resident will be discharged. A separate section of the law requires the facility to which the resident is being discharged to have accepted the resident prior to the actual discharge taking place. Hearing examiners have (incorrectly, but somewhat consistently) interpreted the law to require that the resident be "accepted" at the discharging facility at the time the discharge notice is issued – a practical impossibility. Thus, acting as a procedural bar to discharging residents when no substantive reason exists.

b. H.B. 153: Clarifies the original intent of the discharge language. Requires the discharge notice to include a proposed location to which the resident "may" relocate and requires a notice that the resident (or the resident's sponsor) may choose another location to which the resident will relocate; requires that proposed location be capable of meeting the resident's needs; and clarifies that the proposed location need not have accepted the resident at the time of the discharge notice.[6]

4. *Priority of Debts in Probate Process*

a. Prior Law: Under prior law, the expenses of a decedent's last continuous stay in a nursing home were given the same priority as any other general creditor of the estate, and were payable only after all other statutory expenses were paid (i.e., probate administration, funeral expenses, expenses of the "last sickness" of the decedent, personal property taxes, Medicaid estate recovery, and other governmental obligations).

b. H.B. 153: Provides that the expenses of a decedent's last continuous stay in a nursing home will be granted priority over the decedent's personal property taxes, Medicaid estate recovery, and other governmental obligations, as well as the other general creditors of the estate.[7]

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[5] *ORC §§ 3721.022 and 3701.83; effective September 29, 2011.*

[6] *ORC § 3721.16; effective September 29, 2011.*

[7] *ORC §§ 3721.04; effective September 29, 2011.*

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D. Medicaid (Non-Reimbursement)

1. *Waiver for Transferring Assets for Less than Fair Market Value*

a. Prior law: The law provides a waiver for individuals who are subject to restricted Medicaid coverage based on a transfer assets for less than fair market value, if an "undue hardship" would be created. The prior law, however, was written in such a way that it was practically impossible for anyone to be granted one.

b. H.B. 153: H.B. 153 modifies the "undue hardship" law to *require* a waiver to be granted if a nursing facility has proposed to discharge an individual in a restricted Medicaid coverage period for failure to pay, the individual requests a hearing, and the discharge is upheld.[8]

2. *Payments for Provider-Preventable Conditions*[9]

H.B. 153 prohibits the ODJFS from knowingly making a Medicaid payment for a provider-preventable condition for which federal financial participation is prohibited by regulations adopted under section 2702 of the "Patient Protection and Affordable Care Act".

3. *Automatic Suspension of Medicaid Provider Agreements*[10]

H.B. 153 requires the ODJFS, on determining there is a creditable allegation of fraud for which an investigation is pending under the Medicaid program against a provider, to suspend the provider agreement held by the provider and terminate Medicaid reimbursement to the provider for services rendered, subject to limited due process rights.

4. *SNF Fiscal Emergencies*[11]

H.B. 153 authorizes the ODJFS, with provider consent, to appoint a "temporary resident safety assurance manager" upon determining that a SNF is "experiencing or is likely to experience a serious financial loss or failure that jeopardizes or is likely to jeopardize the health, safety, and welfare of its residents".

[8] *ORC § 5111.011 and 5111.0116; effective September 29, 2011.*

[9] *ORC § 5111.0214; effective September 29, 2011.*

[10] *ORC §§ 5111.031, 5111.035, and 5111.06; effective September 29, 2011.*

[11] *ORC §§ 5111.35, 5111.511, 5111.52, 5111.54 and 5111.62; effective September 29, 2011.*

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5. *Change of Provider*[12]

H.B. 153 makes various revisions to Ohio's Change of Provider Law, including the following:

a. Provides that a change of provider may not be processed until all information and documentation is received from both the entering operator and the exiting operator.

b. Clarifies that an "involuntary termination" from the Medicaid program is considered a "facility closure."

c. Also clarifies that a "facility conversion" is considered a "facility closure" under certain circumstances.

d. Revises the list of information to be provided upon a change of operator.

6. *Cost Report Fines and Audits*[13]

H.B. 153 makes the following changes to the laws governing the filing and auditing of SNF Medicaid reports:

a. Prohibiting a SNF from amending a Medicaid cost report if the ODJFS has provided notice that an audit is to be conducted.

b. Requiring the ODJFS to make certain changes to the Department's manual for field audits.

c. Requiring the ODJFS to fine a SNF (but not ICF/MR) that files a materially incorrect Medicaid cost report (defined as adverse findings greater than 3% or more of total costs, or 20% of a single cost center).

E. Residential Care Facilities

1. *Maximum Amount of Skilled Nursing Care*

a. Prior Law: Limited the provision of more than 120 days of skilled nursing care to hospice patients.

b. H.B. 153: Expands the ability to provide more than 120 days of skilled care to all individuals when certain conditions are met, including a series of agreements with the individual, the individual's personal physician, and the provider of the skilled nursing care.[14]

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[12] *ORC §§ 5111.65 – 5111.689, effective September 29, 2011.*

[13] *ORC §§ 5111.261, 5111.263, 5111.27, 5111.271, and 5111.28, effective September 29, 2011.*

[14] *ORC §§ 3721.011 and 3721.04; effective September 29, 2011.*

2. *Expanded Assisted Living Waiver*

a. Creates a state-funded Assisted Living Waiver benefit for individuals with pending applications and who meet other requirements for up to 3 months.[15]

b. Eliminates the requirement that a Medicaid AL Waiver recipient be an existing nursing home, RCF, PASSPORT, or Choices participant.[16]

3. *Reduced Rates for Assisted Living Waiver*

Rates for the Assisted Living Waiver program have been reduced 3% effective July 1, 2011 (not set forth in H.B. 153, but administrative rule).

F. PASSPORT and HCBS

1. *Rebalancing Long-Term Care*[17]

Requires the ODJFS, ODA and the Ohio Department of Developmental Disabilities to "strive" to meet the following goals by June 30, 2012:

a. Having at least 50% of Medicaid recipients who are 60 years of age or older and need long-term services and supports utilize non-institutionally-based long-term services and supports;

b. Having at least 60% of Medicaid recipients who are less than 60 years of age and have cognitive or physical disabilities for which long-term services and supports are needed utilize non-institutionally-based long-term services and services.

2. *Expanded PASSPORT Waiver*

a. Creates a state-funded PASSPORT Waiver benefit for individuals with pending applications and who meet other requirements for up to 3 months. Certain individuals can quality for an unlimited number of months.[18]

b. Eliminates the requirement that a PASSPORT Waiver recipient be an existing nursing home, RCF, or Choices participant.[19]

3. *Reduced Medicaid Rates for Aide and Nursing Services*[20]

a. Requires ODJFS to make the following rate reductions for HCBS aide and nursing services.

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[15] *Various Sections of ORC Chapters 173 and 5111, effective September 29, 2011.*

[16] *ORC § 5111.891, effective September 29, 2011.*

[17] *Uncodified law effective July 1, 2011.*

[18] *Various Sections of ORC Chapters 173 and 5111, effective September 29, 2011.*

[19] *ORC § 5111.891, effective September 29, 2011.*

[20] *ORC § 5111.0213; effective September 29, 2011.*

b. Effective September 29, 2011, reduce the Medicaid program's first-hour-unit price for aide services to 97% of the price paid on June 30, 2011, and for nursing services to 95% of the price paid on June 30, 2011;

c. Effective September 29, 2011, pay for a service that is an aide service or a nursing service provided by an independent provider 80% of the price it pays for the same service provided by a provider that is not an independent provider;

d. Not sooner than July 1, 2012, adjust the Medicaid reimbursement rates for aide services and nursing services in a manner that reflects, at a minimum, labor market data, education and licensure status, home health agency and independent provider status, and length of service visit.

4. ***Unified Long-Term Services and Support Medicaid Waiver Program***[21]

Requires the ODJFS and the Ohio Department of Aging ("ODA") to seek federal approval for a unified long-term services and support Medicaid waiver to provide HCBS to eligible individuals of any age who require the level of care provided by SNFs. This would presumably bring the PASSPORT, Choices, Assisted Living, and Ohio Home Care waiver program under a single waiver.

5. ***Dual Eligible Integrated Demonstration Project***[22]

Authorize the Director of the ODJFS to seek federal approval to implement a demonstration project to test and evaluate the integration of the care of dual-eligible individuals.

6. ***Expansion and Evaluation of PACE Program***[23]

Authorizes the Director of the ODA and the Director of ODJFS to expand the area served by the current PACE Program if funding is available and savings would result.

7. ***Long-Term Care Consumer Guide***[24]

Allows the Long-Term Care Consumer Guide to include information about HCBS providers in the Guide.

8. ***Joint Legislative Committee for Unified Long-Term Services and Supports***[25]

[21] *Various Sections of ORC Chapters 173 and 5111, effective September 29, 2011.*

[22] *ORC §§ 5111.944 and 5111.981, effective September 29, 2011.*

[23] *Uncodified law effective July 1, 2011.*

[24] *ORC §§ 173.45 and 173.46; effective September 29, 2011.*

[25] *Uncodified law effective July 1, 2011.*

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Creates a legislative committee (no non-legislative members) to study the following issues:

a. The implementation of the dual eligible integrated care demonstration project described above;

b. The implementation of a unified long-term services and support Medicaid waiver component described above;

c. Providing consumers choices regarding a continuum of services that meet their health-care needs, promote autonomy and independence, and improve quality of life;

d. Ensuring that long-term care services and supports are delivered in a cost effective and quality manner;

e. Subjecting county homes, county nursing homes, and district homes operated pursuant to Chapter 5155. of the Revised Code to the franchise permit fee under sections 3721.50 to 3721.58 of the Revised Code;

f. Other issues of interest to the committee.

9. ***Unified Long-Term Care System Advisory Workgroup***[26]

a. Creates a workgroup to serve in an advisory capacity in the implementation of a unified system long-term care that facilitates all of the following:

    i. Providing consumers choices of long-term care services that meet their health-care needs and improve their quality of life;

    ii. Providing a continuum of long-term care services that meets consumers' needs throughout life and promotes consumers' independence and autonomy;

    iii. Assuring that the state has a system of long-term care services that is cost effective and connects disparate services across agencies and jurisdictions.

b. The workgroup will have four subcommittees as follows:

    i. A subcommittee to study the current and future capacity of nursing facilities in Ohio, the configuration of that capacity, and strategies for addressing nursing facility capacity, including the ability of nursing facility operators to determine the number of beds to certify for participation in the Medicaid program (report due not later than September 1, 2011).

    ii. A subcommittee to study the quality incentive payments to be paid to nursing facilities under the Medicaid program for fiscal year 2013,

[26] *Uncodified law effective July 1, 2011.*

including accountability measures to be used in awarding points for the quality incentive payments and the methodology for calculating the quality incentive payments (report due not later than September 1, 2011).

iii. A subcommittee to study the process of making Medicaid eligibility determinations for individuals seeking nursing facility services (report due not later than December 31, 2011).

iv. A subcommittee to shall study Medicaid reimbursement for nursing facility services, including issues related to the composition of peer groups, methodologies used to calculate reimbursement for capital costs, and the proportion of the total nursing facility reimbursement rate that should be based on the quality of care nursing facilities provide (report due not later than December 31, 2012).

G. Medicaid (ICF/MR Reimbursement)[27]

1. *General Reimbursement Provisions*

a. A negotiated interim formula is set forth in uncodified law with lower ceilings and inflation factors will be used to calculate a reimbursement rate for both FY 2012 and 2013. This rate will then be blended 50/50 with the rate calculated under the current formula with the rollback, thereby reducing the rollback.

b. The 1% cut in the statewide average rate cap will be restored, which will reduce the rollback further.

2. *Study of Reimbursement Issues*[28]

ODJFS and ODODD are required to study issues regarding Medicaid reimbursement for ICF/MR services. In conducting the study, the Departments shall examine the following:

a. Revising the Individual Assessment Form Answer Sheet in a manner that provides a more accurate assessment of the acuity and care needs of individuals who need ICF/MR services, especially the acuity and care needs of such individuals who have intensive behavioral or medical needs;

b. Revising the Medicaid reimbursement formula for ICF/MR services to accomplish the following:

c. Ensure that reimbursement for capital costs is adequate for maintaining the capital assets of ICFs/MR in a manner that promotes the well-being of the residents;

[27] *Various Sections of ORC Chapter 5111 and uncodified law of H.B. 153, effective July 1, 2011.*

[28] *Uncodified law effective July 1, 2011.*

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d. Provide capital incentives for reducing the capacity of ICFs/MR as necessary to achieve goals regarding the optimal capacity of ICFs/MR;
e. Ensure that wages paid individuals who provide direct care services to ICF/MR residents are sufficient for ICFs/MR to meet staffing and quality requirements;
f. Provide incentives for high quality services;
g. Achieve other goals developed for the purpose of improving the appropriateness and sufficiency of Medicaid reimbursements for ICF/MR services.

3. ***Miscellaneous Reimbursement Provisions***

a. Sets the franchise permit fee at $17.99 for FY 2012 and $18.32 for FY 2013 (subject to adjustment).

b. Depreciation recapture is repealed for ICFs/MR effective September 29, 2011.

c. Permits partial (as opposed to total) conversion of ICF/MR beds to HCBS on a voluntary basis. Permits ODJFS to see federal approval of 200 (as opposed to 100) slots for these conversions.

d. The ODODD will assume ODJFS's powers and duties with respect to the Medicaid program's coverage of ICF/MR services and to administer the Transitions Developmental Disabilities Medicaid Waiver.

H. ICF/MR Regulatory

1. ***Programs for Children with Intensive Behavioral Needs***

Increases maximum age for participants in these programs from 21 to 22.

2. ***Interagency Work Group on Autism***

Authorizes the establishment of an Interagency Workgroup on Autism.

3. ***Services to Former Residents of Develoopmental Centers***

Repeals a provision that required ODODD to provide or arrange for the provisions of residential services to former residents of developmental centers that have closed.

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