DEPARTMENT OF DEVELOPMENTAL DISABILITIES

Community facility sale proceeds

- Permits a county board of developmental disabilities or board of county commissioners to use the proceeds from the sale of a community adult facility or a community early childhood facility to renovate or make accessible housing for individuals with developmental disabilities.

- Permits the Director of Developmental Disabilities to establish and extend a deadline by which the county board or board of county commissioners must use sale proceeds.

Medicaid payments

- Provides for the FY 2018 Medicaid rates for intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) in peer groups 1 and 2 to be determined in accordance with a formula in continuing law, with certain modifications.

- Provides for the FY 2018 Medicaid rate for all ICFs/IID in peer groups 1 and 2 to be adjusted if the mean total per Medicaid day rate for all such ICFs/IID is other than a certain amount, which cannot be less than $290.10.

- States the General Assembly's intent to enact legislation establishing a new formula to determine the rates beginning not sooner than July 1, 2018, and not later than January 1, 2019.

- Requires the Department of Developmental Disabilities to work in collaboration with certain organizations to finalize recommendations for the new formula.

- Requires that the recommendations include certain features, including a feature that establishes a method to transition ICFs/IID to the new formula during a 36-month period.

- Provides for an ICF/IID's rate for the part of FY 2019 that is before the new formula takes effect to be determined in the same manner that its FY 2018 rate is determined, except that data for a subsequent fiscal or calendar year is to be used to determine certain parts of the rate.

- Provides for an ICF/IID's rate for the part of FY 2019 that begins when the new formula takes effect to be determined in accordance with the new formula and be

subject to (1) a maximum of $295.90 per Medicaid day and (2) the transition that must be included in the Department's recommendations for the new formula.

- Eliminates a requirement that an ICF/IID resident be under age 22 to qualify for outlier ICF/IID services available to certain Medicaid recipients dependent on a ventilator.

- Provides for the Medicaid rate for each 15 minutes of routine homemaker/personal care services provided to a qualifying enrollee of the Individual Options waiver program to be, for 12 months, 52¢ higher than the rate for such services provided to an Individual Options enrollee who is not a qualifying enrollee.

County board share of expenditures

- Modifies a county board's responsibility to pay the nonfederal share of Medicaid expenditures for residents of ICFs/IID.

- Requires the Director to establish a methodology to estimate in FY 2018 and FY 2019 the quarterly amount each county board is to pay of the nonfederal share of the Medicaid expenditures for which the board is responsible.

Developmental centers

- Permits a developmental center to provide services to persons with developmental disabilities living in the community or to providers of services to these persons.

Innovative pilot projects

- Permits the Director to authorize, in FY 2018 and FY 2019, innovative pilot projects that are likely to assist in promoting the objectives of state law governing the Department and county boards.

Use of county subsidies

- Requires, under certain circumstances, that the Director pay the nonfederal share of a claim for ICF/IID services using subsidies otherwise allocated to county boards.

County boards' waiting lists

- Requires a county board to establish a waiting list for Medicaid-funded home and community-based services if resources are insufficient to enroll all individuals assessed as needing the services.

- Replaces statutory criteria for emergency or priority placement on a county board waiting list with a requirement that the Director adopt rules regarding how

individuals are placed on or removed from a waiting list or enrolled in a Medicaid waiver administered by the Department.

County board employment restrictions

- Limits to spouses, sons, and daughters the members of a county commissioner's immediate family who are prohibited from being employed by the county board of developmental disabilities.

Stakeholder workgroup

- Requires the Department to convene a stakeholder workgroup to evaluate services provided to individuals with developmental disabilities living in the community and to develop recommendations related to the provision of such services.

- Requires the workgroup to submit a report with the recommendations to the Department and General Assembly.

Community facility sale proceeds

(R.C. 5123.377 and 5123.378)

The act expands the conditions under which the Director of Developmental Disabilities may change the terms of an agreement with a county board of developmental disabilities or board of county commissioners regarding the construction, acquisition, or renovation of a community adult facility or a community early childhood facility. Under continuing law, agreements for such a facility must include, if the facility is sold, a commitment from the county board or board of county commissioners to use the sale proceeds for housing for individuals with developmental disabilities or to reimburse the outstanding balance owed to the Department of Developmental Disabilities under the agreement. The act permits a county board or a board of county commissioners to also use sale proceeds for the renovation or accessibility modification of housing for individuals with developmental disabilities. The renovation or modification must comply with the requirements established by the Director.

The act permits the Director to establish a deadline by which the county board or board of county commissioners must use the sale proceeds. The Director may extend the deadline as many times as the Director determines necessary.

"Renovation," as defined by the act, is work to restore a building to an acceptable condition and to make it functional for use with individuals with developmental disabilities. It includes architectural and structural changes and the modernization of mechanical and electrical systems, but it does not include work consisting primarily of maintenance repairs and replacements that are necessary due to normal use, wear and tear, or deterioration.

FY 2018 Medicaid rates for ICF/IID services

(Sections 261.165, 261.167, 261.168, and 261.1695)

The act requires Medicaid rates for services provided during FY 2018 by intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) in peer groups 1 and 2 to be determined in accordance with a formula established in continuing law, with certain modifications. It establishes separate modifications for existing ICFs/IID and for new ICFs/IID that begin to participate in Medicaid during the fiscal year.

Peer group 1 consists of ICFs/IID with a Medicaid-certified capacity exceeding eight. Peer group 2 consists of those with a Medicaid-certified capacity not exceeding eight, except for facilities in peer group 3. Peer group 3 consists of ICFs/IID that (1) are certified as an ICF/IID after July 1, 2014, (2) have a Medicaid-certified capacity not exceeding six, (3) have a contract with the Department that is for 15 years and includes a provision for the Department to approve all admissions and discharges, and (4) have residents who are admitted directly from a developmental center or have been determined by the Department to be at risk of admission to a developmental center.[54] These provisions do not apply to ICFs/IID in peer group 3.

FY 2018 modifications for existing ICFs/IID

Under the act, the following modifications are to be made in determining the Medicaid rates for each existing ICF/IID in peer group 1 or 2:

(1) The ICF/IID's efficiency incentive for capital costs is to be reduced by 50%.

(2) The facility's maximum cost per case-mix score is to be the amount the Department determined for the peer group for FY 2016.

(3) An inflation adjustment of 1.4% is to be used in place of the inflation adjustment otherwise calculated as part of the process of determining the ICF/IID's rate for *direct* care costs.

[54] R.C. 5124.01, not in the act.

(4) In place of the efficiency incentive otherwise calculated when determining the rate for indirect care costs, the facility's efficiency incentive for indirect care costs is to be not more than $3.69 if the facility is in peer group 1 or not more than $3.19 if it is in peer group 2.

(5) In place of the maximum rate for indirect care costs otherwise established for the peer group, the maximum rate for indirect care costs for the ICF/IID's peer group is to be an amount the Department is to determine. In determining the maximum rate, the Department must strive to the greatest extent possible to (a) avoid rate reductions under the act's provision concerning maximum and minimum rates (see "**FY 2018 maximum and minimum rate adjustment**," below) and (b) result in payment of all desk-reviewed, actual, allowable indirect care costs for the same percentage of Medicaid days for ICFs/IID in peer group 1 as for those in peer group 2 as of July 1, 2017, based on Medicaid days for May 2017. Medicaid days are all days (1) during which a resident who is a Medicaid recipient occupies a bed in an ICF/IID that is part of the facility's Medicaid-certified capacity and (2) for which a Medicaid payment is made to reserve an ICF/IID bed for a Medicaid recipient temporarily absent from the facility.[55]

(6) An inflation adjustment of 1.4% is to be used in place of the inflation adjustment otherwise calculated when determining the ICF/IID's rate for *indirect* care costs.

(7) In place of the inflation adjustment otherwise made when determining the rate for other protected costs, the facility's desk-reviewed, actual, allowable, per Medicaid day other protected costs, excluding the cost of the ICF/IID franchise permit fee, from calendar year 2016 is to be increased by 1.4%.

(8) After all modifications discussed above are made, the facility's total per Medicaid day rate is to be increased by a direct support personnel payment equal to 3.04% of the facility's allowable per Medicaid day direct care costs from calendar year 2016.

FY 2018 modifications for new ICFs/IID

Under the act, the following modifications are to be made in determining the Medicaid payment rates for each new ICF/IID in peer group 1 or 2:

(1) The new facility's initial per Medicaid day rate for capital costs is to be the median rate for all existing ICFs/IID determined using the modifications discussed above.

[55] R.C. 5124.01, not in the act.

(2) If there is no cost or resident assessment data for the new ICF/IID, its initial per Medicaid day rate for direct care costs is to be determined by (a) determining the median of the costs per case-mix units of each peer group, (b) multiplying that median by the median annual average case-mix score for the new facility's peer group for calendar year 2016, and (c) inflating that product by 1.4%.

(3) The new facility's initial per Medicaid day rate for indirect care costs is to be the maximum rate for indirect care costs that the Department determines for its peer group. The maximum rate is to be determined in the same manner such a maximum rate is to be determined under the act for existing ICFs/IID (see above).

(4) The new facility's initial per Medicaid day rate for other protected costs is to be 115% of the median rate for all existing ICFs/IID determined using the modifications discussed above.

(5) After all modifications discussed above are made, the new facility's initial total per Medicaid day rate is to be increased by the median direct support personal payment made for existing ICFs/IID (see above).

A new ICF/IID's initial rate for FY 2018 is to be adjusted in accordance with continuing law governing the adjustment of initial rates. If the adjustment affects the new facility's FY 2018 rate, the modifications made under the act to the rates of existing ICFs/IID are to apply to the new facility's adjusted rate.

FY 2018 maximum and minimum rate adjustment

The act provides for all ICFs/IID in peer groups 1 and 2 to have their total per Medicaid day rate for FY 2018 adjusted up or down if the mean total per Medicaid day rate for all such facilities (as determined under the act as of July 6, 2017, and weighted by Medicaid days for May 2017) is other than a certain amount. The adjustment is to be the percentage by which the mean total per Medicaid day rate is greater or less than the amount. The amount used for this adjustment may not be less than $290.10, but the Department, in its sole discretion, may use a larger amount. In determining whether to use a larger amount, the Department may consider any of the following:

(1) The reduction in the total Medicaid-certified capacity of all ICFs/IID that occurs in FY 2017, and the reduction that is projected to occur in FY 2018, as a result of (a) a downsizing in an ICF/IID's Medicaid-certified capacity pursuant to a Department-approved plan or (b) a conversion of ICF/IID beds to providing home and community-based services under the Individual Options Medicaid waiver;

(2) The increase in Medicaid payments made for ICF/IID services provided during FY 2017, and the increase that is projected to occur in FY 2018, as a result of the

modifications made to Medicaid payments under continuing law that encourages ICFs/IID to downsize or partially convert to providing home and community-based services;

(3) The total reduction in the number of ICF/IID beds that occurs pursuant to continuing law that requires the Department to strive to achieve a statewide bed reduction by July 1, 2018;

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

FY 2018 rate reduction if franchise permit fee is reduced or eliminated

If the federal Centers for Medicare and Medicaid Services requires that the ICF/IID franchise permit fee be reduced or eliminated, the Department must reduce the amount it pays ICFs/IID in peer groups 1 and 2 for FY 2018 as necessary to reflect the loss of the revenue and federal financial participation generated from the franchise permit fee.

General Assembly's intent to enact new ICF/IID formula

The act states the General Assembly's intent to enact legislation establishing a new formula to determine Medicaid rates for ICF/IID services beginning not sooner than July 1, 2018, and not later than January 1, 2019.

The Department must work in collaboration with the following organizations to finalize recommendations for the new formula to be submitted to the General Assembly: 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. The Department is prohibited from submitting recommendations for the new formula unless all of those organizations support the recommendations.

The act requires that all of the following be included in the recommendations for the new formula:

(1) Using the Ohio Developmental Disabilities Profile as the assessment instrument for determining case-mix scores used to calculate rates for the direct care costs of ICFs/IID;

(2) Determining rates for capital using an ICF/IID's current asset value and a rate of return;

(3) Including all of the following in the calculation of an ICF/IID's current asset value: the facility's age, the date and cost of capital improvements made to the facility,

the facility's current Medicaid-certified capacity, an RS Means Construction Cost Index, a rate of depreciation, estimated equipment value, and estimated land value;

(4) Establishing a quality incentive rate component to take effect July 1, 2019, and having the initial rate determined using data from calendar year 2018;

(5) Establishing new peer groups that are differentiated by Medicaid-certified capacity;

(6) Considering the changing acuity level of ICF/IID residents, including residents with intensive behavioral and intensive medical needs;

(7) Establishing a method to transition ICFs/IID to the new formula for the first 36 months that it is in effect. Specifically, the Department must compare each facility's Medicaid rate under the new formula with its rate under the existing formula as modified for a fiscal year by law (i.e., its current formula rate) and do the following:

(a) Pay the facility its current formula rate instead of the new formula rate, if the new rate is less than its current formula rate;

(b) Subject to a possible rate increase limit (discussed next), pay the facility the new formula rate if that rate is greater than its current formula rate; and

(c) Specify, to the extent the Department determines necessary, a maximum percentage by which an ICF/IID's new formula rate may exceed its current formula rate, and adjust the new rate in accordance with the maximum percentage if the percentage difference between the new and current formula rates exceeds the maximum percentage. If the Department specifies a maximum percentage, it must strive to the greatest extent possible to ensure that the mean per Medicaid day rate for FY 2019 under the new formula equals the rate cap the Department establishes. (See "**FY 2019 rates under new formula**," below.)

FY 2019 rates under current formula

The formula established in continuing law is to be used with certain modifications to determine the Medicaid rates for services provided by ICFs/IID in peer groups 1 and 2 during the period beginning July 1, 2018, and ending on the date that rates begin to be determined using the new formula. The same modifications and limitations that apply to the FY 2018 formula must be made for this period, except that data for a subsequent fiscal year or calendar year is to be used for certain of the modifications. For example, an ICF/IID's per Medicaid day other protected costs, excluding its franchise permit fee, from calendar year 2017, instead of calendar year

2016, is to be used in determining the inflation adjustment made as part of the process of determining the rate for other protected costs.

FY 2019 rates under new formula

Medicaid rates for ICF/IID services are to cease being determined in accordance with the current formula beginning on the date the new formula begins to be used. The rates for the remainder of FY 2019 are to be determined in accordance with the new formula, but will be subject to an adjustment described below and the transition methodology described above.

An adjustment is to be made if the mean total per Medicaid day rate for ICFs/IID under the new formula, weighted by May 2018 Medicaid days, is other than an amount that the Department is to determine, which may not exceed $295.90. If the adjustment is to be made, the Department must adjust the rate by the percentage by which the rate determined under the new formula and in accordance with the transition methodology, is greater or less than the amount determined by the Department.

The Department must reduce the rate if the federal Centers for Medicare and Medicaid Services requires that the franchise permit fee imposed on ICFs/IID be reduced or eliminated. The reduction must reflect the loss of the revenue and federal match generated by the franchise permit fee.

Ventilator-dependent ICF/IID residents

(R.C. 5124.25 with a conforming change in R.C. 5124.15)

The act eliminates a requirement that a Medicaid recipient be under age 22 to qualify to receive outlier ICF/IID services. The recipient must continue to be dependent on a ventilator and meet all other eligibility requirements established in rules to qualify. The Department is permitted by continuing law to pay a Medicaid rate add-on to a facility for outlier ICF/IID services provided to qualifying Medicaid recipients. However, it may not pay the add-on unless the Department of Medicaid has approved the amount of the add-on or the method by which the amount is to be determined.

Medicaid rates for homemaker/personal care services

(Section 261.210)

The act requires that the total Medicaid payment rate for each 15 minutes of routine homemaker/personal care services that a Medicaid provider provides to a qualifying enrollee of the Individual Options Medicaid waiver program be 52¢ higher than the rate for services that a Medicaid provider provides to an enrollee who is not a qualifying enrollee. The higher rate is to be paid only for the first 12 months,

consecutive or otherwise, that the provider provides the services to the qualifying enrollee during the period beginning July 1, 2017, and ending June 30, 2019.

An Individual Options enrollee is a qualified enrollee if all of the following apply:

(1) The enrollee resided in a developmental center, converted ICF/IID,[56] or public hospital immediately before enrolling in the Individual Options Medicaid waiver program.

(2) The enrollee did not receive before July 1, 2011, routine homemaker/personal care services from the Medicaid provider that is to receive the higher Medicaid rate.

(3) The Director of Developmental Disabilities has determined that the enrollee's special circumstances (including diagnosis, service needs, or length of stay at the developmental center, converted ICF/IID, or public hospital) warrant paying the higher Medicaid rate.

Nonfederal share of Medicaid expenditures for ICFs/IID

(R.C. 5123.38)

The act modifies the law making a county board of developmental disabilities responsible for the nonfederal share of Medicaid expenditures for certain individuals' care in a state-operated ICF/IID. Under prior law, a county board was responsible for the nonfederal share if the individual had been involuntarily committed to a state-operated ICF/IID and received supported living or home and community-based services funded by the county board. The act removes the condition regarding supported living or home and community-based services, thereby making a county board responsible for the nonfederal share of all expenditures for individuals who have been involuntarily committed from the county served by the county board.

The act eliminates an exemption to the requirement that applied to a county board that began funding supported living or home and community-based services within 90 days of an individual's commitment to the facility. Instead, it exempts a county board from the requirement if, within 180 days of an individual's commitment, the county board arranges for the provision of alternative services for the individual, and the individual is discharged from the ICF/IID.

[56] A converted ICF/IID is an ICF/IID, or former ICF/IID, that converted some or all of its beds to providing services under the Individual Options Medicaid waiver program.

County board share of nonfederal Medicaid expenditures

(Section 261.130)

The act requires the Director of Developmental Disabilities to establish a methodology to estimate in FY 2018 and FY 2019 the quarterly amount each county board is to pay of the nonfederal share of the Medicaid expenditures for which the board is responsible. With certain exceptions, continuing law requires the county board to pay this share for waiver services provided to an individual who the board determines is eligible for its services.

Each quarter, the Director must submit to the county board written notice of the amount for which the board is responsible. The notice must specify when the payment is due.

Developmental center services

(Section 261.150)

The act permits a residential center for persons with developmental disabilities operated by the Department of Developmental Disabilities (i.e., a developmental center) to provide services to persons with developmental disabilities living in the community or to providers of services to these persons. The Department may develop a method for recovery of all costs associated with the provision of the services.

Innovative pilot projects

(Section 261.160)

For FY 2018 and FY 2019, the act permits the Director to authorize the continuation or implementation of innovative pilot projects that are likely to assist in promoting the objectives of state law governing the Department and county boards. Under the act, a pilot project may be implemented in a manner inconsistent with the laws or rules governing the Department and county boards; however, the Director cannot authorize a pilot project to be implemented in a manner that would cause Ohio to be out of compliance with any requirements for a program funded in whole or in part with federal funds. Before authorizing a pilot project, the Director must consult with entities interested in the issue of developmental disabilities, including the Ohio Provider Resource Association, Ohio Association of County Boards of Developmental Disabilities, Ohio Health Care Association/Ohio Centers for Intellectual Disabilities, the Values and Faith Alliance, and ARC of Ohio.

Use of county subsidies to pay nonfederal share of ICF/IID services

(Section 261.200)

The act requires the Director to pay the nonfederal share of a claim for ICF/IID services using funds otherwise appropriated for subsidies to county boards if (1) Medicaid covers the services, (2) the services are provided to a Medicaid recipient who is eligible for them and the recipient does not occupy a bed that used to be included in the Medicaid-certified capacity of another ICF/IID certified before June 1, 2003, (3) the services are provided by an ICF/IID whose Medicaid certification was initiated or supported by a county board, and (4) the provider of the services has a valid Medicaid provider agreement for the services for the time that they are provided.

County board waiting lists

(R.C. 5126.042, 5126.054, and 5166.22)

When a waiting list is required

The act revises the law governing waiting lists that county boards establish for home and community-based services available under Medicaid waivers administered by the Department. Under prior law, a county board had to establish a waiting list if it determined that available resources were insufficient to meet the needs of all individuals who requested the services. The act requires instead that a county board establish a waiting list for the services if it determines that available resources are insufficient to enroll all individuals who are assessed as needing the services.

Waiting list policies to be established in rules

Prior law specified that an individual's date of placement on a waiting list was the date a request was made to a county board for the services. It also specified when an individual was to receive priority when placed on a waiting list, which included when an individual was at risk of substantial self-harm or substantial harm to others if action was not taken within 30 days. The act eliminates these provisions and instead requires county boards to establish waiting lists in accordance with rules the Director is required to adopt. The rules must establish:

(1) Procedures a county board is to follow to transition individuals from the current waiting list to the new waiting list;

(2) Procedures by which a county board is to ensure that due process rights of individuals placed on the waiting list are observed;

(3) Criteria a county board is to use to determine (a) an individual's eligibility to be placed on the waiting list, (b) the date an individual was assessed as needing the services, (c) the order in which individuals on the waiting list are to be offered enrollment, and (d) the Medicaid waiver in which an individual on the waiting list is to be offered enrollment; and

(4) Grounds for removing an individual from the waiting list.

The Director must consult with the following when adopting the rules:

(1) Individuals with developmental disabilities;

(2) Associations representing individuals with developmental disabilities and their families;

(3) Associations representing providers; and

(4) The Ohio Association of County Boards Serving People with Developmental Disabilities.

County board plans regarding home and community-based services

Continuing law requires each county board to develop a three-calendar-year plan regarding home and community-based services available under Medicaid waivers administered by the Department. The plan must include the following three components: an assessment component, a preliminary implementation component, and implementation component for new recipients.

The assessment component must contain certain information. Under prior law, the information included the number of individuals with developmental disabilities residing in the county who were given priority on a waiting list for home and community-based services. The act instead requires that the information include the number of such individuals who are placed on a county board's waiting list.

Prior law required that the preliminary implementation component specify the number of individuals to be provided home and community-based services pursuant to the waiting list priority given to them during the first year that the plan was in effect. The act requires instead that the component specify the number of individuals to be provided home and community-based services pursuant to their placement on the waiting list.

The implementation component for new recipients must specify how Medicaid case management services and home and community-based services are to be phased in over the period the plan covers. Under prior law, this had to include how the county

board would serve individuals with priority on the waiting list. The act requires instead that this include how the county board will serve individuals placed on the waiting list.

County board allocations for home and community-based services

The Department must consider certain information when allocating to county boards enrollment numbers for home and community-based services. Under prior law, this included information regarding individuals *with priority status* on the county waiting lists. The act eliminates this reference to priority status because it eliminates the priority requirements for waiting lists.

County board employment restrictions

(R.C. 5126.0221)

Under continuing law, certain members of a county commissioner's immediate family[57] are prohibited from being employed by the county board of developmental disabilities for the county the commissioner serves. The act narrows this prohibition so that it applies only to a spouse, son, or daughter. The following, however, are no longer prohibited from employment: a parent, grandparent, brother, sister, aunt, uncle, mother-in-law, father-in-law, brother-in-law, sister-in-law, son-in-law, or daughter-in-law.

Stakeholder workgroup

(Section 261.230)

The act requires the Department to convene a stakeholder workgroup to evaluate services provided to individuals with developmental disabilities living in the community and to develop recommendations related to those services. The workgroup must convene by July 29, 2017, and must develop and submit a report with its recommendations within one year after it first convenes.

Report

The workgroup must develop a report with recommendations addressing the following topics:

(1) Determining whether immediate action is necessary to ensure the health and safety of an individual with a developmental disability or a group of such individuals, including through the use of standardized protocols;

[57] R.C. 5126.01, not in the act.

(2) Supporting quality services beyond those necessary for minimum compliance;

(3) Monitoring the health and safety of individuals with developmental disabilities, including through onsite monitoring and monitoring conducted or arranged for by the Department;

(4) Clarifying the roles and responsibilities of the Department, county boards of developmental disabilities, and service providers, including when adverse actions are taken.

The workgroup may include any other recommendations in the report it determines necessary. The report must be submitted to the Department and General Assembly. On submission of the report, the workgroup ceases to exist.

Rulemaking

The act permits the Director to adopt rules implementing the workgroup's recommendations. If the Director does not have authority to adopt a particular rule or a workgroup recommendation requires a statutory change, the workgroup's report must include a recommendation that the General Assembly grant the Director that authority or enact legislation making the statutory change.

Membership

The workgroup must include as members representatives of the Department, county boards, service providers, and individuals with developmental disabilities and their families. Workgroup members serve without compensation or reimbursement, except to the extent that serving on the workgroup is part of their usual job duties. A representative of the Department is to serve as chairperson. The Department is responsible for providing the workgroup with administrative assistance.