**\* D R A F T \***

**IAF Scores**

*Plan A*

Exception review.

HB 59 as introduced contains statutory provisions authorizing DODD to conduct exception reviews of ICFs (5124.193). Reviews can be based on survey findings, risk analysis, or prior performance. They can be done before or after rates are set. If a review is done before rates are set, it affects the provider's rate prospectively. If it is done afterward, the provider must repay any amounts overpaid. See also 5124.192(B)(1)(b), 5124.38(A), 5124.40, 5124.41(A)(3), and 5124.46(B).

The statute also provides the Director with rulemaking authority relative to exception reviews. The model for the ICF exception review rule presumably would be OAC 5101:3-3-43.4, the existing rule for SNFs (see text below).

The associations support enactment of the exception review provisions in HB 59 and prompt adoption of the rules needed to implement the statutes.

Use of DODD IAF scores.

DODD would use the IAF scores compiled by department reviewers to identify facilities for exception reviews. Variances between the provider's scores and the department's scores, as well as variances in a provider's scores over time, clearly meet the definition of risk analysis set forth in the rule below.

The associations support using the DODD scores to determine the need for an exception review. If the department considers it necessary or helpful, we also would support language explicitly recognizing the DODD scores as a trigger for exception review and shortening the current 80 day period for submitting IAF corrections.

IAF scores for the July 1, 2013, ratesetting and after.

The associations propose basing the July 1, 2013, rates on the average of the facility IAF scores from the December 2012 and March 2013 quarters. The average would be used to set the ceiling, to calculate each facility's cost per case mix unit, and to multiply by the lesser of the ceiling or the facility's CPCMU to set the facility specific rate.

Subsequently, rates and ceilings would be adjusted January 1, 2014, using the average of the provider-generated IAF scores from June and September 2013. The same schedule and process would be followed going forward.

This approach would eliminate the heightened importance of the March quarterly scores by giving each quarter equal weight.

*Plan B*

For purposes of the July 1, 2013, ratesetting, the associations propose to use, both as the "annual score" and the "quarterly score" for purposes of setting ceilings and rates, a four quarter average IAF score. Three of the four quarterly scores that would be averaged would be the facility submitted scores for the June, September, and December quarters of 2012, with the scores from the DODD reviews making up the fourth quarter.

Subsequently, rates and ceilings would be adjusted January 1, 2014, using the average of the facility generated IAF scores from June and September 2013. The semi-annual adjustment using a two quarter average would be used going forward.

This approach would eliminate the heightened importance of the March quarterly scores by giving each quarter equal weight.

As a protection against extreme changes in rates, we propose to maintain the 10% stop loss provision that was in HB 303.

**Downsizing/Conversion**

The associations propose the following language:

"(A) The state of Ohio hereby establishes the following goals for changes in the state's system of services for individuals with intellectual disabilities:

(1) Reduction of the statewide number of beds in ICFs/IID with sixteen or more beds through downsizing into ICFs/IID with fewer than sixteen beds. The specific goal for reduction through downsizing is five hundred beds by July 1, 2018.

(2) Reduction of the statewide number of beds in ICFs/IID of any size through conversion to waiver services. The specific goal for reduction through conversion to waiver services is five hundred to six hundred beds by July 1, 2018.

(B) The Department of Developmental Disabilities and the Ohio Association of County Boards, the Ohio Provider Resource Association, the Ohio Health Care Association/Ohio Centers for Intellectual Disabilities, and the Values and Faith Alliance shall cooperate in achieving the goals specified in division (A) of this section. Cooperation may include all of the following:

(1) Identifying ICFs/IID that are candidates for downsizing or conversion to waiver services;

(2) Encouraging operators of ICFs/IID to downsize and to convert to waiver services, establishing interim timeframes for progress toward the goals;

(3) Creating incentives and removing impediments to downsizing and conversion;

(4) In the case of conversion, developing a mechanism to compensate providers for ICF/IID beds that are removed from service permanently.

(C) The department and the associations identified in division (B) of this section shall meet regularly, no less than twice per year, to review progress in achieving the goals specified in division (A) of this section, to prepare written reports of the progress, and to identify additional measures needed to ensure achievement of the goals."

**5101:3-3-43.4 Exception review process for nursing facilities (NFs).**

(A) The definitions of all terms not defined in this rule are the same as set forth in rules [5101:3-3-01](http://codes.ohio.gov/oac/5101%3A3-3-01) and 5101:3-3- 43.1 of the Administrative Code.

(1) “Combination review” is a type of exception review where the Ohio department of job and family services (ODJFS) reviews records selected in one of the following ways:

(a) A combination of records selected pursuant to random and targeted criteria; or

(b) Records initially selected for a targeted review, but insufficient records were available to meet the targeted review sample size requirements, are combined with randomly selected records to complete the sample size.

(c) Records initially selected for a random review combined with records selected for a targeted review as a result of findings of the random review.

(2) “Exception review” is a review of minimum data set (MDS) assessment data. It is conducted at a selected nursing facility (NF) by registered nurses and other appropriate licensed or certified health professionals employed by or under contract with ODJFS for purposes of identifying any patterns or trends related to resident assessments submitted in accordance with rule 5101:3-3- 43.1 of the Administrative Code, which could result in inaccurate case mix scores used to calculate the direct care rate.

(3) “Effective date of the rate” is either the first day of July or January for a given fiscal year.

(4) “Exception review tolerance level” is the level of variance between the facility and ODJFS in MDS assessment item responses affecting the resource utilization groups, version III (RUG III) classification of a facility’s residents. Two kinds of tolerance levels have been established for exception reviews: initial sample tolerance level, and expanded review tolerance level.

(a) “Initial sample tolerance level” is the percentage of unverifiable records found during the initial sample of an exception review, below which no further review will be pursued for the same six month period. The initial sample tolerance level shall be less than fifteen per cent of the entire sample.

(b) “Expanded review tolerance level” is an acceptable level of variance in the calculation of a provider’s quarterly facility average medicaid case mix score or an acceptable per cent of the records sampled at exception review that were unverifiable.

(5) “Random review” is a type of exception review that examines randomly selected records from any of the RUG III major categories identified in rule 5101:3-3- 43.2 of the Administrative Code.

(6) “Record” is an MDS assessment identified as a medicaid record as set forth in paragraph (D)(2) of rule 5101:3-3- 43.3 of the Administrative Code.

(7) “Targeted review” is a type of exception review that targets records in restorative nursing programs, current toileting program or trial, and/or bowel toileting program, clinically complex with symptoms of depression, or one or more of the seven mutually exclusive RUG III major categories identified in rule [5101:3-3-43.2](http://codes.ohio.gov/oac/5101%3A3-3-43.2) of the Administrative Code. Nursing rehabilitation/restorative care includes records grouped in the following RUG III classifications: RLB, RLA, IB2, IA2, BB2, BA2, PE2, PD2, PC2, PB2, and PA2 as identified in rule [5101:3-3-43.2](http://codes.ohio.gov/oac/5101%3A3-3-43.2) of the Administrative Code. Clinically complex with depression includes records grouped in the following RUG III classification: CC2, CB2, and CA2 as identified in rule 5101:3-3- 43.2 of the Administrative Code.

(8) The “variance” is the percentage difference between the quarterly facility average medicaid case mix score based on exception review findings and the quarterly facility average medicaid case mix score from the provider’s submitted MDS records.

(a) The exception review tolerance level shall be either less than a two per cent variance between the quarterly facility average medicaid case mix score based on exception review findings and the quarterly facility average medicaid case mix score from the provider’s submitted MDS records or less than twenty per cent of the medicaid records sampled at exception review were unverifiable.

(b) The variance calculation will not recognize modifications to MDS

assessments and new assessments following an inactivation, submitted by the facility after notification of the exception review.

(9) A “verifiable MDS record” is a provider’s completed MDS assessment form, based on facility supplied MDS assessment data, submitted to the state for a resident for a specific reporting quarter, which upon examination by ODJFS during an exception review, has been determined to accurately represent the aspects of the resident’s condition, during the specified assessment time frame, that affect the correct RUG III classification of that record.

(10) An “unverifiable MDS record” is a provider’s completed MDS assessment form, based on facility supplied MDS assessment data, submitted to the state for a resident for a specific reporting quarter which, upon examination by ODJFS, has been determined to inaccurately represent the aspects of the resident’s condition, during the specified assessment time frame, that affect the RUG III classification of that record. MDS coding may be deemed unsupported if inconsistencies are found in the sources of information through verification activities.

(B) All exception reviews will comply with the applicable provisions of the medicare and medicaid programs.

(C) Providers may be selected for an exception review by ODJFS based on any of the following:

(1) The findings of a certification survey conducted by the Ohio department of health that may indicate that the facility is not accurately assessing residents, which may result in the resident’s inaccurate classification into the RUG III system;

(2) A risk analysis profile that may include, but is not limited to, one or more of the following:

(a) A change in the frequency distribution of their residents in the major RUG III categories, nursing rehabilitation/restorative care, or clinically complex with depression; or

(b) The frequency distribution of residents in the major RUG III categories, nursing rehabilitation/restorative care, or clinically complex with depression that exceeds statewide averages; or

(c) A sudden or drastic change in the facility average case mix score; or

(d) A change in the frequency distribution of coded responses to a MDS item.

(3) Prior resident assessment performance of the provider, may include but is not limited to, ongoing problems with assessment submission deadlines, error rates, incorrect assessment dates, and apparent unchanged assessment practice(s) following a previous exception review.

(D) Exception reviews shall be conducted at the facility by registered nurses and other licensed or certified health professionals under contract with or employed by ODJFS. When a team of ODJFS reviewers conducts an on-site exception review, the team shall be led by a registered nurse. Persons conducting exception reviews on behalf of ODJFS shall meet the following conditions:

(1) During the period of their professional employment with ODJFS, reviewers must neither have nor be committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a NF which they review in Ohio.

(2) Reviewers shall not review any provider where a member of their family is a current resident.

(3) Reviewers shall not review any provider that has been a client of the reviewer within the past twenty-four months.

(4) Employment of a member of a health professional’s family by a provider that the professional does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of a NF.

(5) Reviewers shall not review any provider that has been an employer of the reviewer within the past twenty-four months.

(E) Prior notice: ODJFS shall notify the provider by telephone at least two working days prior to the review.

(F) Providers selected for exception reviews must provide ODJFS reviewers with reasonable access to residents, professional and nonlicensed direct care staff, the facility assessors, and completed resident assessment instruments and supporting documentation regarding the residents’ care needs and treatments. Providers must also provide ODJFS with sufficient information to be able to contact the resident’s attending or consulting physicians, other professionals from all disciplines who have observed, evaluated or treated the resident, such as contracted therapists, and the resident’s family/significant others. These sources of information may help to validate information provided on the resident assessment instrument submitted to the state. Verification activities may include reviewing resident assessment forms and supporting documentation, conducting interviews with staff knowledgeable about the resident during the observation period for the MDS , and observing residents.

(G) An exception review shall be conducted of a random, targeted, or a combination of random and targeted samples of completed resident assessment instruments. The initial sample size shall be greater than or equal to the minimum sample size presented in appendix A to this rule. The expanded sample is based on the initial sample findings. The expanded sample size is presented in appendix B to this rule.

(H) Results from review of the initial sample shall be used to decide if further action by ODJFS is warranted. If the initial sample is to be expanded for further review, ODJFS reviewers shall hold a conference with facility representatives advising them of the next steps of the review and discussing the initial sample findings. If the sample of reviewed records exceeds the initial sample tolerance level described in paragraph (A)(4)(a) of this rule, ODJFS:

(1) May subsequently expand the exception review process to review MDS assessments as follows:

(a) If the initial sample was a targeted review, the expanded sample size shall be the lesser of the remaining records in the targeted category or the applicable minimum expanded sample size presented in appendix B to this rule.

(b) If the initial sample was a random review that became a targeted review, the expanded sample shall be the lesser of the remaining records in the targeted category or the applicable minimum expanded sample size presented in appendix B to this rule.

(c) If the initial sample was a random review, the expanded sample size shall be at least the applicable minimum sample size as presented in appendix B to this rule.

(d) If the initial sample was a combination review, the expanded sample size shall be at least the applicable minimum sample size as presented in appendix B to this rule. The expanded sample may consist of the remaining records in the targeted and random categories.

(e) If the expanded review tolerance level is exceeded, ODJFS may subsequently expand the sample size for the same reporting quarter up to and including one hundred per cent of the records and continue the review process.

(I) At the conclusion of the on-site portion of the exception review process, ODJFS reviewers shall hold an exit conference with facility representatives. Reviewers will share preliminary findings and/or concerns about verification or failure to verify RUG III classification for reviewed records. Reviewers will give provider representatives one written preliminary copy of the exception review findings indicating whether the facility was under or over the established tolerance levels.

(J) All exception reviews shall include a final written summary of the exception review findings including the final facility tolerance level calculations and revised quarterly facility average total case mix score and revised quarterly facility average medicaid case mix score. ODJFS shall mail a copy of the final written summary to the provider.

(K) All exception review reports shall be retained by ODJFS for at least six years.

(L) If the expanded review tolerance level is exceeded, ODJFS shall use the exception review findings to calculate or recalculate resident case mix scores, quarterly, semiannual, and annual facility average case mix scores. Calculations or recalculations shall apply only to records actually reviewed by ODJFS and shall not be based on extrapolations to unreviewed records of findings from reviewed records. For example, ODJFS shall recalculate quarterly facility average case mix scores by replacing resident case mix scores of reviewed records and not changing the resident case mix scores of unreviewed records.

(M) ODJFS shall use the quarterly, semiannual, and annual facility average case mix scores based on exception review findings which exceed the exception review tolerance level to calculate or recalculate the facility’s rate for direct care costs for the appropriate six month period(s). However, scores recalculated based on exception review findings shall not be used to override any assignment of a quarterly facility average case mix score or a peer group cost per case mix unit made in accordance with rule 5101:3-3- 43.3 of the Administrative Code as a result of the facility’s failure to submit, or submission of incomplete or inaccurate resident assessment information, unless the recalculation results in a lower quarterly or semiannual facility average case mix score or peer group cost per case mix unit than the one to be assigned.

(1) If the exception review of a specific reporting quarter is conducted before the effective date of the rate for the corresponding six month period, and the review results in findings that exceed the tolerance level, ODJFS shall use the recalculated quarterly facility average case mix scores to calculate the facility’s semiannual average case mix score for the facility’s direct care rate for that six month period. Calculated rates based on exception review findings may result in a rate increase or rate decrease compared to the rate based on the facility’s submission of assessment information.

(2) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding six month period, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a lower rate than it was entitled to receive, ODJFS shall increase the direct care rate prospectively for the remainder of the six month period, beginning one month after the first day of the month after the exception review is completed.

(3) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding six month period, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a higher rate than it was entitled to receive, ODJFS shall reduce the direct care rate and apply it to the six month periods when the provider received the incorrect rate to determine the amount of the overpayment. Overpayments are payable in accordance with rule [5101:3-3-22](http://codes.ohio.gov/oac/5101%3A3-3-22) of the Administrative Code.

(N) Except for additional information submitted to ODJFS as part of the processes set forth in paragraphs (O) and (P) of this rule, the ODJFS exception review determination for any resident case mix score shall be considered final. A provider may submit corrections for individual records in accordance with rule 5101:3-3- 43.1 of the Administrative Code; however, the exception review determination for any resident assessment case mix score will be used to establish the facility average case mix score.

(O) The provider may seek reconsideration of any prospective direct care rate which was established by recalculating the direct care rate as a result of an exception review of resident assessment information conducted before the effective date of the rate. Requests for rate reconsideration related to exception review findings must be submitted in accordance with the following procedures:

(1) A reconsideration of a prospective direct care rate on the basis of a dispute with ODJFS exception review findings shall be submitted to ODJFS no more than thirty days after receipt of exception review findings.

(2) The request for a reconsideration of a prospective rate on the basis of a dispute with exception review findings shall be filed in accordance with the following procedures:

(a) The request shall be in writing; and

(b) The request shall be addressed to “Ohio Department of Job and Family Services, Ohio Health Plans, Bureau of Long Term Care Services and Supports, Disability and Aging Policy Section”; and

(c) The request shall indicate that it is a request for rate reconsideration due to a dispute with exception review findings; and

(d) The request shall include a detailed explanation of the items on the resident assessment records under dispute as well as copies of relevant, supporting documentation from specific individual records. The request shall also include the provider’s proposed resolution.

(3) ODJFS shall respond in writing within sixty days of receiving each written request for a rate reconsideration related to disputed exception review findings. If ODJFS requests additional information to determine if the rate adjustment is warranted, the provider shall respond in writing and shall provide additional supporting documentation no more than thirty days after the receipt of the request for additional information. ODJFS shall respond in writing within sixty days of receiving the additional information to the request for a rate reconsideration due to disputed exception review findings.

(4) If the rate is increased pursuant to a rate reconsideration due to disputed exception review findings, the rate adjustment shall be implemented retroactively to the initial service date for which the rate is effective.

(5) When calculating the annual and semiannual facility average case mix scores in accordance with rule 5101:3-3- 43.3 of the Administrative Code, ODJFS shall use any resident case mix scores adjusted as a result of a rate reconsideration determination in lieu of the resident case mix scores from the exception review findings.

(P) The findings of an exception review conducted after the effective date of the rate may be appealed under provisions of the Administrative Procedure Act, Chapter 119. of the Revised Code. ODJFS shall not withhold from the facility’s current payments any amounts ODJFS claims to be due from the facility as a result of the exception review findings while the provider is pursuing administrative or judicial remedies in good faith.