

5123:2-7-20

**Intermediate care facilities - resident assessment classification and case mix payment system.**

(A) For the purposes of this rule, the following definitions shall apply:

- (1) "Annual facility average case mix score" is the score used to calculate the facility's cost per case mix unit.
- (2) "Case mix payment system" is the system used to collect individual assessment form answer sheet data submitted by providers as a file on electronic media for the purpose of assigning residents to the appropriate resident assessment classification group in accordance with paragraph (C) of this rule.
- (3) "Case mix score" means the measure of the relative direct care resources needed to provide care and rehabilitation to a resident of an intermediate care facility.
- (4) "Correction submission due date" is the deadline for the intermediate care facility to submit corrected individual assessment form answer sheets to the department. The correction submission due date applies to corrections submitted in electronic format for facility level and resident record changes.
- (5) "Cost per case mix unit" is calculated by dividing the intermediate care facility's desk-reviewed, actual, allowable, per diem direct care costs for the calendar year preceding the fiscal year in which the rate will be paid by the annual facility average case mix score for the calendar year preceding the fiscal year in which the rate will be paid. The lesser of the intermediate care facility's cost per case mix unit or the maximum allowable cost per case mix unit for the intermediate care facility's peer group for the fiscal year shall be used to determine the intermediate care facility's rate for direct care costs, in accordance with section 5111.23 of the Revised Code.
- (6) "Facility level errors" are errors which must be corrected before a facility average case mix score can be calculated and include the following:
  - (a) Failure to submit the signed certification of individual assessment form data by the correction submission due date.
  - (b) Incomplete or inaccurate data are submitted to the department.
  - (c) The number of individual assessment form records processed is more than the reported number of residents in medicaid-certified beds on the reporting period end date.

- (7) "Filing date" is the deadline for initial quarterly submission of the intermediate care facility's individual assessment form data and the signed certification of individual assessment form data, which is the fifteenth calendar day following the reporting period end date.
- (8) "Payment quarter" is two quarters following the reporting quarter and is the quarter following the processing quarter, in which the direct care rate is paid based on the quarterly facility average case mix score from the reporting quarter's individual assessment form data.
- (9) "Peer group" is a group of Ohio intermediate care facilities determined by the department to have significant per diem cost differences from other peer groups due to reasons other than the differences in care needs among the residents.
- (10) "Postmark" means any of the following:
  - (a) The official postmark applied to the package or envelope by the United States postal service; or
  - (b) The date the material is received by a commercial delivery service, if marked legibly on the package; or
  - (c) If the package or letter is delivered but no date is legible on the package, the department shall consider the postmark to be four calendar days prior to receipt by the department.
- (11) "Processing quarter" is the quarter that follows the reporting quarter and is the quarter in which the department receives the individual assessment form data for the reporting quarter and calculates the direct care rate for the payment quarter.
- (12) "Quarterly facility average case mix score" is the facility average case mix score based on data submitted for one reporting quarter.
- (13) "Record" means a resident's individual assessment form answer sheet processed by the department.
- (14) "Relative resource weight" is the measure of the relative costliness of caring for residents in one case mix classification versus another, indicating the relative amount and cost of staff time required on average for defined job

types to care for residents in a single case mix classification.

- (15) "Reporting period end date" is the last day of each calendar quarter.
  - (16) "Reporting quarter" is the quarter which precedes the processing quarter and from which the intermediate care facility's individual assessment form data are used to establish the direct care rate for the payment quarter.
  - (17) "Resident assessment classification system" is the system for classifying residents of intermediate care facilities into case mix classifications used by the department to gather data for the direct care payment system. The case mix classifications are clusters of intermediate care facility residents, defined by resident characteristics, that explain resource use.
  - (18) "Resident case mix score" is the relative resource weight for the classification to which the resident is assigned based on data elements from the resident's individual assessment form.
- (B) The department shall pay each eligible intermediate care facility a per resident per day rate for direct care costs established prospectively for each facility based on the intermediate care facility case mix payment system for direct care which includes the following components:
- (1) The individual assessment form answer sheet which has been completed in accordance with the individual assessment form instructions;
  - (2) Individual assessment form data elements;
  - (3) A database which provides the core data elements that are used to group residents into case mix classifications;
  - (4) A method, set forth in paragraph (C) of this rule, that uses clinically meaningful criteria to group residents into one of four classifications;
  - (5) The identification of specific job types in the direct care cost category, set forth in paragraph (D) of this rule, that are affected by changes in case mix; and
  - (6) An assignment of a relative resource weight, as set forth in paragraph (E) of this rule, that measures the relative costliness of caring for residents in one group versus another.

(C) The intermediate care facility case mix payment system shall use the resident assessment classification system to classify residents of intermediate care facilities. Residents in each classification utilize similar quantities and patterns of resources. Based upon the data collected in the individual assessment form, a resident that meets the criteria for placement in more than one classification shall be placed in the highest classification according to the hierarchy. Residents without characteristics resulting in assignment to the higher classifications shall be placed in the fourth classification. The resident assessment classification system defines criteria used to assign residents to one of four mutually exclusive classifications listed in descending order of the hierarchy:

(1) The chronic medical classification includes residents receiving one or more of the following types of special care:

- (a) Parenteral therapy on all shifts (on the individual assessment form at the medical domain section, item (24) is scored "4"),
- (b) Tracheostomy care/suctioning on all shifts (on the individual assessment form at the medical domain section, item (25) is scored "4"),
- (c) Oxygen and respiratory therapy on all shifts (on the individual assessment form at the medical domain section, item (27) is scored "4"),
- (d) Oral medication administered more than eight times in a twenty-four-hour day (on the individual assessment form at the medical domain section, item (29a) is scored "3"),
- (e) Topical medication administered more than eight times in a twenty-four-hour day (on the individual assessment form at the medical domain section, item (29b) is scored "3"),
- (f) Injections of medication administered more than eight times in a twenty-four-hour day (on the individual assessment form at the medical domain section, item (29c) is scored "3"),
- (g) Medication administered more than eight times in a twenty-four-hour day using a method other than oral, topical, or injection (on the individual assessment form at the medical domain section, item (29d) is scored "3"), and/or
- (h) Utilization of out-of-home health care requiring over thirty days of staff

time on average per year (on the individual assessment form at the medical domain section, item (31) is scored "3").

- (2) The overriding behaviors classification includes residents exhibiting one or more of the following specific behaviors that require continual staff intervention as defined in the individual assessment form instructions:

- (a) Aggressive behavior (on the individual assessment form at the behavior domain section, item (14) is scored "3"),
- (b) Self-injurious behavior (on the individual assessment form at the behavior domain section, item (17) is scored "3"), and/or
- (c) Acute suicidal behavior (on the individual assessment form at the behavior domain section, item (21) is scored "3").

- (3) The high adaptive needs and/or chronic behaviors classification includes residents requiring a specific level of staff assistance/supervision for one or more personal care and safety needs as described in paragraphs (C)(3)(a) to (C)(3)(f) of this rule, and/or exhibiting one or more of the behaviors set forth in paragraphs (C)(3)(g) to (C)(3)(j) of this rule that require frequent or continual staff intervention:

- (a) Eating (on the individual assessment form at the adaptive skills domain section, item (1) is scored "2" for needing hands-on assistance),
- (b) Toileting (on the individual assessment form at the adaptive skills domain section, item (2) is scored either "3" for as a rule does not indicate the need to toilet and requires assistance with wiping, or "4" for requires colostomy, ileostomy, or urinary catheter),
- (c) Dressing (on the individual assessment form at the adaptive skills domain section, item (5) is scored "3" for requiring hands-on assistance and/or constant supervision to complete the tasks, or tasks must be done completely by staff for the resident),
- (d) Turning and positioning more than twelve times in a twenty-four-hour period (on the individual assessment form at the adaptive skills domain section, item (6) is scored "4"),
- (e) Mobility requiring the help of one or more persons (on the individual

assessment form at the adaptive skills domain section, item (7) is scored "3"),

(f) Transfer requiring direction and/or physical help from one or more persons (on the individual assessment form at the adaptive skills domain section, item (8) is scored "2"),

(g) Aggressive behavior requiring frequent staff intervention as defined in the instructions for completing the individual assessment form (on the individual assessment form at the behavior domain section, item (14) is scored "2"),

(h) Self-injurious behavior requiring frequent staff intervention as defined in the instructions for completing the individual assessment form (on the individual assessment form at the behavior domain section, item (17) is scored "2"),

(i) Disruptive behavior requiring continual staff intervention as defined in the individual assessment form (on the individual assessment form at the behavior domain section, item (19) is scored "4"), and/or

(j) Withdrawn behavior requiring continual staff intervention as defined in the instructions for completing the individual assessment form (on the individual assessment form at the behavior domain section, item (20) is scored "3").

(4) The typical adaptive needs and non-significant behaviors classification includes residents not meeting the criteria of the other three classifications.

(D) Analysis of staff time and resident assessment data, collected in a work measurement study of Ohio medicaid-certified intermediate care facilities for the purpose of establishing common staff times associated with all resident classifications that are standard across residents, staff, facilities, and units, determined that the job classifications listed in paragraphs (D)(1) to (D)(8) of this rule are job types that perform activities that vary by case mix classification. Job types determined not to be positions participating in activities that vary by case mix classification are not used to calculate the relative resource weights as described in paragraph (E) of this rule.

(1) Habilitation specialists consisting of nurse aides and habilitation staff;

- (2) Licensed practical nurses;
  - (3) Occupational therapists;
  - (4) Program specialists;
  - (5) Qualified intellectual disability professionals;
  - (6) Registered nurses;
  - (7) Social workers/counselors; and
  - (8) Speech therapists.
- (E) Each of the four resident classifications is assigned a relative resource weight. The relative resource weight indicates the relative amount and cost of staff time required on average for the job types listed in paragraph (D) of this rule to deliver care to residents in that classification. The relative resource weight was calculated using the average minutes of care per job type per classification as determined during the work measurement study, and the averages of the wages by job type as reported by intermediate care facilities on the medicaid cost report. By setting the wage weight at one for the job type receiving the lowest hourly wage, wage weights for the other job types are calculated by dividing the lowest wage into the wage of each of the other job types. To calculate the total weighted minutes for each classification, the wage weight for each job type is multiplied by the average number of minutes staff of that job type spend caring for a resident in that classification, and the products are summed. The classification with the lowest total weighted minutes receives a relative resource weight of one. Relative resource weights are calculated by dividing the total weighted minutes of the lowest classification into the total weighted minutes of each classification. Weight calculations are rounded to the fourth decimal place. Relative resource weights for the resident classifications are as follows:
- (1) Chronic medical = 2.1762.
  - (2) Overriding behaviors = 2.0311.
  - (3) High adaptive needs and/or chronic behaviors = 1.7274.
  - (4) Typical adaptive needs and non-significant behaviors = 1.000.

(F) Except as provided in paragraph (F)(1) of this rule, relative resource weights may be recalibrated using wage weights based on three-year statewide averages of wages of the job types listed in this rule as reported by intermediate care facilities on the medicaid cost report, and minutes of care per job type per resident assessment classification as follows:

- (1) The department may recalibrate the relative resource weights no more often than every three years, using the minutes of care per job type per classification from the most current work measurement study and the wages per job type per hour, to be effective at the beginning of the next state fiscal year. When recalibrating the relative resource weights, the department shall use medicaid cost report wage data from the most recent three calendar years available ninety days prior to the start of the fiscal year.
  - (2) The department may recalibrate relative resource weights more frequently if significant variances in wage ratios between job types occur.
  - (3) The department may rebase the relative resource weights through the deletion or addition of job types or with revised minutes of care per job type by conducting a new work measurement study, if significant changes in the job types or work roles of the job types occur, or following a change in state policy which would significantly affect statewide case mix of the intermediate care facility population.
  - (4) After recalibrating or rebasing relative resource weights under paragraph (F)(1), (F)(2), or (F)(3) of this rule, the department shall use the recalibrated or rebased relative resource weights to recalculate the quarterly intermediate care facility case mix score for the reporting quarter ending March thirty-first of the calendar quarter preceding the start of the fiscal year and to recalculate the annual intermediate care facility case mix score for the calendar year preceding the fiscal year.
- (G) The department shall process individual assessment form data submitted by intermediate care facilities and classify residents using the resident assessment classification system to determine resident case mix scores. These resident case mix scores, based on relative resource weights as set forth in paragraph (E) of this rule, are used to establish the quarterly facility average case mix score. The methodology for determining the quarterly facility average case mix score is described in paragraph (L) of this rule.
- (1) The individual assessment form shall be administered by intermediate care facility staff authorized by the department. In order to become authorized,



intermediate care facility staff shall attend and successfully complete a training session conducted or approved by the department that includes a demonstration.

- (2) Each intermediate care facility shall electronically submit to the department a quarterly case mix assessment, using Ohio ~~office of medical assistance~~ department of medicaid form 02221, "Individual Assessment Form Answer Sheet" (revised June 2003), for each resident of a medicaid-certified intermediate care facility bed, regardless of payment source or anticipated length of stay, to reflect the resident's condition on the reporting period end day, which is the last day of the calendar quarter.
- (3) The following residents shall be considered residents of a medicaid-certified bed on the reporting period end date:
  - (a) Residents admitted to the intermediate care facility prior to the reporting period end date and physically residing in the intermediate care facility on the reporting period end date; and
  - (b) Residents admitted to the intermediate care facility on the reporting period end date from another setting (e.g., home, hospital, adult care facility, or nursing facility); and
  - (c) Residents transferred or admitted into the intermediate care facility from another intermediate care facility on the reporting period end date; and
  - (d) Residents temporarily absent on the reporting period end date but for whom the facility is receiving payment from any source to hold a bed for the resident during a hospital stay, visit with friends or relatives, or participation in therapeutic programs outside the facility.
- (4) The following residents shall not be considered residents for a medicaid-certified bed as of the reporting period end date:
  - (a) Residents discharged from the intermediate care facility prior to or on the reporting period end date; and
  - (b) Residents transferred to another intermediate care facility prior to or on the reporting period end date; and
  - (c) Residents who die prior to or on the reporting period end date.

- (5) Intermediate care facilities shall complete and submit a signed certification of individual assessment form data with the quarterly submission of individual assessment form answer sheet data identifying the name of the intermediate care facility, its provider number, the total number of beds the provider has certified by the Ohio department of health for medicaid, and total number of residents in the intermediate care facility as of the reporting period end date for whom the provider must submit an individual assessment form answer sheet.
- (6) The signed certification of individual assessment form data shall be submitted to the department with a postmark no later than the fifteenth day of the month following the reporting period end date. The intermediate care facility shall retain the original individual assessment form answer sheet in the resident's record.
- (7) A paper certification of individual assessment form data must accompany the electronic data. The electronic data must be submitted in the exact layout provided in the software made available to intermediate care facilities at no charge. The data in electronic format must be identified with the facility name and medicaid provider number.
- (H) The quarterly facility average case mix score from the reporting quarter is used in conjunction with the lesser of the facility's cost per case mix unit or the maximum allowable cost per case mix unit, adjusted by the inflation rate, to establish the quarterly direct care rate for the payment quarter, as outlined in section 5111.23 of the Revised Code. The facility's cost per case mix unit is calculated using the annual facility average case mix score. The methodology for determining the annual facility average case mix score is described in paragraph (M) of this rule.
- (I) The department shall establish each intermediate care facility's rate for direct care costs quarterly in accordance with section 5111.23 of the Revised Code. The department shall assign a quarterly facility average case mix score or cost per case mix unit used to establish a facility's rate for direct care costs if the facility fails to submit its individual assessment form data in accordance with this rule or fails to correct facility level errors. Before taking such action, the department shall permit the provider a reasonable period of time to correct the information, as described in paragraph (K)(3) of this rule. The department's assignment of the quarterly facility average case mix score or cost per case mix unit will occur as follows:
  - (1) The department may assign a quarterly facility average case mix score that is five per cent less than the facility's quarterly average case mix score for the preceding calendar quarter instead of using the quarterly average case mix score calculated based on the facility's submitted information as described in

paragraph (L) of this rule.

- (a) If the facility was subject to an exception review for the preceding calendar quarter, the assigned quarterly facility average case mix score shall be the score that is five per cent less than the score determined by the exception review.
  - (b) If the facility was assigned a quarterly average case mix score for the preceding calendar quarter, the assigned quarterly facility average case mix score shall be the score that is five per cent less than that score assigned for the preceding quarter.
- (2) The department may assign a cost per case mix unit that is five per cent less than the provider's calculated or assigned cost per case mix unit for the preceding calendar year if the provider has fewer than two acceptable quarterly average case mix scores.
- (J) The department shall calculate and use the actual quarterly facility average case mix score described in paragraph (L) of this rule for determining the quarterly direct care rate if:
  - (1) The intermediate care facility submits individual assessment form data by the filing date and includes assessments for at least ninety per cent of all residents of the intermediate care facility as of the reporting period end date; and
  - (2) In accordance with the procedures outlined in paragraph (K) of this rule for correcting inaccurate information, the intermediate care facility timely submits and timely corrects individual assessment form data for that reporting quarter; and
  - (3) The intermediate care facility's submission of individual assessment form data and the signed certification of individual assessment form data does not contain facility level errors or such errors have been timely corrected.
- (K) After the department has processed the intermediate care facility's individual assessment form data for a reporting quarter, the department shall send the "Case Mix Provider Summary Report" to the intermediate care facility. The intermediate care facility may correct errors or omissions identified by either the department or the intermediate care facility by sending in a modification submission and submitting corrections to the department along with, if necessary, an amended and signed certification of individual assessment form data.

- (1) The department shall notify intermediate care facilities of a missing or incomplete certification of individual assessment form data.
- (2) The department may notify intermediate care facilities of its initial quarterly submission through three documents:
  - (a) The "Submission Tracking Summary" report which shows the status of the individual assessment form data after initial processing by the department.
  - (b) The "Detailed Listing of Successfully Grouped Assessments" report which is a list of individual assessment form records that were grouped into resident assessment classification system groups one through four.
  - (c) The "Deleted/Discharged Assessments" report which is a list of resident records being deleted and/or a list of residents being discharged from the facility.
- (3) The department shall allow ~~eighty~~forty-five days after the reporting period end date for intermediate care facilities to make corrections and return them to the department. Timeliness of the submission to the department shall be determined by the postmark.
- (4) Corrections received by the department will be used in computing the quarterly facility average case mix score, in accordance with the conditions outlined in paragraph (J) of this rule.
- (5) The department will process corrections submitted in electronic format if the file format is the same as used by the department.
- (6) Changes made on the individual assessment form modification submission data element entries must be consistent with changes made to the original individual assessment form maintained at the facility.
- (L) The quarterly facility average case mix score for intermediate care facilities that submitted individual assessment form data and modifications timely, and have no facility level errors is calculated as follows:
  - (1) All residents' case mix scores for the quarter are added together.

- (2) The sum of resident case mix scores is divided by the total number of residents.
- (M) The annual facility average case mix score is used to compute the cost per case mix unit for the intermediate care facility and the peer group maximum cost per case mix unit. Individual assessment form data for all four quarters of the calendar year shall be used to calculate the annual facility average case mix score:
- (1) The department-assigned facility average case mix scores will be omitted from the facility's annual average case mix score calculation.
  - (2) The annual facility average case mix score shall be calculated from no fewer than two acceptable quarterly average case mix scores. Acceptable quarterly facility average case mix scores shall be summed and divided by the total number of quarters of acceptable scores. Acceptable quarterly average case mix scores for the purposes of calculating the annual facility average case mix score include, in order of hierarchy:
    - (a) Adjusted quarterly facility average case mix scores as a result of exception review findings, or
    - (b) Quarterly facility average case mix scores calculated based on the facility's submitted information as described in paragraph (L) of this rule.
  - (3) If at least two acceptable quarterly facility average case mix scores are not available, the department shall assign the cost per case mix unit in accordance with paragraph (I)(2) of this rule.
- (N) During state fiscal year 2013, the department may conduct or contract with a third party to conduct individual assessments of individuals residing in every intermediate care facility.
- (1) The individual assessments shall be conducted by appropriate health professionals employed by or under contract with the department.
  - (2) During the period of their professional engagement or employment with the department, the health professionals shall neither have nor be committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of an intermediate care facility in this state.
  - (3) A health professional shall not assess any individual who is a resident of an

intermediate care facility that has been a client of the health professional.

- (4) The intermediate care facility may request reconsideration of the results of an individual assessment based on material error in the assessment. The request for reconsideration shall be submitted in writing no later than fifteen days from receipt of the assessment results and shall include a detailed explanation of the possible material error.
- (5) The Department shall review the request for reconsideration and make a determination of the correct assessment score. The determination of the department is not subject to further appeal.
- (6) If the intermediate care facility does not timely submit a request for reconsideration, the data obtained in the department's or contractor's assessment are final.