**Synopsis**: Amends existing law to allow the Department of Developmental Disabilities to conduct or contract to conduct Individual Assessment Form (IAF) evaluations for individuals residing in intermediate care facilities (ICF) for the first quarter of calendar year 2013. Currently R.C. 5111.232 requires the assessments to be completed by the intermediate care facilities. The amendment allows the department to use the results from these evaluations in the rate-setting methodology for intermediate care facilities beginning in state fiscal year 2014. The amendment is necessary to rebase the ICF/IID system to ensure uniformity of application and scoring, and to ensure that facility rates are established based on the resource needs of the residing individuals.

**5111.232 Case-mix scores for nursing facilities**

(A)(1) The department of job and family services shall determine semiannual and annual average case-mix scores for nursing facilities by using all of the following:

(a) Data from a resident assessment instrument specified in rules adopted under section 5111.02 of the Revised Code pursuant to section 1919(e)(5) of the “Social Security Act,” 49 Stat. 620 (1935), 42 U.S.C.A. 1396r(e)(5), as amended, for the following residents:

(i) When determining semiannual case-mix scores for fiscal year 2012, each resident who is a medicaid recipient;

(ii) When determining semiannual case-mix scores for fiscal year 2013 and thereafter, each resident who is a medicaid recipient and not placed in either of the two lowest resource utilization groups, excluding any resource utilization group that is a default group used for residents with incomplete assessment data;

(iii) When determining annual average case-mix scores, each resident regardless of payment source.

(b) Except as provided in rules authorized by divisions (A)(2)(a) and (b) of this section, the case-mix values established by the United States department of health and human services;

(c) Except as modified in rules authorized by division (A)(2)(c) of this section, the grouper methodology used on June 30, 1999, by the United States department of health and human services for prospective payment of skilled nursing facilities under the medicare program established by Title XVIII.

(2) The director of job and family services may adopt rules under section 5111.02 of the Revised Code that do any of the following:

(a) Adjust the case-mix values specified in division (A)(1)(b) of this section to reflect changes in relative wage differentials that are specific to this state;

(b) Express all of those case-mix values in numeric terms that are different from the terms specified by the United States department of health and human services but that do not alter the relationship of the case-mix values to one another;

(c) Modify the grouper methodology specified in division (A)(1)(c) of this section as follows:

(i) Establish a different hierarchy for assigning residents to case-mix categories under the methodology;

(ii) Prohibit the use of the index maximizer element of the methodology;

(iii) Incorporate changes to the methodology the United States department of health and human services makes after June 30, 1999;

(iv) Make other changes the department determines are necessary.

(B) The department shall determine case-mix scores for intermediate care facilities for the mentally retarded using data for each resident, regardless of payment source, from a resident assessment instrument and grouper methodology prescribed in rules adopted under section 5111.02 of the Revised Code and expressed in case-mix values established by the department in those rules.

(C) (1)

The Ohio department of developmental disabilities may conduct or contract with a third party to conduct the Individual Assessment Forms (IAF) evaluations of individuals residing in intermediate care facilities utilizing an inter-rater reliable process for the first quarter of calendar year 2013. Additionally, during the first quarter of calendar year 2013, providers of intermediate care facilities shall continue to administer the IAF for residents in the provider’s intermediate care facility.

(2) Results from the department or third party administration of the IAF for the first quarter of calendar year 2013 shall be provided to the provider of the intermediate care facility in which the individual resides within 3 days of the administration of the IAF.

(3) Results from the departmentor third party assessment in division (C)(1) may be considered the calendar 2012 annual case mix score

(4) Pending the outcome of any request for reconsideration in division (C)(6), for state fiscal year 2014, the department may use the results of the state-wide assessments completed (or “to be completed”) in the first quarter of calendar year 2013 in the rate-setting calculations as the first quartercase mix score for calendar year 2013 and the average annual case-mix scores for each intermediate care facility for calendar year 2012. If the results from the department or third party IAF assessment are used in the rate-setting calculations for fiscal year 2014 as described in this division, the results shall be considered the quarterly case mix score for the first quarter of calendar year 2013 and the average annual case mix score for each intermediate care facility for calendar year 2012. To the extent that a provider of an intermediate care facility’s state fiscal year 2014 rate in the direct care cost category is reduced as a result of the department or third party IAF assessment conducted in the first quarter of calendar year 2013, no provider’s intermediate facility rate in the direct cost category shall be reduced in fiscal year 2014 by more than ten (10) percent when comparing the results of the IAF administered by the department or third party to the results of the IAF administered by the provider of the intermediate care facility in the first quarter of calendar year 2013 and the results of the IAF administered by the provider of the intermediate care facility in CY2012.

(5) All IAF evaluations conducted after the first quarter of calendar year 2013 shall be conducted by providers of intermediate care facilities for the individuals residing in the provider’s intermediate care facility.

(6) The department shall hear requests for reconsideration of the results of the IAF evaluation conducted by the department or the third party pertaining to residents in intermediate care facility. A provider that seeks reconsideration shall file their request with the department in writing within 15 days of receipt of the IAF score for any individual in the provider’s intermediate care facility. Providers may wait until all IAF scores are completed for each facility before filing their written request for reconsideration from the department and have 15 days from the date of receipt of all IAF results per facility in which to file their request for reconsideration. The request for reconsideration shall include a detailed explanation of the items in the IAF result under dispute as well as copies of relevant, supporting documentation from specific individual records. The request shall also include the provider’s proposed resolution. The department shall consider the following, including but not limited to, the historical results of the provider’s administration of the individual assessment form and all data and records included in the provider’s request for reconsideration. The department shall issue their written decision within 30 days of receipt of the request for reconsideration. No rate adjustments in division (C)(4) for fiscal year 2014 shall be implemented until the department has issued in writing the result of the provider’s request for reconsideration. ~~(C)~~ (D) Each calendar quarter, each provider shall compile complete assessment data, from the resident assessment instrument specified in rules authorized by division (A) or (B) of this section, for each resident of each of the provider’s facilities, regardless of payment source, who was in the facility or on hospital or therapeutic leave from the facility on the last day of the quarter. Providers of a nursing facility shall submit the data to the department of health and, if required by rules, the department of job and family services. Providers of an intermediate care facility for the mentally retarded shall submit the data to the department of job and family services. The data shall be submitted not later than fifteen days after the end of the calendar quarter for which the data is compiled.

Except as provided in division ~~(D)~~ (E) of this section, the department, every six months and after the end of each calendar year, shall calculate a semiannual and annual average case-mix score for each nursing facility using the facility’s quarterly case-mix scores for that six-month period or calendar year. Also except as provided in division ~~(D)~~ (E) of this section, the department, after the end of each calendar year, shall calculate an annual average case-mix score for each intermediate care facility for the mentally retarded using the facility’s quarterly case-mix scores for that calendar year. The department shall make the calculations pursuant to procedures specified in rules adopted under section 5111.02 of the Revised Code.

~~(D)~~ (E) (1) If a provider does not timely submit information for a calendar quarter necessary to calculate a facility’s case-mix score, or submits incomplete or inaccurate information for a calendar quarter, the department may assign the facility a quarterly average case-mix score that is five per cent less than the facility’s quarterly average case-mix score for the preceding calendar quarter. If the facility was subject to an exception review under division (C) of section 5111.27 of the Revised Code for the preceding calendar quarter, the department may assign a quarterly average case-mix score that is five per cent less than the score determined by the exception review. If the facility was assigned a quarterly average case-mix score for the preceding quarter, the department may assign a quarterly average case-mix score that is five per cent less than that score assigned for the preceding quarter.

The department may use a quarterly average case-mix score assigned under division ~~(D)~~ (E) (1) of this section, instead of a quarterly average case-mix score calculated based on the provider’s submitted information, to calculate the facility’s rate for direct care costs being established under section 5111.23 or 5111.231 of the Revised Code for one or more months, as specified in rules authorized by division ~~(E)~~ (F) of this section, of the quarter for which the rate established under section 5111.23 or 5111.231 of the Revised Code will be paid.

Before taking action under division ~~(D)~~ (E) (1) of this section, the department shall permit the provider a reasonable period of time, specified in rules authorized by division ~~(E)~~ (F) of this section, to correct the information. In the case of an intermediate care facility for the mentally retarded, the department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the provider fails to submit corrected information prior to the eighty-first day after the end of the calendar quarter to which the information pertains. In the case of a nursing facility, the department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the provider fails to submit corrected information prior to the earlier of the forty-sixth day after the end of the calendar quarter to which the information pertains or the deadline for submission of such corrections established by regulations adopted by the United States department of health and human services under Titles XVIII and XIX.

(2) If a provider is paid a rate for a facility calculated using a quarterly average case-mix score assigned under division ~~(D)~~ (E) (1) of this section for more than six months in a calendar year, the department may assign the facility a cost per case-mix unit that is five per cent less than the facility’s actual or assigned cost per case-mix unit for the preceding calendar year. The department may use the assigned cost per case-mix unit, instead of calculating the facility’s actual cost per case-mix unit in accordance with section 5111.23 or 5111.231 of the Revised Code, to establish the facility’s rate for direct care costs for the following fiscal year.

(3) The department shall take action under division ~~(D)~~ (E) (1) or (2) of this section only in accordance with rules authorized by division ~~(E)~~ (F) of this section. The department shall not take an action that affects rates for prior payment periods except in accordance with sections 5111.27 and 5111.28 of the Revised Code.

(E) The director shall adopt rules under section 5111.02 of the Revised Code that do all of the following:

(1) Specify whether providers of a nursing facility must submit the assessment data to the department of job and family services;

(2) Specify the medium or media through which the completed assessment data shall be submitted;

(3) Establish procedures under which the assessment data shall be reviewed for accuracy and providers shall be notified of any data that requires correction;

(4) Establish procedures for providers to correct assessment data and specify a reasonable period of time by which providers shall submit the corrections. The procedures may limit the content of corrections by providers of nursing facilities in the manner required by regulations adopted by the United States department of health and human services under Titles XVIII and XIX.

(5) Specify when and how the department will assign case-mix scores or costs per case-mix unit under division ~~(D)~~ (E) of this section if information necessary to calculate the facility’s case-mix score is not provided or corrected in accordance with the procedures established by the rules. Notwithstanding any other provision of sections 5111.20 to 5111.331 of the Revised Code, the rules also may provide for the following:

(a) Exclusion of case-mix scores assigned under division ~~(D)~~ (E) of this section from calculation of an intermediate care facility for the mentally retarded’s annual average case-mix score and the maximum cost per case-mix unit for the facility’s peer group;

(b) Exclusion of case-mix scores assigned under division ~~(D)~~ (E) of this section from calculation of a nursing facility’s semiannual or annual average case-mix score and the cost per case-mix unit for the facility’s peer group.

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