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John R. Kasich, Governor

Barbara R. Sears, Director

Ohio Department of Medicaid

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ICF-MR Transmittal Letters

ICF-MRTL 12-04 (Rule Changes to Implement ORC Section 5111.226)

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 12-04

January 22, 2013

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Rule Changes to Implement ORC Section 5111.226

Proposed Rescission of Administrative Code Rules 5101:3-3-02.1 and 5101:3-3-04.1

Proposed Adoption of Administrative Code Rule 5101:3-3-01.1

Proposed Amendment of Administrative Code Rules 5101:3-3-02, 5101:3-3-02.2, 5101:3-3-02.3, 5101:3-3-02.7, 5101:3-3-04, 5101:3-3-16.1, 5101:3-3-20, 5101:3-3-22, 5101:3-3-30.1, 5101:3-3-30.4, 5101:3-3-32, 5101:3-3-32.1, 5101:3-3-32.2, and 5101:3-3-39

The following proposed rule changes are being made to implement provisions of Section **5111.226** of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly, and in accordance with Sections 119.03 and 119.032 of the Ohio Revised Code, which outline the procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Proposed for Rescission

Rule 5101:3-3-02.1, entitled Length and type of long term care provider agreements, sets forth provisions regarding the length and type of provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). This rule is being rescinded in conjunction with adoption of a new rule by the same number so that the new rule applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule 5101:3-3-04.1, entitled Payment to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) during the survey agency's administrative appeals process, sets forth provisions for Medicaid payment to be made to NFs and ICFs-MR during the survey agency's administrative appeals process. This rule is being rescinded in conjunction with adoption of a new rule by the same number so that the new rule applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Proposed for Adoption

Rule **5101:3-3-01.1**, entitled Authorization for the Ohio department of developmental disabilities (DODD) to administer the medicaid program for services provided by intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the provisions for DODD to administer Medicaid program services provided by ICFs-MR. This rule is being adopted since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Proposed for Amendment

Rule **5101:3-3-02**, entitled Provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for the execution and maintenance of provider agreements between the Ohio Department of Job and Family Services and the operators NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR

Rule **5101:3-3-02.2**, entitled Termination, denial, and non-renewal of long term care provider agreements, sets forth provisions for the termination, denial, and non-renewal of provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-02.3**, entitled Institutions eligible to participate in medicaid as nursing facilities (NFs) or intermediate care facilities for the mentally retarded (ICFs-MR), sets forth eligibility provisions for NFs and ICFs-MR to participate in the Medicaid program. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR. In paragraph (A)(10), the date referenced in the Social Security Act citation, as well as the phrase "as amended," are being removed due to rule filing guidelines.

Rule **5101:3-3-02.7**, entitled Emergency management and resident relocation plan for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for the preparation for, response to, and recovery from an emergency at a NF or ICF-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-04**, entitled Payment during the Ohio department of job and family services (ODJFS) administrative appeals process for denial or termination of a provider agreement, sets forth provisions for Medicaid payments to be made during the ODJFS administrative appeals process for denial or termination of the provider agreement of a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR). This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-16.1**, entitled Resource assessment notice for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions regarding JFS form 04080 "Medicaid Resource Assessment Notice" that are specific to NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-20**, entitled Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements, sets forth provisions for

Medicaid cost report filing, record retention, and disclosure requirements for NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR. In paragraph (I)(5), the phrase "as amended (through 1/1/07)" is being removed from the Social Security Act citation due to rule filing guidelines.

Rule **5101:3-3-22**, entitled Rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-30.1**, entitled Appeal of the franchise permit fee (FPF) determination and re-determination, sets forth provisions for an appeal of the franchise permit fee determination or re-determination for nursing homes or hospital long term care units in accordance with Section 3721.55 of the Revised Code, or an appeal of the franchise permit fee determination for intermediate care facilities for the mentally retarded (ICFs-MR) in accordance with Section 5112.35 of the Revised Code. This rule is being amended so that it applies only to nursing homes and hospital long term care units since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-30.4**, entitled Procedure for terminating the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), long term care hospital beds, and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the procedure for terminating the franchise permit fee for NFs, NHs, long term care hospital beds, ICFs-MR. This rule is being amended so that it applies only to nursing facilities, nursing homes, and long term care hospital beds since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-32**, entitled Debt estimation methodology for change of operator, facility closure, voluntary termination, involuntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the debt estimation methodology for change of operator, facility closure, voluntary termination, involuntary termination, and voluntary withdrawal for NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-32.1**, entitled Debt estimate and debt summary report procedure for change of operator, facility closure, voluntary termination, involuntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the debt summary report procedure for change of operator, facility closure, voluntary termination, involuntary termination, and voluntary withdrawal for NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the

Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-32.2**, entitled Successor liability agreements for operators of nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for successor liability agreements for operators of NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-39**, entitled Payment and adjustment process for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), is being amended due to five-year review, and to implement provisions of Section 5111.226 of the Revised Code. This rule sets forth the Medicaid payment and adjustment process for NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR. Changes being made to the rule due to five-year review are: in paragraph (A), the revision dates of the JFS 09400 and 09401 forms are being updated; in paragraph (D), an Administrative Code rule number is being updated; and in paragraph (E), the word "shall" is being added to correct a typographical error.

ICF-MRTL 12-03 (Rescission of Rules to Implement ORC Section 5111.226 - Part 2)

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 12-03

January 16, 2013

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Rescission of Rules to Implement ORC Section 5111.226 - Part 2

Proposed Rescission of Administrative Code Rules 5101:3-3-73.1, 5101:3-3-73.2, 5101:3-3-73.3, 5101:3-3-81, 5101:3-3-81.1, 5101:3-3-81.2, 5101:3-3-82, 5101:3-3-82.1, 5101:3-3-84.2, 5101:3-3-84.3, 5101:3-3-85, 5101:3-3-94, and 5101:3-3-96

The following proposed rule changes are being made to implement provisions of Section 5111.226 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly. These changes are being made in accordance with Sections 119.03 and 119.032 of the Ohio Revised Code, which outline procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Proposed for Rescission

Rule **5101:3-3-73.1**, entitled Intermediate care facilities for the mentally retarded (ICFs-MR) case mix assessment instrument: individual assessment form (IAF) answer sheet, sets forth provisions for the IAF answer sheet for residents of ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-73.2**, entitled Resident assessment classification system (RACS): the intermediate care facility for the mentally retarded (ICF-MR) case mix payment system, sets forth provisions for the RACS case mix payment system for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-73.3**, entitled Calculation of quarterly and annual intermediate care facility for the mentally retarded (ICF-MR) facility average case mix scores, sets forth provisions for the calculation of quarterly and annual facility average case mix scores for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-81**, entitled Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for owners, relatives of owners, and administrators in intermediate care facilities for the mentally retarded (ICFs-MR), sets forth general provisions for compensation cost limits, reasonable costs for compensation, and compensation disallowances for owners, relatives of owners, and administrators who work in ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-81.1**, entitled Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for owners, relatives of owners in intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the provisions, including calculation methodology, for compensation cost limits, reasonable costs for compensation, and compensation disallowances for owners and relatives of owners who work in ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-81.2**, entitled Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for administrators in intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the provisions, including calculation methodology, for compensation cost limits, reasonable costs for compensation, and compensation disallowances for administrators who work in ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-82**, entitled Intermediate care facilities for the mentally retarded (ICFs-MR): method for establishing the other protected costs component of the prospective rate, sets forth the method for establishing the other protected costs component of the prospective rate for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-82.1**, entitled Method for establishing reimbursement to intermediate care facilities for the mentally retarded (ICFs-MR) for the franchise permit fee, sets forth the method for establishing reimbursement to ICFs-MR for the franchise permit fee. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-84.2**, entitled Cost of ownership, efficiency incentive, and reporting of accumulated depreciation for intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for the cost of ownership, efficiency incentive, and reporting of accumulated depreciation for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-84.3**, entitled Nonextensive renovations for intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for non-extensive renovations for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-85**, entitled Approval of nonextensive renovations for intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for approval of non-extensive renovations for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job

and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-94**, entitled Active treatment day programming services of intermediate care facilities for the mentally retarded (ICFs- MR), sets forth provisions for active treatment day programming services provided to residents of ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-96**, entitled Prospective rate reconsideration for intermediate care facilities for the mentally retarded (ICFs-MR) for possible calculation errors, sets forth provisions for prospective rate reconsideration for ICFs-MR on the basis of a possible error in the calculation of the rate. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

ICF-MRTL 12-02 (Rescission of Rules to Implement ORC Section 5111.226 - Part 1)

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 12-02

January 16, 2013

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Rescission of Rules to Implement ORC Section 5111.226 - Part 1

Proposed Rescission of Administrative Code Rules 5101:3-3-16.6, 5101:3-3-16.7, 5101:3-3-16.8, 5101:3-3-16.9, 5101:3-3-17.4, 5101:3-3-17.5, 5101:3-3-19.1, 5101:3-3-30, 5101:3-3-30.2, 5101:3-3-71, 5101:3-3-71.1, 5101:3-3-71.2, 5101:3-3-71.3, and 5101:3-3-71.4

The following proposed rule changes are being made to implement provisions of Section 5111.226 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly. These changes are being made in accordance with Sections 119.03 and 119.032 of the Ohio Revised Code, which outline procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Proposed for Rescission

Rule **5101:3-3-16.6**, entitled Resident rights for intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for resident rights for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-16.7**, entitled Private rooms in intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for private rooms in ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-16.8**, entitled Coverage of bed-hold days for medical necessity and other limited absences from intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for bed-hold days for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-16.9**, entitled Personal needs allowance (PNA) accounts and other resident funds for intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for personal needs allowance accounts and other resident funds for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-17.4**, entitled Outlier services for behavioral redirection and medical monitoring (BRMM) for intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for BRMM outlier services for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code,

the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-17.5**, entitled Payment methodology for the provision of outlier services in intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the payment methodology for the provision of outlier services in ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-19.1**, entitled Relationship of other covered medicaid services to intermediate care facility for the mentally retarded (ICF-MR) services, sets forth the relationship of other covered Medicaid services to ICF-MR services. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-30**, entitled Beds excluded from the franchise permit fee (FPF) for intermediate care facilities for the mentally retarded (ICFs-MR), identifies beds in ICFs-MR that are excluded from the franchise permit fee. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-30.2**, entitled Prohibition against billing residents for the franchise permit fee (FPF), prohibits directly billing residents of nursing facilities, nursing homes, long term care hospital units, or intermediate care facilities for the mentally retarded (ICFs-MR) for the franchise permit fee. The ICF-MR provisions of this rule are being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR. The remaining provisions are being rescinded because they are set forth in the Ohio Revised Code.

Rule **5101:3-3-71**, entitled Intermediate care facilities for the mentally retarded (ICFs-MR): chart of accounts, sets forth provisions for the chart of accounts for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-71.1**, entitled Intermediate care facility for the mentally retarded (ICF-MR): medicaid cost report, sets forth provisions for the Medicaid cost report for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-71.2**, entitled Intermediate care facilities for the mentally retarded (ICFs-MR): leased employees, sets forth provisions for leased employees for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code

that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-71.3**, entitled Capital asset and depreciation guidelines - intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the capital asset and depreciation guidelines for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-71.4**, entitled Intermediate care facilities for the mentally retarded (ICFs-MR): nonreimbursable costs, sets forth provisions for non-reimbursable costs for ICFs-MR. This rule is being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

ICF-MRTL 12-01 (HB 153 and Five-Year Review Rule Changes for ICFs-MR)

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 12-01

March 21, 2012

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: HB 153 and Five-Year Review Rule Changes for ICFs-MR

Amendment of Administrative Code Rules 5101:3-3-20, 5101:3-3-22, 5101:3-3-30.1, 5101:3-3-32, 5101:3-3-32.1, 5101:3-3-82, 5101:3-3-82.1, and 5101:3-3-84.2 (effective March 19, 2012)

Rescission of Administrative Code Rules 5101:3-3-83, 5101:3-3-84, 5101:3-3-84.4, 5101:3-3-84.5, and 5101:3-3-98 (effective March 19, 2012)

The following rule changes are being made to implement provisions of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly, or in accordance with Sections 119.03 and 119.032 of the Ohio Revised Code, which outline the procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Amended Rules

Rule **5101:3-3-20**, entitled Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements, is being amended due to five year review, and to implement provisions of Section 5111.261 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth provisions for Medicaid cost report filing, record retention, and disclosure requirements for nursing facilities and intermediate care facilities for the mentally retarded. Changes to this rule include the following: In the opening paragraph, the date of JFS form 02524N, the Medicaid Nursing Facility Cost Report, is being updated to 09/2011; and paragraph (D) is being restructured and the language in it amended to provide that although the general rule is that a provider may amend their cost report within three years of filing it with the Department, a provider may not amend a cost report if the Department has notified the provider of an audit of that cost report or an audit of a subsequent cost reporting period.

Rule **5101:3-3-22**, entitled Rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), is being amended due to five year review, and to implement provisions of Section 5111.271 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth the provisions for rate recalculations, interest on overpayments, imposition of penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities and intermediate care facilities for the mentally retarded. Changes to this rule include the following: In paragraph (A) the reference to OAC rule 5101:3-3-21 is being replaced with reference to ORC section 5111.27 because rule 5101:3-3-21 is being proposed for rescission; in paragraph (A)(3), the internet address for the publication "Selected Interest Rates" is being added; in the heading to paragraph (B) the words "and fines" is being added for clarification; new paragraphs (B)(3) and (B)(4) identify the fines to be issued based on the amount of adverse findings included in the report of an audit conducted under ORC section 5111.27; new paragraph (B)(5) prohibits the Department from collecting fines issued under paragraph (B)(3) until all appeals relating to the audit report that is the basis for the fine are exhausted; language has been added in paragraph (D) so that fines collected pursuant to paragraph (B)(3) shall be deposited into the Health Care Services Administration Fund created under ORC section 5111.94; and language has been added to paragraph (D) specifying where all other penalties issued under this rule will be deposited.

Rule **5101:3-3-30.1**, entitled Appeal of the franchise permit fee (FPF) determination, is being amended due to five year review, and to implement provisions of Sections 3721.531 and 3721.532 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth provisions for appeal of the franchise permit fee (FPF) determination. Changes to this rule include the following: The addition of "and re-determination" in the rule title; re-wording of paragraph (A) for clarification; and insertion of new language in paragraph (A) regarding an appeal of the FPF re-determination in accordance with section 3721.55 of the Revised Code.

Rule **5101:3-3-32**, entitled Debt estimation methodology for change of operator, facility closure, voluntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), is being amended due to five year review, and to implement provisions of Section 5111.68 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth the debt estimation methodology for change of operator, facility closure, voluntary termination, involuntary termination, or voluntary withdrawal for nursing facilities and intermediate care facilities for the mentally retarded. This rule is being changed to add involuntary termination to the title to clarify that it is one of the cases to which the debt estimation methodology applies.

Rule **5101:3-3-32.1**, entitled Debt estimate and debt summary report procedure for change of operator, facility closure, voluntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), is being amended due to five year review, and to implement provisions of Section 5111.68 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth the debt estimate and debt summary report procedure in cases of a change of operator, facility closure, voluntary termination, involuntary termination, or voluntary withdrawal for nursing facilities and intermediate care facilities for the mentally retarded. This rule is being changed to add involuntary termination to the title to clarify that it is one of the cases to which the debt estimate and debt summary report procedure applies.

Rule **5101:3-3-82**, entitled Intermediate care facilities for the mentally retarded (ICFs-MR): method for establishing the other protected costs component of the prospective rate, is being amended due to five year review, and to implement provisions of Section 5111.235 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth the method for establishing the other protected costs component of the prospective rate for intermediate care facilities for the mentally retarded. This rule is being changed to replace "The Consumer Price Index for All Urban Consumers for Nonprescription Drugs and Medical Supplies" with two separate indexes, "The Consumer Price Index for All Urban Consumers for Nonprescription Drugs" and "The Consumer Price Index for All Urban Consumers for Medical Supplies."

Rule **5101:3-3-82.1**, entitled Method for establishing reimbursement to intermediate care facilities for the mentally retarded (ICFs-MR) for the franchise permit fee, is being amended due to five year review. This rule sets forth the method for establishing reimbursement for the franchise permit fee to intermediate care facilities for the mentally retarded. Changes to this rule include: Removal of language that refers to the franchise permit fee as an "add-on" to the per diem rate; replacement of references to Administrative Code rules 5101:3-3-30 to 5101:3-3-30.4 with references to relevant sections of Revised Code; and movement of the language in paragraph (B)(1) to a new paragraph under (B) in order to comport with rule drafting guidelines of the Legislative Service Commission.

Rule **5101:3-3-84.2**, entitled Cost of ownership and efficiency incentive for intermediate care facilities for the mentally retarded (ICFs-MR), is being amended due to five year review. This rule sets forth provisions for the reporting of accumulated depreciation for a change of provider, the cost of ownership, and the efficiency incentive for intermediate care facilities for the mentally retarded (ICFs-MR). Part of rule 5101:3-3-84.5, which is being rescinded, is being moved to this rule. Changes to this rule include: Provisions regarding the reporting of accumulated depreciation for new owners of ICFs-MR are being moved from rule 5101:3-3-84.5 to new paragraph (G) of this rule; references to rule 5101:3-3-84.5 are being replaced with references to new paragraph (G); the name of the applicable consumer price index is being corrected; and the website address for the consumer price index is being added.

Rescinded Rules

Rule **5101:3-3-83**, entitled Method for establishing the indirect care costs component of the prospective rate for intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the method for establishing the indirect care costs component of the prospective rate for intermediate care facilities for the mentally retarded. This rule is being rescinded because the provisions in it are set forth in the Ohio Revised Code.

Rule **5101:3-3-84**, entitled Method for establishing capital reimbursement for intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the methodology for establishing reimbursement for capital costs for intermediate care facilities for the mentally retarded. This rule is being rescinded because the provisions in it are set forth in the Ohio Revised Code.

Rule **5101:3-3-84.4**, entitled Intermediate care facilities for the mentally retarded (ICFs-MR): return on equity, sets forth the method for establishing the return on equity for intermediate care facilities for the mentally retarded. This rule is being rescinded because the provisions in it are set forth in the Ohio Revised Code.

Rule **5101:3-3-84.5**, entitled Recovery of excess depreciation paid and the reporting of accumulated depreciation for new owners of intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the method for calculation and recovery of excess depreciation paid, and the reporting of accumulated depreciation, for new owners of intermediate care facilities for the mentally retarded. This rule is being rescinded because the provisions in it are set forth in the Ohio Revised Code, are no longer needed, or are being moved to rule 5101:3-3-84.2, which is being proposed for amendment.

Rule **5101:3-3-98**, entitled Intermediate care facilities for the mentally retarded (ICFs-MR): method for establishing the fiscal year 2006 and 2007 medicaid reimbursement rate for ICFs-MR, sets forth the method for establishing the Medicaid reimbursement rate for intermediate care facilities for the mentally retarded for fiscal years 2006 and 2007. This rule is being rescinded because it sets forth the method for establishing the reimbursement rate for services provided in intermediate care facilities for the mentally retarded for the period beginning July 1, 2005 and ending June 30, 2007, and is therefore obsolete.

ICF-MRTL 10-06 (Successor Liability Rules for ICFs-MR)

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 10-06

September 21, 2010

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Successor Liability Rules for ICFs-MR

Proposed Adoption of Administrative Code Rules 5101:3-3-32, 5101:3-3-32.1, and 5101:3-3-32.2 (effective on or about November 29, 2010)

The following are proposed rule changes made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for Adoption

The following rules are being proposed for adoption in order to implement provisions of Amended Substitute House Bill 398 of the 128th General Assembly.

Rule **5101:3-3-32** entitled Debt estimation methodology for change of operator, facility closure, voluntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) sets forth the methodology used to estimate the actual and potential debts owed to ODJFS and CMS by the exiting operator of a NF or ICF-MR in cases of a change of operator, facility closure, voluntary termination, or voluntary withdrawal from the Medicaid program.

Rule **5101:3-3-32.1** entitled Debt estimate and debt summary report procedure for change of operator, facility closure, voluntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) sets forth the procedure used to issue the debt estimate and the debt summary reports for NFs and ICFs-MR in cases of a change of operator, facility closure, voluntary termination, or voluntary withdrawal from the Medicaid program.

Rule **5101:3-3-32.2** entitled Successor liability agreements for operators of nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) sets forth approval and signature provisions for successor liability agreements for NFs and ICFs-MR.

If no revisions occur, the above rule will become effective on or about November 29, 2010.

ICF-MRTL 10-05 (Emergency Rule: Debt Estimation Methodology)

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 10-05

September 2, 2010

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Emergency Rule: Debt Estimation Methodology

Adoption of Emergency Rule 5101:3-3-32 (effective August 31, 2010 - November 28, 2010)

The following rule change is being made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Adoption of Emergency Rule

Rule **5101:3-3-32** entitled Debt estimation methodology for change of operator, facility closure, voluntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) sets forth the methodology used to estimate the actual and potential debts owed to the Ohio Department of Job and Family Services (ODJFS) and the United States Centers for Medicare and Medicaid Services (CMS) by the exiting operator of a NF or ICF-MR in cases of a change of operator, facility closure, voluntary termination, or voluntary withdrawal from the Medicaid program. This rule is being adopted on an emergency basis in order to comply with provisions required by Amended Substitute House Bill 398.

ICF-MRTL 10-04 (Provider Agreement Rules for ICFs-MR)

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 10-04

December 6, 2010

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Provider Agreement Rules for ICFs-MR

Proposed Amendment of Administrative Code Rules 5101:3-3-02.1, 5101:3-3-02.2, and 5101:3-3-02.3 (effective on or about February 15, 2011)

The following are proposed rule changes made in accordance with section 119.032 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for Amendment

Rule **5101:3-3-02.1** entitled Length and type of long term care provider agreements sets forth the length and type of provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). This rule is being proposed for amendment due to five-year review. Changes to this rule include the following: in paragraph (A)(1) the word "nursing" is being changed to the phrase "long term care" so that the definition of "reasonable assurance period" applies to ICFs-MR as well as to NFs; in paragraph (B) the phrase "developmentally disabled" is being deleted in order to conform to current federal terminology; also in paragraph (B), and throughout the rule, the acronym "ICFs-MR/DD" is being changed to "ICFs-MR" in order to conform to current federal terminology; in paragraph (B)(2)(a) the existing provision is being identified as applying in cases of initial certification of ICFs-MR; in paragraph (B)(2) language is being added that explains existing procedure requiring satisfaction of the reasonable assurance period in cases when an ICF-MR wants to re-enter the Medicaid program following involuntary termination by CMS; in paragraph (C)(4)(b) the phrase "except as specified in paragraph (D) of this rule" is being added so that the term extensions described in paragraph (D) are exceptions to the 12-month limit on time-limited agreements for ICFs-MR; in paragraph (D)(3)(a) new language is being added that explains existing policy whereby, in cases of a term extension for an ICF-MR, the time period of a subsequent provider agreement is reduced by the number of months by which the first provider agreement was extended; and citations, grammar, and punctuation are being corrected throughout the rule.

Rule **5101:3-3-02.2** entitled Termination, denial, and non-renewal of long term care provider agreements sets forth the provisions for termination, denial, and non-renewal of provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). This rule is being proposed for amendment due to five-year review. Changes to this rule include the following: in paragraph (A)(1) the phrase "developmentally disabled" is being deleted in order to conform to current federal terminology; also in paragraph (A)(1), and throughout the rule, the acronym "ICF-MR/DD" is being changed to "ICF-MR" in order to conform to current federal terminology; in paragraph (B) the phrase "pursuant to division (B) of section 5111.06 of the Revised Code" is being deleted to better clarify the authority for termination, denial, or non-renewal of provider agreements; also in paragraph (B) the phrase "or shall in certain circumstances" is being deleted in order to clarify departmental policy; in paragraph (B)(1) the phrase "According to section 5111.22 of the Revised Code" is being added in order to give the statutory authority under which ODJFS may terminate, deny, or not renew a provider agreement if ODJFS determines such an agreement is not in the best interest of the state or Medicaid residents of long term care facilities; also in paragraph (B)(1), and in paragraph (B)(2), the wording is being changed in order to more precisely express existing policy; paragraph (B)(2)(j) is being deleted because that provision is being moved to new paragraph (C)(1)(g) as one of the reasons for which ODJFS shall terminate, deny, or not renew a provider agreement; the ORC citation in paragraph (C) is being moved to paragraph (C)(1) in order to clarify the provisions to which the citation applies; language in paragraph (C)(1) is being changed so that the reasons for which ODJFS shall terminate, deny, or not renew a provider agreement are more inclusive; in paragraphs (D)(1) and (D)(2) references to the Revised Code are

being added in order to give the statutory authority under which ODJFS takes the actions described in these paragraphs; paragraph (E) is being added in order to explain existing policy regarding the reasonable assurance period; and citations, grammar, and punctuation are being corrected throughout the rule.

Rule **5101:3-3-02.3** entitled Institutions eligible to participate in Medicaid as nursing facilities (NFs) or intermediate care facilities for the mentally retarded (ICFs-MR) sets forth the eligibility provisions for institutions to participate in the Medicaid program as NFs or ICFs-MR. This rule is being proposed for amendment due to five-year review. Changes to this rule include the following: in the title and in paragraph (A)(3) the phrase "developmentally disabled" is being deleted in order to conform to current federal terminology; also in the title, and throughout the rule, the acronym "ICFs-MR/DD" is being changed to "ICFs-MR" in order to conform to current federal terminology; paragraphs (D), (E), and (F) are being restructured in order to conform to LSC rule drafting guidelines; in new paragraph (D)(1) reference to the Cincinnati Department of Health is being deleted since that department no longer licenses nursing homes; paragraph (E)(2), which lists veterans' homes operated under Chapter 5907. of the Revised Code and RNHCIs as institutions exempt from mandatory dual participation, is being deleted because this information is contained in OAC rule 5101:3-3-02.4; in paragraph (F)(1) the phrase "Ohio department of mental retardation and developmental disabilities" is being changed to "Ohio department of developmental disabilities" in order to reflect that agency's recent name change; also in paragraph (F)(1), and throughout the remainder of the rule, the acronym "ODMR/DD" is being changed to "DODD" in order to reflect the agency's name change; in paragraph (G)(2)(b) language is being added as clarification that the exception described also applies in cases of a change of operator; and citations and punctuation are being corrected throughout the rule.

If no revisions occur, the above rules will become effective on or about February 15, 2011.

ICF-MRTL 10-03 (Proposed Amendment of Rule 5101:3-3-01 (Effective on or About October 1, 2010))

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 10-03

August 2, 2010

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: PROPOSED AMENDMENT OF RULE 5101:3-3-01 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT OCTOBER 1, 2010)

The following rules are being proposed for amendment pursuant to Section 119.032 of the Revised Code.

Rule **5101:3-3-01** entitled Definitions, is being proposed for amendment to accommodate the October 1, 2010 implementation of the Minimum Data Set Version 3.0 (MDS 3.0) resident assessment instrument (RAI) by the Centers for Medicare and Medicaid Services (CMS). The RAI is the assessment tool used in Ohio to measure resident acuity, is the foundation for planning and delivering care to NF residents, and is used in the calculation of NF reimbursement rates. This rule defines terms in Chapter 5101:3-3 of the Administrative Code except as otherwise provided in that chapter. This rule defines terms relating to reimbursement and case mix resident acuity for services provided by nursing facilities (NFs). This rule also defines terms relating to reimbursement for services provided by intermediate care facilities for the mentally retarded (ICFs-MR). The proposed amendments to the rule are as follows:

In paragraph (B) of the proposed rule, the definition of ancillary and support costs was changed to refer to rule 5101:3-3-42 of the Administrative Code. In paragraph (D) of the proposed rule, language was added to delineate the definition of "Capital Costs" by provider type. In paragraph (H) of the proposed rule, language was added to clarify that the cost per case mix unit for NFs is determined at least once every ten years for a peer group while the cost per case mix unit for ICFs-MR is determined annually. In paragraph (I) of the proposed rule, a typographical error was corrected. In paragraph (Q) of the proposed rule, the version number was removed from the Minimum Data Set (MDS) RAI. In paragraphs (Q) and (HH) of the proposed rule, the version number was removed from the Resource Utilization Group (RUG) case mix classification system. The MDS version and the RUG version will be specified in Administrative Code rules 5101:3-3-43.1 and 5101:3-3-43.2 respectively. In paragraph (EE) of the proposed rule, NF was removed from the definition of non-extensive renovation as this only applies to ICF-MR providers.

The above rule is being proposed for amendment as indicated above. Should revisions to the proposed rule occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions to the rule occur, the aforementioned rule will become effective on or about October 1, 2010 on a permanent basis.

ICF-MRTL 10-02 (FPF Rules for ICFs-MR)

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 10-02

August 18, 2010

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Proposed Rescission of Administrative Code Rules 5101:3-3-30, 5101:3-3-30.1, 5101:3-3-30.2, and 5101:3-3-30.3 (effective on or about October 15, 2010)

Proposed Adoption of Administrative Code Rules 5101:3-3-30, 5101:3-3-30.1, and 5101:3-3-30.2 in Conjunction with Rescission of Rules by the Same Number (effective on or about October 15, 2010)

Proposed Amendment of Administrative Code Rule 5101:3-3-30.4 (effective on or about October 15, 2010)

The following rules are being proposed for rescission, adoption, or amendment pursuant to section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Proposed for Rescission

The following rules are being proposed for rescission because most of the provisions in them exist in Sections 3721.50 to 3721.58, 5112.30 to 5112.35, and 5112.37 to 5112.39 of the Ohio Revised Code (ORC). Provisions in these rules that do not exist in the ORC are being moved to proposed new rules 5101:3-3-30, 5101:3-3-30.1, and 5101:3-3-30.2.

Rule **5101:3-3-30** entitled Beds and facilities subject to the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD) identifies beds and facilities subject to the franchise permit fee for NFs, NHs, long term care hospital beds, and ICFs-MR. This rule is being proposed for rescission because most of the provisions in it are set forth in the ORC. Provisions not contained in the ORC are being moved to proposed new rule 5101:3-3-30.

Rule **5101:3-3-30.1** entitled Calculation, billing, payment remittance, and appeal process for the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD) establishes the calculation method, billing cycle, payment remittance procedure, and appeal process for the franchise permit fee for NFs, NHs, long term care hospital beds, and ICFs-MR. This rule is being proposed for rescission because most of the provisions in it are set forth in the ORC. Provisions not contained in the ORC are being moved to proposed new rules 5101:3-3-30.1 and 5101:3-3-30.2.

Rule **5101:3-3-30.2** entitled Enforcement of the franchise permit fee (FPF) program for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD) sets forth the procedures for enforcement of the franchise permit fee program for NFs, NHs, long term care hospital beds, and ICFs-MR. This rule is being proposed for rescission because the provisions in it are set forth in the ORC.

Rule **5101:3-3-30.3** entitled Distribution method for franchise permit fee (FPF) proceeds from nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD) sets forth the distribution method for franchise permit fee proceeds from NFs, NHs, long term care hospital beds, and ICFs-MR. This rule is being proposed for rescission because the provisions in it are set forth in the ORC.

Proposed for Adoption in Conjunction with Rescission of a Rule by the Same Number

Rule **5101:3-3-30** entitled "Beds excluded from the franchise permit fee (FPF) for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the beds excluded from the ICF-MR franchise permit fee. The provisions in this rule are being moved from rule 5101:3-3-30, which is being proposed for rescission, and do not exist in the ORC.

Rule **5101:3-3-30.1** entitled "Appeal of the franchise permit fee (FPF) determination" sets forth the procedure for appealing a FPF determination that has been submitted in accordance with sections 3721.55 and 5112.35 of the Revised Code. The provisions in this rule are being moved from rule 5101:3-3-30.1, which is being proposed for rescission, and do not exist in the ORC.

Rule **5101:3-3-30.2** entitled "Prohibition against billing residents for the franchise permit fee (FPF)" sets forth the prohibition against directly billing or directly passing through the FPF to residents of NFs, NHs, hospitals, or ICFs-MR. The provisions in this rule are being moved from rule 5101:3-3-30.1, which is being proposed for rescission, and do not exist in the ORC.

Proposed for Amendment

Rule **5101:3-3-30.4** entitled "Procedure for terminating the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), long term care hospital beds, and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the procedure for terminating the franchise permit fee for NFs, NHs, long term care hospital beds, and ICFs-MR if the Centers for Medicare and Medicaid Services (CMS) determines the FPF is an impermissible health care related tax. Changes to the rule are as follows:

In the title and in paragraph (B) the word "assessment" is being deleted in order to conform more closely to statutory language; the term "developmentally disabled" is being deleted from the title in order to conform to current federal terminology, and the acronym "ICF-MR/DD" is being changed to "ICF-MR" throughout the rule; references to Ohio Administrative Code rules proposed for rescission are being replaced throughout the rule with references to the applicable Ohio Revised Code sections; in paragraph (D)(1)(d)(i) the term "nursing homes" is being replaced with the acronym "NHs," and in paragraph (D)(1)(d)(ii) the term "nursing home" is being replaced with the acronym "NH" in order to follow rule drafting convention; also in paragraph (D)(1)(d)(i) the acronym "SN" is being replaced with "NF" in order to correct a typographical error, and the acronym "SNF/NF" is being replaced with the phrase "skilled nursing facility/nursing facility (SNF/NF)" in order to follow rule drafting convention; and in paragraph (D)(3)(a)(iii) the phrase "claims payment offsets for subsequent dates of service" is being changed to "offsets of future payments" in order to clarify departmental procedure.

If no revisions occur, the above rules will become effective on or about October 15, 2010.

ICF-MRTL 09-05 (Provider Agreements and Emergency Management Plan for ICFs-MR)

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 09-05

April 20, 2010

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Provider Agreements and Emergency Management Plan for ICFs-MR

Proposed amendment of rule 5101:3-3-02 of the Administrative Code (effective on or about June 20, 2010)

Proposed adoption of rule 5101:3-3-02.7 of the Administrative Code in conjunction with rescission of a rule by the same number (effective on or about June 20, 2010)

Proposed rescission of rule 5101:3-3-02.7 of the Administrative Code (effective on or about June 20, 2010)

Emergency Preparedness Resources

Attached are proposed rule changes made in accordance with section 119.032 of the Ohio Revised Code, which outlines the procedures for the amendment, adoption, and rescission of administrative rules.

Proposed for amendment

Rule **5101:3-3-02** **"Provider agreements for nursing facilities (NFs) and intermedicate care facilities for the mentally retarded (ICFs-MR)"** contains the provider agreement provisions for NFs and ICFs-MR. This rule is being proposed for amendment due to five-year review. Changes to this rule include the following: in paragraph (A) the definition of closure has been expanded for additional clarity; also in paragraph (A) the definitions of continuing care, failure to pay, and Medicaid eligible have been changed for additional clarity; in paragraph (B)(3) the provider agreement has been added as a document with which providers must comply; in paragraph (B)(8)(c)(iv) the word "persons" has been replaced with "individuals" in order to reflect current terminology; in paragraph (B)(9) reference to the July 1, 1997 effective date has been removed; in paragraphs (B)(9)(b) and (B)(9)(c)(i) the phrase "vendor payment" has been replaced with "medicaid payment" in order to reflect current terminology; in paragraph (B)(11)(a) the word "provider" has been replaced with the phrase "operator or owner and entering operator" in order to clarify who is required to give notice of a change of operator; also in paragraph (B)(11)(a) language has been added regarding the requirement for a 90-day notice when residents are relocated and penalties for lack of proper notice in cases of a change of operator; language has been inserted at (B)(11)(d) regarding assignment of an exiting operator's provider agreement to the entering operator; in paragraph (B)(14) language has been added requiring notice to ODJFS and the Attorney General's Office within thirty days of any bankruptcy or receivership pertaining to the provider; also in paragraph (B)(14) a provision requiring that notice of bankruptcy or receivership also be mailed to the Office of the Attorney General has been added; language has been inserted at (C)(4) that describes the requirements for a NF provider who voluntarily withdraws from the Medicaid program; in paragraph (D) the language regarding closure or voluntary withdrawal of an ICF-MR has been changed to provide additional clarity; in paragraph (E)(3) new language has been added to clarify the issue of pre-admission deposits for individuals whose Medicaid eligibility is pending; paragraph (I) has been revised to clarify the function of the JFS 09401; rule references and other citations throughout the rule have been updated and corrected as necessary; and corrections to grammar and punctuation have been made throughout the rule.

Proposed for adoption in conjunction with rescission of a rule by the same number

Rule **5101:3-3-02.7** **"Emergency management and resident relocation plan for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"** contains the provisions for facility

management and resident relocation for NFs and ICFs-MR in case of emergencies. This rule is being proposed for adoption due to five-year review. It replaces rescinded rule 5101:3-3-02.7. Changes include the following: new paragraph (A) sets forth the purpose of the rule; new paragraph (B) sets forth the definition of "emergency"; and subsequent paragraphs contain requirements for the preparation and communication of the written emergency relocation plan, the components of the plan, notification, compliance and reimbursement, and termination of NF services.

Proposed for rescission

Rule **5101:3-3-02.7** **"Emergency management and resident relocation plan for long term care facilities"** contains the provisions for facility management and resident relocation for NFs and ICFs-MR in case of emergencies. This rule is being proposed for rescission due to five-year review. It is being replaced by new rule 5101:3-3-02.7.

If no revisions occur, the above rules will become effective on or about June 20, 2010.

Emergency Preparedness Resources

The following emergency preparedness documents are available for download from the CMS website, and may be used as resources by administrators of ICFs-MR. They are available at web address **http://www.cms.hhs.gov/SurveyCertEmergPrep/03_HealthCareProviderGuidance.asp#TopOfPage:**

1. "Survey and Certification Emergency Preparedness Checklist - Recommended Tool for Effective Health Care Facility Planning"
2. "Survey and Certification Emergency Planning Checklist - Recommended Tool for Persons in Long-Term Care Facilities"

ICF-MRTL 09-03 (Rules 5101:3-3-20, 5101:3-3-71, 5101:3-3-94)

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 09-03

December 21, 2009

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: PROPOSED AMENDMENT OF RULES 5101:3-3-20, 5101:3-3-71, and 5101:3-3-94 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT JANUARY 31, 2010)

The following rules are being proposed for amendment pursuant to Section 119.032 of the Revised Code.

Rule **5101:3-3-20**, entitled "Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements" sets forth the requirement for the timely filing of cost reports by NFs and ICFs-MR, the methodology for processing those reports by ODJFS, and penalties that may be applied for failure to file cost reports as required. Changes to the proposed rule are as follows:

> In the leading paragraph, the revision date for the NF cost report is being changed from "rev. 01/2007" to "Rev. 1/2010".
>
> Language is being modified to more clearly state the existing policy regarding the assessment of a penalty for the late filing of a cost report. The proposed language states that late file penalties are assessed beginning with the start of the thirty day termination period and ending when a complete and adequate cost report is filed or the provider agreement is terminated. In paragraph (D) of the proposed rule, language is being stricken to remove the requirement that in order to file there must be a change in the total per diem cost of the applicable cost center by ten cents or more per patient day. A reference to section 5111.27 of the Revised Code is being added to paragraph (D) making it clear that the ODJFS review is conducted in accordance with section 5111.27 of the Revised Code.

Rule **5101:3-3-71**, entitled: "Intermediate care facilities for the mentally retarded (ICFs-MR): chart of accounts", sets forth the chart of accounts for ICFs-MR. The existing Appendix A to the rule, entitled "Chart of Accounts", is being proposed for rescission and a new Appendix A with the same title is being proposed for adoption. Changes are being made to Appendix A to implement section 5111.233 of the Ohio Revised Code as enacted in Amended Substitute House Bill 1.

> New language is being added to the description for account number 6215 to indicate services reported under account 6215 should not include services reported under other account numbers elsewhere in the cost report. Language is also being added to indicate payment for "Active Treatment Off-site Day Programming Services" is to be reimbursed through the direct care rate per diem of the Medicaid rate calculation. Language is being added to explain that costs of off-site day programming shall be reimbursed as part of the ICF-MR's direct care costs regardless of whether or not the area in which the day programming is provided is less than two hundred feet away from the ICF-MR or whether or not the day programming is provided by an individual who, or organization that, is a related party to the provider of the ICF-MR.

Rule **5101:3-3-94**, entitled "Payment for active treatment day programming services of intermediate care facilities for the mentally retarded (ICFs-MR)", sets forth the provisions to reimburse facilities for active treatment day programming services. The following changes to the proposed rule remove the references in the rule to the add-on that ended on June 30, 2007.

> In the title of the proposed rule, "Payment for active" is being deleted and being replaced by "Active". Paragraph (A) of the proposed rule is being stricken and replaced with "The costs of active treatment day programming shall be part of the direct care costs of an ICF-MR as off-site active treatment day programming". In paragraph (B) of the proposed rule, "For the purposes of this add-on, active" is being stricken and replaced with "Active". Appendix A to the rule entitled "Counties and Active Treatment Add-On Rates" is being proposed for rescission.

The above rules are being proposed for amendment, rescission, or adoption as indicated above. Should revisions to the proposed permanent rules occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions to the rules occur, the aforementioned rules will become effective on or about January 31, 2010 on a permanent basis.

ICF-MRTL 09-02

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 09-02

August 25, 2009

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT ICF-MR - Rules for Consolidated Services

Proposed adoption of new rule **5101:3-3-19.1** of the Administrative Code (effective October 29, 2009)

Attached are proposed rule changes made in accordance with Amended Substitute House Bill 1 of the 128th General Assembly.

Proposed for adoption

Rule **5101:3-3-19.1** entitled "**Relationship of Other Covered Medicaid Services to Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)**" sets forth covered services generally available to medicaid recipients and describes the relationship of such services to those provided by an ICF-MR. This rule is being proposed for adoption to separately identify covered services in ICFs-MR. Previously, these services were identified along with those covered in nursing facilities (NFs) in rule 5101:3-3-19.

Should revisions of the proposed rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. If no revisions occur, the above rule will become effective October 29, 2009.

ICF-MRTL 09-01

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 09-01

May 21, 2009

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: PROPOSED AMENDMENT OF RULE 5101:3-3-02 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT AUGUST 1, 2009)

PROPOSED RESCISSION OF RULE 5101:3-3-31 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT AUGUST 1, 2009)

ODJFS RULE DISTRIBUTION

The rules are being proposed for permanent amendment, rescission, or adoption in accordance with section 119.032 of the Revised Code.

Proposed for amendment

Rule **5101:3-3-02** entitled "Provider Agreements: Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the requirements of the agreement between NF and ICF-MR providers and the Ohio Department of Job and Family Services (ODJFS). This rule is being proposed for amendment in conjunction with the ODJFS paper reduction strategy which will increase communication efficiency and cost effectiveness with NF and ICF-MR providers.

The paragraph number (D)(1) was eliminated since there was no paragraph (D)(2) in the rule. This results in existing rule language in paragraph (D)(1) moving to paragraph (D).

Paragraph (F)(3) of this rule was modified to require electronic notification from ODJFS to affected persons whenever ODJFS files proposed rules or proposed rules in revised form. ODJFS shall provide this notification by posting the full text of proposed rules on its website for viewing and printing purposes. Language requiring ODJFS to provide hard copies of proposed rules was stricken from paragraph (F)(3) of this rule. ODJFS may also send an email notice of the rule action to all persons whose name or contact information appears on a distribution list maintained by ODJFS.

Proposed for rescission

Rule **5101:3-3-31** entitled "Capital compensation program eligibility and payment methodology" sets forth the program eligibility and payment methodology for the capital compensation program. This rule is being proposed for rescission because the capital compensation program set forth in this rule has expired.

The above rules are being proposed for amendment, rescission, or adoption as indicated above. Should revisions to the proposed permanent rules occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions to the rules occur, the aforementioned rules will become effective on or about August 1, 2009 on a permanent basis.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTLs). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard copy rules ICF-MR providers can obtain proposed rules from the ODJFS eManuals website which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."

2) Select "Long Term Care."

3) In the "Table of Contents" drop-down menu, scroll to and select the desired ICF-MRTL #.

4) Scroll to and select the desired rule number.

5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

ICF-MRTL 09-01 Order Form

ICF-MRTL 08-04

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 08-04

August 14, 2008

TO: Administrators, Intermediate Care Facility for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: PROPOSED AMENDMENT OF RULES 5101:3-3-19 AND 5101:3-3-20 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT OCTOBER 24, 2008)

ODJFS RULE DISTRIBUTION

The following rules are being proposed for permanent amendment pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-3-19 entitled: "Relationship of other covered medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services" identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. Changes to the proposed rule are as follows:

In the introductory paragraph of the proposed rule, "the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable." was corrected to read: "the rules governing such reimbursement are set forth in Chapter 5101:3-3 of the Administrative Code." The sentence "For state operated ICFs-MR reimbursement is made in accordance with rule 5101:3-3-99 of the Administrative Code." was stricken, and the last sentence of the introductory paragraph was edited to read: "All references to "ICFs-MR" in paragraphs (A) to (I) of this rule do not include state-operated ICFs-MR for which reimbursement is made in accordance with rule 5101:3-3-99 of the Administrative Code."

In paragraph (C)(2)(d) of the proposed rule, "except that emergency stand-by oxygen is" was changed to "except emergency stand-by oxygen which is."

Paragraph (D)(2) was shortened to simply point to Chapter 5101:3-9 of the Administrative Code and provisions established by the Ohio State Board of Pharmacy for limitations on pharmaceuticals reimbursable directly to the pharmacy provider. Paragraphs (D)(2)(a), (D)(2)(b) and (D)(2)(c) were stricken for being duplicative of language found in Chapter 5101:3-9 and provisions of the Ohio State Board of Pharmacy.

In paragraph (E)(1) of the proposed rule, references to rules 5101:3-3-47, 5101:3-3-47.3, and 5101:3-3-46 were corrected to 5101:3-3-46, 5101:3-3-46.3, and 5101:3-3-46.1, respectively. In paragraph (E)(2) of the proposed rule, "rule 5101:3-3-78 of the Administrative Code" was replaced with "sections 5111.20 to 5111.33 of the Revised Code." Paragraph (E)(3) of the proposed rule was deleted as psychologist services and respiratory therapy are addressed in paragraphs (E)(1) and (E)(2) of the proposed rule for NFs and ICFs-MR respectively.

The wording of paragraph (F)(1) was changed from "services provided by a physician to a resident of a NF or ICF-MR" to "services provided to a resident of a NF or ICF-MR by a physician." In paragraphs (F)(1)(c)(iii) and (F)(1)(c)(iv)(a) of the proposed rule, "nurse practitioner" was changed to "certified nurse practitioner" to comport with current terminology. Paragraph (F)(1)(c)(iv)(a) was expanded to reference Revised Code Chapter 4730 and Administrative Code Chapter 4730-1 for physician assistants, and Revised Code Chapter 4723 and Administrative Code Chapter 4723-4 for certified nurse practitioners. Duplicative language in subsequent paragraphs of the rule was stricken where the provisions were covered in Revised Code Chapters 4730 and 4723 and Administrative Code Chapters 4730-1 and 4723-4, and paragraph references were updated accordingly.

Existing paragraphs (G) and (H) regarding psychologist services and respiratory therapy services respectively were deleted from the proposed rule, and the deleted language was included in paragraphs (E)(1) and (E)(2) to better organize the rule content. Lastly, new paragraphs (G) through (I) of the proposed rule were arranged in alphabetical order according to paragraph titles.

Rule 5101:3-3-20 entitled: "Nursing Facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements" sets forth the requirement for the timely filing of cost reports by NFs and ICFs-MR, the methodology for processing those reports by ODJFS, and penalties that may be applied for not filing cost reports as required. Changes to the proposed rule are as follows:

In the introductory paragraph of the proposed rule, the revision dates for the "Medicaid Nursing Facility Cost Report" (JFS 02524N) and the "Medicaid ICF-MR Cost Report" (JFS 02524) were both updated. In paragraph (A)(1)(b) of the proposed rule, the reporting period end date in the case of a facility closure was clarified by referencing the definition of "closure" in rule 5101: 3-3-02(A)(1) of the Administrative Code. Paragraph (A)(1)(b) of the proposed rule also clarifies that a facility closure under any circumstance would trigger submission of a final cost report. Paragraph (A)(1)(b) was also rearranged such that new language is inserted following stricken language pursuant to the LSC rule drafting manual.

In paragraph (A)(3) of the proposed rule, "the Ohio department of job and family services" was replaced with the agency's acronym, and a paragraph reference was corrected.

The last sentence of paragraph (C) was edited to remove the colon in the middle of the sentence and to read as follows: "ODJFS shall notify each NF and ICF-MR of any costs preliminarily determined not to be allowable and provide the reasons for the determination." In paragraph (D) of the proposed rule, "…per diem cost…" was changed to "…per diem cost or rate…," in both of the first two sentences so that the rule applies to both NFs and ICFs-MR.

In paragraphs (H) and (I)(1) of the proposed rule, paragraph references were corrected. In paragraph (I)(5) of the proposed rule, an amended date was added for the cited reference to the Social Security Act.

The above rules are being proposed for permanent amendment. Should revisions to the proposed permanent rules occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions occur, the aforementioned rules will become effective on or about October 24, 2008 on a permanent basis.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTLs). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard copy rules ICF-MR providers can obtain proposed rules from the ODJFS eManuals website which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."
2) Select "Long Term Care."
3) In the "Table of Contents" drop-down menu, scroll to and select the desired ICF-MRTL #.
4) Scroll to and select the desired rule number.
5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

ICF-MRTL 08-04 Order Form

ICF-MRTL 08-02

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 08-02

May 5, 2008

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: ICF-MR Outlier Rules

Proposed adoption of rule 5101:3-3-17.4 of the Administrative Code in conjunction with rescission of a rule by the same number (effective on or about August 1, 2008)

Attached are proposed rule changes made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for adoption in conjunction with rescission of rules by the same number

Rule 5101:3-3-17.4 **"Outlier services for behavioral redirection and medical monitoring (BRMM) for intermediate care facilities for the mentally retarded (ICFs-MR)"** contains the provisions for behavioral redirection and medical monitoring (BRMM) outlier services in intermediate care facilities for the mentally retarded. This rule is being proposed for adoption in conjunction with the rescission of a rule by the same number as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It replaces rule 5101:3-3-17.4 that is being proposed for rescission. Changes to the rule include grammatical revisions and reorganization of the rule body for improved comprehension. In paragraph (B), the term "primary diagnosis" has been removed, and the term "outlier prior authorization committee" has been changed to "ODJFS outlier prior authorization committee." All instances throughout the rule of "ICF-MR/DD" have been changed to "ICF-MR."

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about August 1, 2008.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTLs). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard copy rules ICF-MR providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."
2) Select "Long Term Care."
3) In the "Table of Contents" drop-down menu, scroll to and select the desired ICF-MRTL #.
4) Scroll to and select the desired rule number.
5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you

may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

ICF-MRTL 08-02 Order Form

ICF-MRTL 08-01

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 08-01

April 9, 2008

TO: Ohio Medicaid Nursing Facility Providers

FROM: Helen E. Jones-Kelley, Director

SUBJECT: PROPOSED PERMANENT AMENDMENT OF RULES 5101:3-3-04 AND 5101:3-3-04.1 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT JULY 1, 2008)

Rule 5101:3-3-04 titled "Payment during the Ohio department of job and family services (ODJFS) administrative appeals process for denial or termination of a provider agreement" sets forth payment for eligible NF and ICF-MR residents during a proposed termination or non-renewal of a facility's provider agreement by ODJFS, and during the appeals process of that proposed action. Payment after termination or non-renewal of a provider agreement, and following an administrative hearing upholding ODJFS' termination or non-renewal action, as well as when ODJFS is acting under instruction from the U.S. Department of Health and Human Services, are also addressed in this rule.

This rule is proposed for permanent amendment to correct the department name in the title from "...jobs and family services" to "job and family services", correct the spelling of "pursuant" in Section (A), and change "nonrenewal" to "non-renewal" throughout the rule.

Rule 5101:3-3-04.1 titled "Payment to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) during the survey agency's administrative appeals process" sets forth requirements for ODJFS payment of eligible NF and ICF-MR residents during the appeals process for termination or non-renewal of a facility's certification proposed by the State survey agency (Ohio Department of Health). The rule contains information and requirements specific to NFs, specific to ICFs-MR, and common to both NFs and ICFs-MR, including when ODJFS acts under instruction from the U.S. Department of Health and Human Services. Payment after termination or non-renewal of certification, or following an administrative hearing upholding ODH's termination or non-renewal of certification are also addressed.

This rule is proposed for permanent amendment to correct the department name in Section (A)(3) from "jobs and family" to "job and family", change "ICF's-MR" in Section (D)(2)(b) to "ICF-MR's", add a colon to the end of the sentence in Section (E), to change "nonrenewal" to "non-renewal" throughout the rule, and to change "nonrenewed" in Section (B) to "not renewed".

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above mentioned rules will become effective July 1, 2008.

ICF-MRTL 08-01 Order Form

ICF-MRTL 07-07

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 07-07

January 4, 2008

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Proposed Rules: Resident Rights for Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)

Proposed adoption of rule 5101:3-3-16.1 of the Administrative Code in conjunction with the rescission of a rule by the same number (Effective on or about March 31, 2008)

Proposed adoption of rules 5101:3-3-16.6 and 5101:3-3-16.7 of the Administrative Code (Effective on or about March 31, 2008)

Proposed rescission of rules 5101:3-3-16, 5101:3-3-16.1, and 5101:3-3-23 of the Administrative Code (Effective on or about March 31, 2008)

Enclosed are proposed rule changes made in accordance with section 119.03 of the Revised Code, which outlines procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for adoption in conjunction with rescission of a rule by the same number

Rule 5101:3-3-16.1 **"Resource assessment notice for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"** contains the provisions regarding the resource assessment notice for both NFs and ICFs-MR. It is being proposed for adoption in conjunction with the rescission of a rule by the same number as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The provisions of this rule remain substantively unchanged. Section headings have been added and the rule body has been restructured for improved comprehension.

Proposed for adoption

Rule 5101:3-3-16.6 **"Resident rights for intermediate care facilities for the mentally retarded (ICFs-MR)"** contains the general provisions of resident rights for ICFs-MR. This is a new rule being proposed for adoption as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. ICF-MR provisions in former rule 5101:3-3-16 are being moved to this rule. Paragraph (A) contains a new definition for the term "intermediate care facility for the mentally retarded." Section headings have been added and the rule body has been restructured for improved comprehension. There are additional references to state laws and regulations, and the reference to federal regulations has been updated.

Rule 5101:3-3-16.7 **"Private rooms in intermediate care facilities for the mentally retarded (ICFs-MR)"** contains the provisions for private rooms in ICFs-MR. This is a new rule being proposed for adoption as part of a reorganization of rules by the Bureau of Long Term Care Facilities. ICF-MR provisions in former rule 5101:3-3-23 are being moved to this rule and remain substantively unchanged, but include a new requirement that a copy of a written request for a private room shall be kept in the resident's file. Section headings have been added and the rule body has been restructured for improved comprehension.

Proposed for rescission

Rule **5101:3-3-16 "Resident rights in nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"** contains the statutory authority for the establishment of resident rights in long term care facilities. This rule is being proposed for rescission as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The NF and ICF-MR provisions are being separated and moved to two new rules, each of which addresses one provider type only. The ICF-MR provisions in this rule are being moved to new rule 5101:3-3-16.6.

Rule **5101:3-3-16.1 "Resource assessment notice"** contains the provisions regarding the resource assessment notice for NFs and ICFs-MR. It is being proposed for rescission as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The provisions in this rule are being moved to new rule 5101:3-3-16.1.

Rule **5101:3-3-23 "Private rooms for medicaid residents in nursing facilities (NFs) and intermediate-care facilities for the mentally retarded (ICFs-MR)"** contains the provisions for private rooms for medicaid residents in long term care facilities. This rule is being proposed for rescission as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The NF and ICF-MR provisions are being separated and moved to two new rules, each of which addresses one provider type only. The ICF-MR provisions in this rule are being moved to new rule 5101:3-3-16.7.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about March 31, 2008.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTLs). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard copy rules ICF-MR providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."
2) Select "Long Term Care."
3) In the "Table of Contents" drop-down menu, scroll to and select the desired ICF-MRTL #.
4) Scroll to and select the desired rule number.
5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

ICF-MRTL 07-07 Order Form

ICF-MRTL 07-05

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 07-05

September 11, 2007

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Proposed Bed-Hold Rules for Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)

Proposed adoption of new rule 5101:3-3-16.8 of the Administrative Code (effective on or about November 15, 2007)

Proposed rescission of rule 5101:3-3-92 of the Administrative Code (effective on or about November 15, 2007)

Attached are proposed rule changes made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for adoption

Rule 5101:3-3-16.8 **"Coverage of bed-hold days for medically necessary and other limited absences from intermediate care facilities for the mentally retarded (ICFs-MR)"** is a new rule being proposed for adoption as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It replaces rule 5101:3-3-92, which is being proposed for rescission. This rule contains the bed-hold provisions for ICFs-MR. A new provision at paragraph (B) prohibits preadmission bed-hold payments. New paragraph (J) adds provisions regarding provider compliance with bed-hold restrictions and requirements.

Proposed for rescission

Rule **5101:3-3-92 "Coverage of bed-hold days for medically necessary and other limited absences from intermediate care facilities for the mentally retarded (ICFs-MR)"** is being proposed for rescission as a result of the five-year rule review and a reorganization of rules administered by the Bureau of Long Term Care Facilities. This rule contains the bed-hold provisions for ICFs-MR. It is being replaced by new rule 5101:3-3-16.8.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about November 15, 2007.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTLs). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard copy rules ICF-MR providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."
2) Select "Long Term Care."
3) In the "Table of Contents" drop-down menu, scroll to and select the desired ICF-MRTL #.

4) Scroll to and select the desired rule number.

5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

ICF-MRTL 07-05 Order Form

ICF-MRTL 07-04

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 07-04

July 5, 2007

TO: Administrators of Intermediate Care Facilities for the Mentally Retarded

Directors of County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Personal Needs Allowance (PNA) Rules for Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)

Proposed adoption of new rule 5101:3-3-16.9 of the Administrative Code (effective on or about September 15, 2007)

Proposed rescission of rule 5101:3-3-93 of the Administrative Code (effective on or about September 15, 2007)

Attached are proposed rule changes made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for adoption

Rule 5101:3-3-16.9 **"Personal needs allowance (PNA) accounts and other resident funds for intermediate care facilities for the mentally retarded (ICFs-MR)"** is a new rule being proposed for adoption as a result of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It replaces rule 5101:3-3-93, which is being proposed for rescission. This new rule contains the provisions for the management of PNA accounts and other resident funds for ICFs-MR. The content is being restructured and section headings are being added for improved comprehension. In paragraph (D), the amount of resident funds requiring deposit in an interest-bearing account is being corrected from fifty dollars to one hundred dollars in accordance with section 3721.15 of the Revised Code.

Proposed for rescission

Rule **5101:3-3-93 "Personal needs allowance (PNA) and other resident funds for intermediate care facilities for the mentally retarded (ICFs-MR)"** is being proposed for rescission as a result of the five-year rule review and a reorganization of rules administered by the Bureau of Long Term Care Facilities. This rule contains the provisions for the management of PNA accounts and other resident funds for ICFs-MR. It is being replaced by new rule 5101:3-3-16.9.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about September 15, 2007.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTLs). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard copy rules ICF-MR providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."

2) Select "Long Term Care."

3) In the "Table of Contents" drop-down menu, scroll to and select the desired ICF-MRTL #.

4) Scroll to and select the desired rule number.

5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

ICF-MRTL 07-04 Order Form

ICF-MRTL 07-03

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 07-03

April 25, 2007

TO: Administrators, Intermediate Care Facility for the Mentally Retarded Directors, County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Proposed Adoption of Rules 5101:3-3-17.5, 5101:3-3-24.1, 5101:3-3-73.3, 5101:3-3-78, 5101:3-3-79, 5101:3-3-81, 5101:3-3-81.1, 5101:3-3-81.2, 5101:3-3-82, 5101:3-3-82.1, 5101:3-3-83, 5101:3-3-84, 5101:3-3-84.2, 5101:3-3-84.3, 5101:3-3-84.4, 5101:3-3-84.5, 5101:3-3-86, 5101:3-3-96 of the Administrative Code (Effective on or About July 1, 2007)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

The rules set forth in this notice are being proposed for permanent adoption to reinstate the Medicaid ICF-MR reimbursement methodology for state fiscal year 2008 which was suspended for state fiscal years 2006 and 2007 pursuant to the temporary law provisions of Section 206.66.25 of Sub. H. B. 66 of the 126th General Assembly. The provisions of these rules impact the way ICFs-MR are reimbursed for services rendered to Medicaid recipients in state fiscal year 2008 (July 1, 2007 - June 30, 2008) and beyond. The following rules are being proposed for permanent adoption:

Rule 5101:3-3-17.5 entitled "Payment methodology for the provision of outlier services in intermediate care facilities for the mentally retarded (ICFs-MR)" is being proposed for permanent adoption to set forth the payment methodology for outlier services in ICFs-MR.

Rule 5101:3-3-24.1 entitled "Rate adjustments for intermediate care facilities (ICFs-MR): government mandates" is being proposed for permanent adoption to set forth the process of applying for rate adjustments for government mandates for ICFs-MR.

Rule 5101:3-3-73.3 entitled "Calculation of quarterly and annual intermediate care facility for the mentally retarded (ICF-MR) facility average case mix scores" is being proposed for permanent adoption to set forth the calculation methodology used to determine facility average case mix scores for ICFs-MR.

Rule 5101:3-3-78 entitled "Intermediate care facilities for the mentally retarded (ICFs-MR): method for establishing the total prospective rate" is being proposed for permanent adoption to set forth the total prospective per diem rate for ICFs-MR.

Rule 5101:3-3-79 entitled "Method for establishing the direct care costs component of the prospective rate for intermediate care facilities for the mentally retarded (ICFs-MR)" is being proposed for permanent adoption to set forth the method for establishing the direct care costs component of the prospective rate for ICFs-MR.

Rule 5101:3-3-81 entitled "Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for owners, relatives of owners, and administrators in intermediate care facilities for the mentally retarded (ICFs-MR)" is being proposed for permanent adoption to specify the two components that determine the methodology for compensation cost limits and reasonable costs for compensation of administrators, owners, and relatives of owners as set forth in rules 5101:3-3-81.1 and 5101:3-3-81.2 for ICFs-MR.

Rule 5101:3-3-81.1 entitled "Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for owners, relatives of owners in intermediate care facilities for the mentally retarded (ICFs-MR)" is being proposed for permanent adoption to set forth the process for determining reasonable and allowable compensation of owners and/or their relatives of ICFs-MR.

Rule 5101:3-3-81.2 entitled "Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any, for administrators in intermediate care facilities for the mentally retarded (ICFs-MR)" is being proposed for permanent adoption to set forth the process for determining reasonable and allowable compensation for administrators of ICFs-MR.

Rule 5101:3-3-82 entitled "Intermediate care facilities for the mentally retarded (ICFs-MR): method for establishing the other protected costs component of the prospective rate" is being proposed for permanent adoption to set forth the process for determining the other protected costs component of the prospective rate for ICFs-MR.

Rule 5101:3-3-82.1 entitled "Method for establishing reimbursement to intermediate care facilities for the mentally retarded (ICFs-MR) for the franchise permit fee" is being proposed for permanent adoption to set forth the method for establishing reimbursement of the franchise permit fee to ICFs-MR.

Rule 5101:3-3-83 entitled "Method for establishing the indirect care costs component of the prospective rate for intermediate care facilities for the mentally retarded (ICFs-MR)" is being proposed for permanent adoption to set forth the methodology for establishing the indirect care costs component of the prospective rate for ICFs-MR.

Rule 5101:3-3-84 entitled "Method for establishing capital reimbursement for intermediate care facilities for the mentally retarded (ICFs-MR)" is being proposed for permanent adoption to set forth the methodology for establishing the capital costs component for ICFs-MR.

Rule 5101:3-3-84.2 entitled "Cost of ownership and efficiency incentive for intermediate care facilities for the mentally retarded (ICFs-MR)" is being proposed for permanent adoption to set forth the methodology for establishing the cost of ownership and efficiency incentive reimbursement for ICFs-MR.

Rule 5101:3-3-84.3 entitled "Nonextensive renovations for intermediate care facilities for the mentally retarded (ICFs-MR)" is being proposed for permanent adoption to set forth the methodology for establishing nonextensive renovations reimbursement for ICFs-MR.

Rule 5101:3-3-84.4 entitled "Intermediate care facilities for the mentally retarded (ICFs-MR): return on equity" is being proposed for permanent adoption to set forth the methodology for establishing return on equity reimbursement for ICFs-MR.

Rule 5101:3-3-84.5 entitled "Recovery of excess depreciation paid and the reporting of accumulated depreciation for new owners of intermediate care facilities for the mentally retarded (ICFs-MR)" is being proposed for permanent adoption to set forth the methodology for the recovery of excess depreciation paid and the reporting of accumulated depreciation for new owners of ICFs-MR.

Rule 5101:3-3-86 entitled "Intermediate care facilities for the mentally retarded (ICFs-MR): rates for providers new to the medical assistance program and for change of operator(s)" is being proposed for permanent adoption to set forth the methodology for ICFs-MR new to the medical assistance program and for ICFs-MR that change operator(s).

Rule 5101:3-3-96 entitled "Prospective rate reconsideration for intermediate care facilities for the mentally retarded (ICFs-MR) for possible calculation errors" is being proposed for permanent adoption to set forth the process by which ICFs-MR may request a reconsideration of a prospective rate on the basis of a possible error in calculation.

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTL). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronic Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals

At the Electronic Manuals Internet site home page, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider."

2) Select "Long Term Care."

3) From the "Table of Contents" drop down menu, scroll to and select the desired "ICF-MRTL #"

4) Scroll to the desired rule number highlighted in blue, select desired rule number

5) Once the desired rule appears, print or view as desired, print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 07-03 Order Form

ICF-MRTL 07-02

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED TRANSMITTAL LETTER (ICF-MRTL) 07-02

April 20, 2007

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Proposed Adoption of Rules 5101:3-3-73.1, 5101:3-3-73.2, and 5101:3-3-73.4 of the Administrative Code (Effective on or About July 1, 2007)

Proposed Rescission of Rules 5101:3-3-75, 5101:3-3-76, and 5101:3-3-85.1 of the Administrative Code (Effective on or About July 1, 2007)

ODJFS Rule Distribution

These rules are being proposed for permanent adoption or rescission pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. The following rules are being proposed for permanent **adoption** to replace, in part, the rules listed above that are being rescinded, to renumber the rules as part of an overall project by the Bureau of Long Term Care Facilities to reorganize the rules pertaining to NFs and ICFs-MR, to clarify certain provisions, and to add the requirement that effective December 31, 2007, ICF-MR providers will be required to submit all IAF data electronically.

Rule 5101:3-3-73.1 entitled "Intermediate care facilities for the mentally retarded (ICFs-MR) case mix assessment instrument: Individual Assessment Form (IAF)" sets forth the process ICFs-MR must follow when performing resident assessments. The rule replaces, in part, rule 5101:3-3-75 that is being proposed for rescission. The rule proposed for adoption identified the assessment instrument that must be used, the instructions that must be followed when completing the IAF, and the certification form that must be submitted with the assessments of residents of intermediate care facilities for the mentally retarded. In addition, effective December 31, 2007, this rule will require all ICFs-MR to submit the IAF data electronically. The new numbering of this rule is part of an overall project by the Bureau of Long Term Care Facilities to reorganize the rules pertaining to reimbursement of NFs and ICFs-MR.

Rule 5101:3-3-73.2 entitled "Resident assessment classification system (RACS): the intermediate care facility for the mentally retarded (ICF-MR) case mix payment system" sets forth the components of the Medicaid reimbursement methodology for the ICF-MR direct care payment system including the resident assessment classification system for ICF-MR residents. It replaces, in part, rule 5101:3-3-76 that is being proposed for rescission. The rule being proposed for adoption eliminates language regarding the RACS default classification since the ODJFS IAF submission software precludes records from grouping in the default classification, thus resulting in records grouping in one of the four remaining resident assessment classifications. The new numbering of this rule is part of an overall project by the Bureau of Long Term Care Facilities to reorganize the rules pertaining to reimbursement of NFs and ICFs-MR.

Rule 5101:3-3-73.4 entitled "Exception review process for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth protocols for the exception review process and the process for requesting a reconsideration of exception review findings. This rule replaces, in part, rule 5101:3-3-85.1 that is being proposed for rescission. The rule being proposed for adoption sets forth the process for selecting facilities for exception reviews including the components of a risk analysis profile. The definitions contained in this rule were expanded to include definitions for the terms "variance" and "unverified IAF record" to improve clarity. The parameters for determining when ODJFS will conduct an expanded exception review are clarified in this rule. The rule provides additional detail about the process for a provider to request a rate reconsideration of the results of an exception review. The new numbering of this rule is part of an overall project by the Bureau of Long Term Care Facilities to reorganize the rules pertaining to reimbursement of NFs and ICFs-MR.

The following rules are being proposed for permanent rescission pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period:

Rule 5101:3-3-75 entitled "Intermediate care facilities for the mentally retarded (ICFs-MR) case mix assessment instrument: Individual Assessment Form (IAF)." This rule is being rescinded and replaced in part by rule 5101:3-3-73.1.

Rule 5101:3-3-76 entitled "Resident assessment classification system (RACS): the intermediate care facility for the mentally retarded (ICF-MR) case mix payment system." This rule is being rescinded and replaced in part by rule 5101:3-3-73.2.

Rule 5101:3-3-85.1 entitled "Exception review process for intermediate care facilities for the mentally retarded (ICFs-MR)." This rule is being rescinded and replaced in part by rule 5101:3-3-73.4.

The above rules are being proposed for permanent amendment. Should revisions to the proposed permanent rules occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions occur, the aforementioned rules will become effective July 1, 2007 on a permanent basis.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTLs). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard copy rules ICF-MR providers are instructed to obtain proposed rules from the ODJFS eManuals website which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."

2) Select "Long Term Care."

3) In the "Table of Contents" drop-down menu, scroll to and select the desired ICF-MRTL #.

4) Scroll to and select the desired rule number.

5) To print, click on the "Print Page" icon at the top or bottom of the web page.

ICF-MR providers will receive a hard copy of the transmittal letter and the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the internet, the JFS 03400 may be used to request hard copies of proposed rules. When requesting hard copies of proposed rules, complete all of the boxes on the JFS 03400. The form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 07-02 Order Form

ICF-MRTL 07-01

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 07-01

March 21, 2007

TO: Administrators, Intermediate Care Facility for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Proposed Rescission of Rule 5101:3-3-30.1 of the Administrative Code (Effective on or About April 30, 2007)

Proposed Adoption of Rule 5101:3-3-30.1 of the Administrative Code (Effective on or About April 30, 2007)

The following rule is being proposed for permanent rescission due to similar provisions that exist in Sections 3721.50 to 3721.58, 5112.30 to 5112.35, and 5112.37 to 5112.39 of the Ohio Revised Code.

Rule 5101:3-3-30.1 entitled Calculation, billing, payment remittance, and appeal process for the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD).

The following rule is being proposed for permanent adoption to clarify and update language from Sections 3721.50 to 3721.58, 5112.30 to 5112.35, and 5112.37 to 5112.39 of the Ohio Revised Code.

Rule 5101:3-3-30.1 entitled Calculation, billing, payment remittance, and appeal process for the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD). The rule sets forth franchise permit fee calculation, billing, payment remittance and appeal process for NFs, NHs, and ICFs-MR/DD.

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronic Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals

At the Electronic Manuals Internet site home page, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider"
2) Select "Long Term Care"
3) From the "Table of Contents" drop down menu, scroll to and select the desired "ICF-MRTL #"
4) Scroll to the desired rule number highlighted in blue, select desired rule number
5) Once the desired rule appears, print or view as desired, print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of

proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 07-01 Order Form

ICF-MRTL 06-04

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 06-04

December 28, 2006

TO: Administrators, Intermediate Care Facility for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Amendment of Rules 5101:3-3-01, 5101:3-3-22,

5101:3-3-71 and 5101:3-3-71.1 of the Administrative Code

(Effective on or About December 31, 2006)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

The rules are being proposed for permanent Amendment pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period and to implement provisions of Section 5111.20 of Am. Sub. H.B. 530 of the 126th General Assembly.

Rule 5101:3-3-01 entitled Definitions defines terms relating to reimbursement for services provided by nursing facilities and intermediate care facilities for the mentally retarded. The proposed amendment implements provisions of Section 5111.20 of Am. Sub. H.B. 530 of the 126th General Assembly, updates the date for the Code of Federal Regulations, and adds "Ancillary and Support Costs" to the rule.

Rule 5101:3-3-22 entitled Rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) provides general provisions regarding rate recalculations, penalties, and interest, repayment and deposit of overpayments to NFs and ICFs-MR. The proposed amendment corrects a spacing error within the text of the rule.

Rule 5101:3-3-71 entitled Intermediate care facilities for the mentally retarded (ICFs-MR): chart of accounts sets forth the chart of accounts for intermediate care facilities for the mentally retarded (ICFs-MR). The rule is being proposed for permanent amendment to change cost report number 9775 to 6215. The account moved from active treatment off-site day programming services to direct care costs.

Rule 5101:3-3-71.1 entitled Intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report sets forth the cost report for intermediate care facilities for the mentally retarded (ICFs-MR). The rule is being proposed for permanent amendment to change cost report number 9775 to 6215. The account moved from active treatment off-site day programming services to direct care costs.

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronic Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals

1) Select "Ohio Health Plans - Provider"

2) Select "Long Term Care"

3) From the "Table of Contents" drop down menu, scroll to and select the desired "ICF-MRTL #"

4) Scroll to the desired rule number highlighted in blue, select desired rule number

5) Once the desired rule appears, print or view as desired, Print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range. Once the desired rule appears, print or view as desired, print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 06-03

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 06-03

June 2, 2006

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Rescission of Rule 5101:3-3-18 of the Administrative Code (Effective on or About October 1, 2006)

Changes in ODJFS Hard Copy Rule Distribution

The following draft rule is being proposed for permanent rescission due to similar provisions that exist in Section 447.272 of Title 42 of the Code of Federal Regulations and Section 5111.021 (A) of the Ohio Revised Code:

Rule 5101:3-3-18 entitled Inpatient Services: Application of Medicare Upper Payment Limit Calculation (MUPLC) for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR).

For questions regarding the above-referenced rule, please contact the Planning and Research Section, in the Bureau of Long Term Care Facilities, at (614) 466-9243.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facility for the Mentally Retarded Transmittal Letters (ICF-MRTL). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronic Manuals Internet site home page, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider"
2) Select "Long Term Care"
3) From the "Table of Contents" drop down menu, scroll to and select the desired "ICF-MRTL #"
4) Scroll to the desired rule number highlighted in blue, select desired rule number
5) Once the desired rule appears, print or view as desired

Print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 06-02

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 06-02

June 14, 2006

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of New Rule 5101:3-3-31 of the

Administrative Code (Effective on or About August 10, 2006)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Proposed for adoption

The rule being proposed for adoption is in accordance with Section 606.18.06 of the Am. Sub. H.B. 530 of the 126th General Assembly.

Rule 5101:3-3-31 entitled, "Capital compensation program eligibility and payment methodology" sets forth the eligibility criteria for providers and the payment methodology for the capital compensation program. Specifically the rule describes capital projects that are eligible for compensation, the timeframes that must be met in order to receive payments, the calculation methodology to be used in determining payments, and the methodology to be used to proportionally reduce payments in order to avoid exceeding the $10 million cap. A process by which providers can seek administrative review of a calculation is also included.

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICFs-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronic Manuals Internet site home page, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider"

2) Select "Long Term Care"

3) From the "Table of Contents" drop down menu, scroll to and select the desired "ICFMRTL #"

4) Scroll to the desired rule number highlighted in blue, select desired rule number

5) Once the desired rule appears, print or view as desired, Print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 06-02 Order Form

ICF-MRTL 06-01

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 06-01

May 5, 2006

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of Rule 5101:3-3-02.7 of the Administrative Code (Effective on or About July 1, 2006)

Proposed Rescission of Rules 5101:3-3-17, 5101:3-3-25, and 5101:3-3-26 of the Administrative Code (Effective on or About July 1, 2006)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

The following rules are being proposed for permanent adoption or rescission pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. The department is providing facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

The following rule is being proposed for **adoption**:

Rule 5101:3-3-02.7 entitled Emergency management and resident relocation plan for long term care facilities sets forth the requirements for emergency relocation of residents in long term care facilities. This rule is being proposed for adoption as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The provisions in this rule are being moved from former rule 5101:3-3-17 which is proposed for rescission. Minor grammatical changes have been made, and the title has been changed.

The following rules are being proposed for **rescission**:

Rule 5101:3-3-17 entitled Emergency relocation plan.

Rule 5101:3-3-25 entitled Payment methodology for the provision of outlier services.

Rule 5101:3-3-26 entitled Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): implementation of timely rates.

For questions regarding the above-referenced rules, please contact the Reimbursement Section, in the Bureau of Long Term Care Facilities, at (614) 752-8196.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICFs-MRTL). In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)
2) Select "Long Term Care Manual" (right column)
3) Select "ICF-MR Transmittal" (left column)
4) Select "ICF-MRTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 06-01 Order Form

ICF-MRTL 05-10A

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 05-10A

February 6, 2006

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Refiled Proposed Permanent Adoption of Rules 5101:3-3-71 and 5101:3-3-71.1 of the Administrative Code (Effective on or About February 13, 2006)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Rule 5101:3-3-71 entitled ICFs-MR: Chart of Accounts sets forth the chart of accounts for intermediate care facilities for the mentally retarded (ICFs-MR). This rule was originally proposed for permanent adoption in conjunction with the rescission of rule 5101:3-3-20.1. This rule is being refiled for proposed permanent adoption to reinstate cost report account 6320 that was omitted from the Medicaid intermediate care facility for the mentally retarded chart of accounts during the development of separate chart of accounts for nursing facilities and intermediate care facilities for the mentally retarded pursuant to Am. Sub. H.B. 66.

Rule 5101:3-3-71.1 entitled ICF-MR Medicaid Cost Report sets forth the cost report for intermediate care facilities for the mentally retarded (ICFs-MR). This rule was originally proposed for permanent adoption in conjunction with the rescission of rule 5101:3-3-20.2. This rule is being refiled for proposed permanent adoption to eliminate the reference to recreational therapy in the cost report instructions for intermediate care facilities for the mentally retarded.

Instructions:

Obsolete rule 5101:3-3-71 and its appendix and rule 5101:3-3-71.1 and its appendix as set forth in ICF-MRTL 05-10 and replace the rules and appendices as contained in this transmittal.

For questions regarding the above-referenced rules, please contact the Reimbursement Section, in the Bureau of Long Term Care Facilities, at (614) 752-8196.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICFs-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)
2) Select "Long Term Care Manual" (right column)
3) Select "ICF-MR Transmittal" (left column)
4) Select "ICF-MRTL #" (left column)
5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)
6) Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 05-10A Order Form

ICF-MRTL 05-10

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 05-10

December 16, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of Rules 5101:3-3-71, 5101:3-3-71.1, 5101:3-3-71.2, 5101:3-3-71.3, and 5101:3-3-71.4 of the Administrative Code (Effective on or About February 9, 2006)

Proposed Amendment of Rule 5101:3-3-20 of the Administrative Code (Effective on or About February 9, 2006)

Proposed Rescission of Rules 5101:3-3-20.1, 5101:3-3-20.2, 5101:3-3-20.3, 5101:3-3-77, 5101:3-3-84.1, and 5101:3-3-89 of the Administrative Code (Effective on or About February 9, 2006)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

These rules are being proposed for permanent adoption, amendment, or rescission pursuant to Section 119.32 of the Revised Code, which requires the review of all state agency rules within a five year period. The following changes to the Medicaid long term care facility reimbursement system emerged as a result of House Bill 66 of the 126th General Assembly and will take effect for services provided on and after July 1, 2005. In accordance with Section 5111.22 of the Revised Code, the department is providing facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

These rules are being proposed for permanent **Adoption** pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-3-71 entitled ICFs-MR: Chart of Accounts sets forth the chart of accounts for intermediate care facilities for the mentally retarded (ICFs-MR). In order to implement Section 5111.26 of Am. Sub. H.B. 66 of the 126th General Assembly, the charts of accounts for nursing facilities and intermediate care facilities for the mentally retarded must be separated. This rule replaces in part Ohio Administrative Code rule 5101:3-3-20.1.

Rule 5101:3-3-71.1 entitled ICF-MR Medicaid Cost Report sets forth the cost report for intermediate care facilities for the mentally retarded (ICFs-MR). This rule is proposed for adoption on a permanent basis in accordance with Section 5111.26 of Am. Sub. H.B. 66 of the 126th General Assembly. Significant changes include the addition of a box for the reporting of National Provider Identifier on Schedule A, addition of fields to Schedule A to permit reporting of additional provider information including Type of Control for the facility and Chain Home Office Information, deletion of the Government Mandate cost account, removal of Group B costs from schedules D and D-1, and the removal of Attachment 5 Nurse Aide Training.

Rule 5101:3-3-71.2 entitled Intermediate care facilities for the mentally retarded (ICFs-MR): Leased employees sets forth the definition of leased staff services, the conditions under which leased staff services are reimbursable to ICFs-MR as other/contracted costs, and the manner in which staff leasing arrangements are reimbursable through the medicaid cost reporting mechanism. This rule amplifies Section 5111.26 of Am. Sub. H.B. 66 of the 126th General Assembly and replaces in part former rule 5101:3-3-20.3, which is being rescinded.

Rule 5101:3-3-71.3 entitled Capital asset and depreciation guidelines - intermediate care facilities for the mentally retarded (ICFs-MR) sets forth capital asset and depreciation guidelines for ICFs-MR, the guidelines for determining if an expenditure should be capitalized, the method of depreciation to be used, and a table for determining the useful life of a capital asset contained in appendix A of the rule. The rule also sets forth the conditions for reporting disposal of assets, and the records that must be maintained by providers to support

the reporting of capital asset depreciation. This rule amplifies Section 5111.251 of Am. Sub. H.B. 66 of the 126th General Assembly and replaces former rule 5101:3-3-84.1, which is being rescinded.

Rule 5101:3-3-71.4 entitled Intermediate care facilities for the mentally retarded (ICFs-MR): nonreimbursable costs identifies costs which are not reimbursable to ICFs-MR through the prospective cost reporting mechanism. This rule implements Sections 5111.20 and 5111.26 of Am. Sub. H.B. 66 of the 126th General Assembly and replaces former rule 5101:3-3-89, which is being rescinded.

This rule is being proposed for permanent **Amendment** pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-3-20 entitled Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements sets forth the requirement for the timely filing of cost reports by NFs and ICFs-MR, the methodology for processing those reports by ODJFS, and penalties that may be applied for not filing cost reports as required. The rule is being amended to implement Sections 5111.26, 5111.27, and 5111.28 of Am. Sub. H.B. 66 of the 126th General Assembly. Changes include the elimination of language describing the nursing facility reimbursement formula that is no longer valid based on these sections. Former paragraph (A) is deleted because it required that rates be calculated each fiscal year based on the prior calendar year cost report. Language in former paragraph (C), allowing rate reconsiderations for disputed costs has been deleted. Language regarding desk reviews has been updated based on Section 5111.27 of Am. Sub. H.B. 66 of the 126th General Assembly. Former paragraph (K) has been changed to require providers to provide, on request, all contracts of ten thousand dollars or more during a twelve month period rather than twenty five thousand. Former paragraph (M)(3) was updated to show that maintenance and repair costs of transport vehicles should now be reported by NFs as Ancillary and Support costs. The proposed amendment also updates or eliminates references to Ohio Administrative Code rules that are being rescinded to implement Am. Sub. H.B. 66 of the 126th General Assembly, and various grammatical changes appear throughout the body of the rule.

These rules are being proposed for permanent **Rescission** pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-3-20.1 entitled Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): Chart of accounts.

Rule 5101:3-3-20.2 entitled Nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR): medicaid cost report.

Rule 5101:3-3-20.3 entitled Leased staff reimbursement for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-77 entitled Calculation of quarterly and annual intermediate care facility for the mentally retarded (ICF-MR) facility average case mix scores.

Rule 5101:3-3-84.1 entitled Capital asset and depreciation guidelines - intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-89 entitled Intermediate care facilities for the mentally retarded (ICFs-MR): nonreimbursable costs.

Should revisions to the proposed rules occur during the JCARR hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on February 9, 2006 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICFs-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics

Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)
2) Select "Long Term Care Manual" (right column)
3) Select "ICF-MR Transmittal" (left column)
4) Select "ICF-MRTL #" (left column)
5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)
6) Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 05-10 Order Form

ICF-MRTL 05-09

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 05-09

December 8, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of Rules 5101:3-3-85 and Rule 5101:3-3-98 of the Administrative Code (Effective on or About February 2, 2006)

Proposed Amendment of Rules 5101:3-3-01, 5101:3-3-19, 5101:3-3-22, 5101:3-3-25, 5101:3-3-75, 5101:3-3-76, and 5101:3-3-85.1 of the Administrative Code (Effective on or About February 2, 2006)

Proposed Rescission of Rules 5101:3-3-24, 5101:3-3-24.1, 5101:3-3-78, 5101:3-3-79, 5101:3-3-81, 5101:3-3-81.1, 5101:3-3-81.2, 5101:3-3-82, 5101:3-3-82.1, 5101:3-3-83, 5101:3-3-83.1, 5101:3-3-84, 5101:3-3-84.2, 5101:3-3-84.3, 5101:3-3-84.4, 5101:3-3-84.5, 5101:3-3-86, and 5101:3-3-90 of the Administrative Code (Effective on or About February 2, 2006)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

These rules are being proposed for permanent adoption, amendment, or rescission pursuant to Am. Sub. H.B. 66 of the 126th General Assembly, and Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five-year period. The following changes to the Medicaid long term care facility reimbursement system emerged as a result of Am. Sub. House Bill 66 of the 126th General Assembly and will take effect for services provided on and after July 1, 2005. In accordance with Section 5111.22 of the Revised Code, the department is providing facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

These rules are being proposed for permanent **Adoption**:

Rule 5101:3-3-85 entitled Approval of nonextensive renovations for intermediate care facilities for the mentally retarded (ICFs-MR) details requirements for the authorization of ICF-MR to report nonextensive renovations. The new rule replaces, in part, rescinded rule 5101:3-3-84.3 and specifies criteria and procedures for prior approval of renovation projects in accordance with Section 5111.258 of Am. Sub. H.B. 66 of the 126th General Assembly.

Rule 5101:3-3-98 entitled Intermediate care facilities for the mentally retarded (ICFs-MR): method for establishing the fiscal year 2006 and 2007 Medicaid reimbursement rate for ICFs-MR is being proposed to implement provisions of Sections 206.66.25 and 206.66.27 of Am. Sub. H.B. 66 of the 126th General Assembly relating to the administration of the Medicaid reimbursement program for intermediate care facilities for the mentally retarded. This rule sets forth the method for establishing the reimbursement rate for ICFs-MR for fiscal years 2006 and 2007. The rule also sets forth the method of establishing the reimbursement rate for a provider that undergoes a change in operator, a provider that obtains certification as an ICF-MR and begins participation in the medicaid program, or a provider that adds one or more certified beds during the period from July 1, 2005 to June 30, 2007. The rule also sets forth the method of reimbursing the provider for active treatment day programming services as specified under rule 5101:3-3-94. The rule also states that the ICF-MRs rate established under this rule is not subject to adjustments except to reflect an adjustment resulting from an audit of a 2003 cost report. ODJFS estimates that the reimbursement change will result in a decrease in aggregate expenditures by the department of approximately $95 million over the biennium. The net impact to the Medicaid program of the reimbursement for active treatment day programming to ICFs-MR is expected to be minimal due to the fact that, prior to this change, the Medicaid program paid other provider types for the provision of active treatment services. Medicaid will now make payments for active treatment only to ICFs-MR.

These rules are being proposed for permanent **Amendment** pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-3-01 entitled Definitions defines terms relating to reimbursement for services provided by nursing facilities and intermediate care facilities for the mentally retarded. The proposed amendment eliminates references to Ohio Administrative Code rules that are being rescinded to implement Am. Sub. H.B. 66 of the 126th General Assembly. The amendment also eliminates references to the Ohio Revised Code and sections describing the nursing facility reimbursement formula that are no longer valid based on Am. Sub. H.B. 66 of the 126th General Assembly.

Rule 5101:3-3-19 entitled Relationship of other covered medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. The proposed amendment eliminates references to Ohio Administrative Code rules that are being rescinded to implement Am. Sub. H.B. 66 of the 126th General Assembly. In (D)(1) and (D)(2) of the rule, reference to Ohio Medicaid Drug Formulary was changed to appendix A of rule 5101:3-9-12 of the Administrative Code. Paragraph (E) subparagraphs (1), (2), and (3), have been revised to specify the reimbursement method for therapy services rendered to residents of NFs and ICFs-MR. In (F)(1)(c)(iv)(a)(i)(A), reference to the American Nurses' Association has been changed to American Nurses Association, and reference to the National Board of Pediatric Nurse Practitioners and Associates has been changed to Pediatric Nursing Certification Board. In (F)(1)(c)(iv)(a)(ii)(B)(3), reference to American Medical Association's Committee on Allied Health Education and Accreditation has been changed to American Medical Association's Commission on Accreditation of Allied Health Education Programs. Various grammatical changes appear throughout the body of the rule.

Rule 5101:3-3-22 entitled Rate recalculations, interest on overpayments, penalties, repayment of overpayments and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) identifies the provisions for rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). The proposed amendment eliminates references to Ohio Administrative Code rules that are being rescinded to implement Am. Sub. H.B. 66 of the 126th General Assembly. The amendment also changes "sale of the facility" to "facility closure, voluntary termination, or voluntary withdrawal" to be consistent with Section 5111.28 of Am. Sub. H.B. 66 of the 126th General Assembly.

Rule 5101:3-3-25 entitled Payment methodology for the provision of outlier services sets forth provisions under which outlier services are reimbursed. This rule is being proposed for permanent amendment to comply with the provisions of Section 5111.258 of Amended Substitute House Bill 66 of the 126th General Assembly. The proposed amendment eliminates references to Ohio Administrative Code rules that are being rescinded to implement reimbursement system changes included in this bill. Changes include the elimination of language in paragraphs (B)(3), (B)(5), (C)(1), (C)(2), and (D)(2) describing the nursing facility reimbursement formula that is no longer valid based on Section 5111.258 of Am. Sub. H.B. 66 of the 126th General Assembly. Paragraph (A)(3) was deleted from the proposed rule as it referenced calculation of a prospective rate for cost centers that have been realigned for nursing facilities. Paragraph (B)(5) eliminates the phrase prior to July 1 and replaces it with the phrase after June 30 in accordance with 5111.258 (A)(2) of Amended Substitute House Bill 66 of the 126th General Assembly. Paragraph (C)(1) eliminates the phrase ICFS-MR and replaces it with ICFs-MR. Paragraphs (C)(2) and (D)(2) eliminates the phrase in accordance with paragraph (E) of this rule, which has been amended. Paragraph (D)(2) also eliminates language which describes payment of per diem rate for outlier services if the required information is not submitted, also in accordance to changes mandated by Section 5111.258 of Am. Sub. H.B. 66 of the 126th General Assembly. Paragraph (D)(3)(a) eliminates the word Sheets and replaces it with the word Sheet and eliminates the phrase ICF-IMR and replaces it with the phrase ICF-MR. Paragraph (D)(3)(d)(ii) eliminates the word march and replaces it with the word March. Paragraph (E) of the former rule, which described the determination of per diem rates for outlier services, has been eliminated as it describes the nursing facility reimbursement formula that is no longer valid based on Section 5111.258 of Am. Sub. H.B. 66 of the 126th General Assembly. Therefore, what was formerly Paragraph (F) has now become Paragraph (E).

Rule 5101:3-3-75 entitled Intermediate care facilities for the mentally retarded (ICFs-MR) case mix assessment instrument: Individual Assessment Form (IAF), sets forth the resident assessment instrument specified by the state for ICFs-MR. This rule is being proposed for permanent amendment to comply with the provisions of Amended Substitute House Bill 66. In paragraph (A) of the proposed rule, language referring to the determination of Medicaid payment rates was deleted as it was not valid based on Section 206.66.25 of Am. Sub. H.B. 66 of the 126th General Assembly limiting rate adjustments for ICFs-MR. In paragraph (B) of the proposed rule, an was corrected to a. The department estimates the annual aggregate Medicaid payments will not increase or decrease as a result of this amendment.

Rule 5101:3-3-76 entitled Resident assessment classification system (RACS): the intermediate care facility for the mentally retarded (ICF-MR) case mix payment system, sets forth components of the Medicaid reimbursement methodology for the direct care payment system, based on the IAF, a uniform resident assessment instrument specified by the state for ICFs-MR. In the introductory paragraph of the proposed rule, the sentence indicating the department shall establish each facility's rate for direct care costs on a quarterly basis was deleted as it was not valid based on Section 206.66.25 of Am. Sub. H.B. 66 of the 126th General Assembly limiting rate adjustments for ICFs-MR. In paragraph (E) of the proposed rule, the reference to rule 5101:3-3-77 was deleted as this rule is being rescinded. A revision date of 11/1992 was added to references to form JFS 02220 throughout the proposed rule. The department estimates the annual aggregate Medicaid payments will not increase or decrease as a result of this amendment.

Rule 5101:3-3-85.1 entitled Exception review process for intermediate care facilities for the mentally retarded, sets forth protocols for the exception review process for ICFs-MR. This rule is being proposed for permanent amendment. The following changes are proposed to comply with the provisions of Section 206.66.25 of Am. Sub. H.B. 66 of the 126th General Assembly limiting rate adjustments for ICFs-MR. Paragraph (A)(2) was deleted from the proposed rule. The last sentence was deleted from paragraph (F) of the proposed rule. Language referencing adjustment to the facility's direct care component of the rate was deleted from paragraph (M) of the proposed rule. Paragraphs (N), (N)(1), (N)(2), and (N)(3) were deleted from the proposed rule. Paragraph (P) was deleted from the proposed rule, and the reference to paragraph (P) was deleted from paragraph (O) accordingly.

These rules are being proposed for permanent **Rescission** pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-3-24 entitled Prospective rate reconsideration for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-24.1 entitled Rate adjustments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): government mandates.

Rule 5101:3-3-78 entitled Intermediate care facilities for the mentally retarded(ICFs-MR): method for establishing the total prospective rate.

Rule 5101:3-3-79 entitled Method for establishing the direct care costs component of the prospective rate for intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-81 entitled Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for owners, relatives of owners, and administrators in intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-81.1 entitled Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for owners, relatives of owners in intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-81.2 entitled Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for administrators in intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-82 entitled Intermediate care facilities for the mentally retarded (ICFs-MR): method for establishing the other protected costs component of the prospective rate.

Rule 5101:3-3-82.1 entitled Method for establishing reimbursement to intermediate care facilities for the mentally retarded (ICFs-MR) for the franchise permit fee.

Rule 5101:3-3-83 entitled Method for establishing the indirect care costs component of the prospective rate for intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-83.1 entitled Method for establishing the out of facility meal cost limits for intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-84 entitled Method for establishing capital reimbursement for intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-84.2 entitled Cost of ownership and efficiency incentive for intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-84.3 entitled Nonextensive renovations for intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-84.4 entitled Intermediate care facilities for the mentally retarded (ICFs-MR): return on equity.

Rule 5101:3-3-84.5 entitled Notice, escrow, and recovery of excess depreciation paid, change in the medicaid provider agreement, closure or voluntary withdrawal from the medical assistance program, for intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-86 entitled Intermediate care facilities for the mentally retarded (ICFs-MR): Rates for providers new to the medical assistance program and for providers that change provider agreements.

Rule 5101:3-3-90 entitled Intermediate care facilities for the mentally retarded (ICFs-MR): expenditure limitation.

Should revisions to the proposed rules occur during the JCARR hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on February 2, 2006 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICFs-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)
2) Select "Long Term Care Manual" (right column)
3) Select "ICF-MR Transmittal" (left column)
4) Select "ICF-MRTL #" (left column)
5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)
6) Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 05-09 Order Form

ICF-MRTL 05-08

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 05-08

October 26, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Rescission of Rules 5101:3-3-82.2, 5101:3-3-82.3, 5101:3-3-82.6, 5101:3-3-82.7, and 5101:3-3-87.1 of the Administrative Code (Effective on or About December 30, 2005)

Proposed Adoption of New Rules 5101:3-3-17.4, 5101:3-3-30, 5101:3-3-30.1, 5101:3-3-30.2, 5101:3-3-30.3, and 5101:3-3-30.4 of the Administrative Code (Effective on or About December 30, 2005)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Enclosed are proposed rule changes made in accordance with section 119.03 of the Revised Code, which outlines procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for rescission

Rule 5101:3-3-82.2 entitled "The intermediate care facility for the mentally retarded (ICF-MR) franchise permit fee (FPF)" sets forth the meaning of ICF-MR for FPF purposes, and explains how proceeds from the assessment are distributed. This rule is being proposed for rescission as a result of provisions in HB66 relating to the administration of the Medicaid program. It is being replaced by new rule 5101:3-3-30, which identifies beds and facilities subject to, and those exempt from, the FPF for both NF and ICF-MR/DD provider types, and by new rule 5101:3-3-30.3, which sets forth the distribution method for FPF proceeds from both NF and ICF-MR/DD provider types.

Rule 5101:3-3-82.3 entitled "Calculation, billing, collection and appeal process for the franchise permit fee (FPF)" sets forth the calculation method and the billing, collection, and calculation appeal processes for the FPF for ICFs-MR. This rule is being proposed for rescission as a result of provisions in HB66 relating to the administration of the Medicaid program. It is being replaced by new rule 5101:3-3-30.1, which sets forth the FPF calculation method, billing cycle, payment remittance procedure, and calculation appeal process for both NF and ICF-MR/DD provider types.

Rule 5101:3-3-82.6 entitled "Enforcement of the franchise permit fee (FPF) program for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the provisions for enforcement of the FPF program for ICFs-MR. This rule is being proposed for rescission as a result of provisions in HB66 relating to the administration of the Medicaid program. It is being replaced by new rule 5101:3-3-30.2, which sets forth the procedures for enforcement of the FPF program for both NF and ICF-MR/DD provider types.

Rule 5101:3-3-82.7 entitled "Procedure for terminating the franchise permit fee (FPF) program for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the process for terminating the FPF program if the Centers for Medicare and Medicaid Services (CMS) determines the FPF is an impermissible health care related tax. This rule is being proposed for rescission as a result of provisions in HB66 relating to the administration of the Medicaid program. It is being replaced by new rule 5101:3-3-30.4, which sets forth the termination procedure for both NF and ICF-MR/DD provider types.

Rule 5101:3-3-87.1 entitled "Intermediate care facility for the mentally retarded (ICF-MR) outlier services for behavioral redirection and medical monitoring (BRMM)" sets forth the eligibility requirements and prior authorization process for participation in the BRMM outlier program. This rule is being proposed for rescission as a result of provisions in HB66 relating to the administration of the Medicaid program. It is being replaced by new rule 5101:3-3-17.4.

Proposed for adoption

Rule 5101:3-3-17.4 entitled "Intermediate care facility for the mentally retarded/developmentally disabled (ICF-MR/DD) outlier services for behavioral redirection and medical monitoring (BRMM)" sets forth sets forth the eligibility requirements and prior authorization process for participation in the BRMM outlier program. This is a new rule being proposed for adoption to implement provisions in HB66 relating to the administration of the Medicaid program. It replaces rule 5101:3-3-87.1 Rule references have been updated as necessary.

Rule 5101:3-3-30 entitled "Beds and facilities subject to the franchise permit fee (FPF) - for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" identifies beds and facilities subject to, and those exempt from, the FPF. This is a new rule being proposed for adoption to implement provisions in HB66 relating to the administration of the Medicaid program. It replaces part of rule 5101:3-3-82.2, and combines provisions for both NF and ICF-MR/DD provider types. Rule references have been updated as necessary. Information in paragraphs (B) and (C) explaining the distribution of FPF proceeds has been moved from this rule to new rule 5101:3-3-30.3.

Rule 5101:3-3-30.1 entitled "Calculation, billing, payment remittance, and appeal process for the franchise permit fee (FPF) - for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" sets forth the FPF calculation method, billing cycle, payment remittance procedure, and calculation appeal process. This is a new rule being proposed for adoption to implement provisions in HB66 relating to the administration of the Medicaid program. It replaces rule 5101:3-3-82.3, and combines provisions for both NF and ICF-MR/DD provider types. Rule references have been updated as necessary, and FPF rates and applicable dates have been updated.

Rule 5101:3-3-30.2 entitled "Enforcement of the franchise permit fee (FPF) program - for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" sets forth the procedures for enforcement of the FPF program. This is a new rule being proposed for adoption to implement provisions in HB66 relating to the administration of the Medicaid program. It replaces rule 5101:3-3-82.6, and combines provisions for both NF and ICF-MR/DD provider types. Rule references have been updated as necessary. Paragraph (B) has been expanded to list the specific enforcement measures available to ODJFS.

Rule 5101:3-3-30.3 entitled "Distribution method for franchise permit fee (FPF) proceeds from nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" sets forth the distribution method for FPF proceeds. This is a new rule being proposed for adoption to implement provisions in HB66 relating to the administration of the Medicaid program. It replaces part of rule 5101:3-3-82.2, and combines provisions for both NF and ICF-MR/DD provider types. Rule references have been updated as necessary.

Rule 5101:3-3-30.4 entitled "Procedure for terminating the franchise permit fee (FPF) assessment - for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD" sets forth the termination procedure for the FPF program if the Centers for Medicare and Medicaid Services (CMS) determines that the FPF is an impermissible health care related tax. This is a new rule being proposed for adoption to implement provisions in HB66 relating to the administration of the Medicaid program. It replaces rules 5101:3-3-82.7, and combines provisions for both NF and ICF-MR/DD provider types. Rule references have been updated as necessary. A definition for "effective FPF termination date" (EFTD) has been added in paragraph (A). Explanations have been clarified for FPF claim reconciliation and adjustment procedures.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about December 30, 2005.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facility for the Mentally Retarded Transmittal Letters (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers

are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1.) Select "Ohio Health Plans - Provider" (left column)

2.) Select "Long Term Care Manual" (right column)

3.) Select "ICF-MR Transmittal" (left column)

4.) Select "ICF-MRTL #" (left column)

5.) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6.) Once the desired rule appears, print or view as desired

ICF-MR/DD providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a ICF-MR/DD provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR/DD provider.

ICF-MRTL 05-08 Order Form

ICF-MRTL 05-07

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 05-07

August 12, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: New JFS Form 04080 (Effective on or About October 1, 2005)

Revised JFS Forms 09402 and 09405 (Effective on or About August 1, 2005)

Instructions for Downloading and Printing JFS Forms

Enclosed are summaries of new JFS form 04080 entitled "Medicaid Resource Assessment Notice," revised JFS form 09402 entitled "ICF-MR/DD Extended Bed Hold Day(s) Prior Authorization," and revised JFS form 09405 entitled "Personal Needs Allowance Account Remittance Notice."

New **JFS 04080** "Medicaid Resource Assessment Notice"

This document was previously Appendix A of OAC rule 5101:3-3-16.1, and was entitled "Resource assessment notice". The notice has been removed from rule, redesigned as a one page PDF document for enhanced functionality, and reworded for easier comprehension. Spaces at the bottom of the form have been added for the resident's name, signature, and date of request.

Revised **JFS 09402** "ICF-MR/DD Extended Bed Hold Day(s) Prior Authorization"

This form has been redesigned for enhanced readability, and is being issued as a PDF document to allow online completion.

Revised **JFS 09405** "Personal Needs Allowance Account Remittance Notice"

This form has been redesigned as a PDF document to allow online completion. The instruction section that summarizes relevant sections of OAC rules 5101:3-3-60 and 5101:3-3-93, and that explains how to complete the form, has been revised. Additionally, the mailing address for the Ohio Attorney General's office has been updated.

Instructions for Downloading and Printing JFS Forms

These forms may be downloaded to your computer from the ODJFS online forms website at **http://www.odjfs.state.oh.us/forms/inter.asp**.

To print a form you have filled out online, use the "Print" icon in the Adobe Reader toolbar, just above the document window. *If you are viewing the application in your web browser's window, do not use your web browser's print command; this will almost always result in garbled output.*

JFS forms 04080, 09402, and 09405 are letter size, and in portrait mode. You will need to change the Print Setup in order for the documents to print correctly, as follows:

1. After clicking on the "Print" icon, select "Setup...".
2. In the Print Setup dialog box, set Paper Size to *US Letter* and set Orientation to *Portrait*.
3. Click "OK" to dismiss the Print Setup dialog box.
4. Click "OK" to print out the form.

Please remember that, due to a limitation in Adobe Reader, you can fill out the form online and print the result, but you cannot save the completed document to your computer after it has been filled out. You must have Adobe Writer on your computer in order to save the completed document.

ICF-MRTL 05-07 Order Form

JFS 04080 - Medicaid Resources Assessment Notice

Click here to view the JFS 04080 - Medicaid Resources Assessment Notice

JFS 09402 - ICF-MR/DD Extended Bed Hold Day(s) Prior Authorization

Click here to view the JFS 09402 - ICF-MR/DD Extended Bed Hold Day(s) Prior Authorization

JFS 09405 - Personal Needs Allowance Account Remittance Notice

Click here to view the JFS 09405 - Personal Needs Allowance Account Remittance Notice

ICF-MRTL 05-05A

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 05-05A

August 17, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Revised Adoption of Rules 5101:3-3-02.2 and 5101-3-3-02.3 of the Administrative Code (Effective on or About October 1, 2005)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Rule 5101:3-3-02.2 entitled "Termination, denial, and non-renewal of long term care provider agreements" sets forth the conditions for termination, denial, and non-renewal of Medicaid provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded and developmentally disabled (ICFs-MR/DD). This rule was originally adopted in conjunction with the rescission of a rule by the same number in order to expand the explanation of situations requiring mandatory termination, denial, or non-renewal of the Medicaid provider agreement, and to add a new paragraph on adjudication orders.

This rule was revised pursuant to House Bill 66 to add paragraph (B)(2)(m), which allows the Ohio Department of Job and Family Services (ODJFS) to terminate a provider agreement for failure to pay the full franchise permit fee (FPF) installment when due.

Rule 5101:3-3-02.3 entitled "Institutions eligible to participate in Medicaid as nursing facilities (NFs) or intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" sets forth the eligibility requirements for participation of long term care facilities in the Medicaid program. This rule was originally adopted in conjunction with the rescission of a rule by the same number in order to add definitions and to specify mandatory dual participation of nursing facilities in both the Medicare and Medicaid programs.

This rule was revised in order to update paragraph (A)(11), which specifies the accrediting organization for religious non-medical health care institutions (RNHCIs). RHNCIs sponsored by the Church of Christ, Scientist were previously certified by the Mother Church in Boston, the First Church of Christ, Scientist. They are now accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

Instructions:

Obsolete rules 5101:3-3-02.2 and 5101:3-3-02.3 as set forth in ICF-MRTL 05-05A and replace them with rules 5101:3-3-02.2 and 5101:3-3-02.3 as contained in this transmittal.

For questions regarding the above referenced rule, please contact the Facility Contracting Section in the Bureau of Long Term Care Facilities at (614) 466-6467.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facility for the Mentally Retarded Transmittal Letters (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1.) Select "Ohio Health Plans - Provider" (left column)

2.) Select "Long Term Care Manual" (right column)

3.) Select "ICF-MR Transmittal" (left column)

4.) Select "ICF-MRTL #" (left column)

5.) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6.) Once the desired rule appears, print or view as desired

ICF-MR/DD providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a ICF-MR/DD provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR/DD provider.

ICF-MRTL 05-05A Order Form

ICF-MRTL 05-06

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 05-06

July 25, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption on a Permanent Basis New Rule 5101:3-3-94 of the Administrative Code (Effective on or About September 29, 2005)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

This new rule sets forth the method of payment for active treatment day programming services of intermediate care facilities for the mentally retarded (ICFs-MR) and is proposed for adoption on a permanent basis as a result of Substitute House Bill 66 of the 126th General Assembly. This rule was filed on an emergency basis on July 1, 2005 for an effective date of July 1, 2005.

Rule 5101:3-3-94 entitled Payment for active treatment day programming services of intermediate care facilities for the mentally retarded (ICFs-MR) identifies the amount of an add-on to the ICF-MR per diem rate and encourages an Intermediate Care Facility for the Mentally Retarded (ICF-MR) to continue to provide active treatment day programming services off-site whenever appropriate. Specifically, the rule sets forth the amount to be added to the Medicaid per diem paid to an ICF-MR. The add-on provides funding to an ICF-MR for active treatment day programming services provided on or after July 1, 2005 due to the termination of the community alternative funding system (CAFS). Prior to July 1, 2005, the Medicaid program paid active treatment day programming service providers directly. As of July 1, 2005, ICFs-MR are responsible for making payment to active treatment day programming providers. The add-on provides funding to ICFs-MR in order that required levels of active treatment day programming services continue to be provided to Medicaid residents.

The proposed amount of the add-on is one of eight rates that is in addition to the per diem that is paid to every ICF-MR. Because the add-on is an increase to the per diem amount, an ICF-MR will receive the increase for every day a Medicaid recipient is a resident of the ICF-MR. The amount of the add-on was based on an in-depth survey performed by the department. In order to recognize the difference in the cost of doing business throughout the state, every county was placed into one of eight categories that reflect the relative cost of doing business (CODB). The statewide daily add-on rate was either inflated or deflated to derive eight rates that correspond to the eight CODB categories. The county in which the ICF-MR is located determines which of the eight rates will be added to an ICF-MR's per diem. The rates are identified in Appendix A of rule 5101:3-3-94.

All ICFs-MR will experience an increase in their per diem, but ICFs-MR may not receive an amount of funding through the add-on that is equivalent to the payments made by the CAFS program for the care of their residents. The additional funds received by ICFs-MR may be the same, higher or lower than the amount of funds CAFS provided for the care of their residents.

Should revisions to the proposed rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur, the attached rule will become effective on or about September 29, 2005 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronic

Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronic Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "ICF-MR Transmittal" (left column)

4) Select "ICF-MRTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

Appendix A - Counties And Active Treatment Add-On Rates

Click here to view Appendix A. Counties And Active Treatment Add-On Rates

ICF-MRTL 05-06 Order Form

ICF-MRTL 05-05

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 05-05

July 21, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of New Rules 5101:3-3-02.1, 5101:3-3-02.2, 5101:3-3-02.3, and 5101:3-3-16.1 of the Administrative Code in Conjunction with Recission of Rules by the Same Number (Effective on or About October 1, 2005)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Enclosed are proposed rule changes made in accordance with section 119.03 of the Revised Code, which outlines procedures for the adoption of administrative rules.

Rule 5101:3-3-02.1 entitled "Length and type of long term care provider agreements" sets forth the length and type of long term care provider agreements for Medicaid nursing facilities (NFs) and intermediate care facilities for the mentally retarded and developmentally disabled (ICFs-MR/DD). This rule is being adopted in conjunction with the rescission of a rule by the same number. Definitions are added for the terms "reasonable assurance period", "state survey agency", and "time-limited agreement". Explanations of effective dates, term limits, and term extensions are expanded and refined in paragraphs (B), (C), and (D). Paragraph (E) explains conditional agreements, cancellation clauses, and post-survey revisits for ICFs-MR/DD.

Rule 5101:3-3-02.2 entitled "Termination, denial, and non-renewal of long term care provider agreements" sets forth the conditions for termination, denial, and non-renewal of Medicaid provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded and developmentally disabled (ICFs-MR/DD). This rule is being adopted in conjunction with the rescission of a rule by the same number. Paragraph (C) has expanded explanations of situations that require mandatory termination, denial, or non-renewal of the Medicaid provider agreement. Paragraph (D) is new, and addresses adjudication orders.

Rule 5101:3-3-02.3 entitled "Institutions eligible to participate in Medicaid as nursing facilities (NFs) or intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" sets forth the eligibility requirements for participation of long term care facilities in the Medicaid program. This rule is being adopted in conjunction with the rescission of a rule by the same number. Definitions are added for the terms "certification", "distinct part", "dually participating long term care facility", "long term care facility", "religious non-medical health care institution" (RNHCI), and "state survey agency". Paragraph (E) is new, and specifies mandatory dual participation of nursing facilities in both the Medicare and Medicaid programs.

Rule 5101:3-3-16.1 entitled "Resource assessment notice" sets forth the requirements of the resource assessment notice for nursing facilities (NFs) and intermediate care facilities for the mentally retarded and developmentally disabled (ICFs-MR/DD). This rule is being adopted in conjunction with the rescission of a rule by the same number. A substantial portion of the language in this rule is deleted because of duplication in rule 5101:1-39-35 of the Revised Code, which specifically explains the requirements of the resource assessment notice. Appendix A of this rule, entitled "Resource Assessment Notice", is removed from rule and assigned form number JFS 04080.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "ICF-MR Transmittal" (left column)

4) Select "ICF-MRTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

ICF-MRTL 05-05 Order Form

ICF-MRTL 05-04

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 05-04

April 27, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Amendment of Rules 5101:3-3-02, 5101:3-3-20, 5101:3-3-39 of the Administrative Code (Effective on or About July 1, 2005)

Changes in ODJFS Hard-Copy Rule Distribution

In accordance with section 119.03 of the Ohio Revised Code that outlines the process for amendment and adoption of rules, enclosed are proposed rule changes. These rules set forth Medicaid policy to implement direct bill for nursing facilities (NFs) by which NFs will submit claims directly to the department for payment by Medicaid.

Rule 5101:3-3-02 entitled "Provider agreements: nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the execution and maintenance of a provider agreement between the Ohio department of job and family services (ODJFS) and the operator of a NF or ICF-MR. The proposed amendment to this rule specifies that NFs use the 9400 process for dates of service preceding July 1, 2005 to initiate, terminate or adjust vendor payment, and the 837I claim, as required in rule 5101:3-3-39.1 for dates of service on or after July 1, 2005 to initiate, terminate or adjust payment Also, "vendor payment" is amended to read "payment."

Rule 5101:3-3-20 entitled "Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements" sets forth the process by which each nursing facility (NF) and intermediate care facility for the mentally retarded (ICFs-MR) files a cost report with the Ohio department of job and family services (ODJFS). The proposed amendment modifies "medicaid vendor payment" to read "medicaid payment."

Rule 5101:3-3-39 entitled "Payment and adjustment process for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the payment and adjustment process for NFs and ICF/MRs. The proposed amendment to this rule specifies that NFs use the form 9400, Nursing Facility Payment and Adjustment Authorization for dates of service preceding July 1, 2005 for the reimbursement of services. The amendment also clarifies that the for dates of service preceding July 1, 2005, the CDJFS shall stop vendor payment within ten days of receipt of the JFS 09401, Facility/CDJFS Transmittal, in the case of death, discharge or hospice enrollment.

Should further revisions to the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about July 1, 2005, on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/medicaid/LTC/

At the Electronic Manual Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "ICF-MRTL Transmittal" (left column)

4) Select "ICF-MRTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 05-04 Order Form

ICF-MRTL 05-03

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 05-03

April 27, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Amendment of Rules 5101:3-3-20.1 and 5101:3-3-20.2 of the Administrative Code (Effective July 01, 2005)

Changes in ODJFS Hard-Copy Rule Distribution

Rule 5101:3-3-20.1 entitled "Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): Chart of accounts" sets forth the methodology for filing costs reports according to the chart of accounts included with this rule. The Ohio Department of Job and Family Services requires that all facilities file cost reports annually to comply with Section 5111.26 of the Ohio Revised Code. Rule 5101:3-3-20.1 and its appendix are being proposed for permanent amendment due to the five year rule review. The changes to the rule are: changing the example that is given for reporting petty cash and other cash accounts in paragraph (B)(2), hyphenating a word in (C)(4), and adding account 6700, for ICFs-MR to be used to report the costs for "Active Treatment Off-site Day Programming Services" as defined in the Chart of Accounts.

Rule 5101:3-3-20.1, Appendix A, entitled "Chart of Accounts," effective September 30, 2002, is being proposed for rescission to be replaced with the Appendix A, "Chart of Accounts," with the changes to the appendix that are detailed below.

Rule 5101:3-3-20.1, Appendix A, entitled "Chart of Accounts" is being proposed for enactment for use by nursing facilities and intermediate care facilities for the mentally retarded to establish the minimum level of detail to allow for cost report preparation. The word "administrator" has been inserted in references to accounts 6057, 6535, and 7075, to complete the title of the EAP individual for each category. Account 6090 has been revised to specify items that are not to be reported as government mandated assessments or fees. A website reference has been included in accounts 6200, 6205, and 7110. For account 6205, reference to the Cincinnati Municipal Code has been updated by adding the chapter title and revising the section number. For account 7100, the reference to "plus MDS+" has been replaced by "version 2.0 (MDS 2.0)." Account 7270 has been revised to delete language no longer applicable due to an amendment of section 5111.20 of the Ohio Revised Code. Under account 6615, "Non-Reimbursable Expenses - NFs Only," the word "salary" has been added to 6615.1, to distinguish salary from contract. New language has been inserted in account 8065, to specify that leases effective after 12/01/92 for assets acquired prior to 7/01/93 are to be reported in account 8065, and that for leases executed before 2/01/92, the costs are to be reported in account 7400. For ICFs-MR only, account 6700 is being added to capture the costs of "Active Treatment Off-site Day Programming Services."

Rule 5101:3-3-20.2 entitled "Nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR): Medicaid cost report" sets forth the Medicaid Cost Report for NFs and ICFs-MR. Each nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR) shall file a cost report as a condition of participation in the Title XIX Medicaid program, as specified in rules 5101:3-3-20 and 5101:3-3-20.1 of the Administrative Code. Rule 5101:3-3-20.2 is being proposed for permanent amendment due to the five year rule review.

Rule 5101:3-3-20.2, Appendix A,, entitled "Medicaid Cost Report" sets forth the schedules that comprise the cost report. Nursing home providers or their representatives are required to complete and file a cost report for each cost reporting period. Rule 5101:3-3-20.2, Appendix A, revised October 2002, is being proposed for permanent rescission to be replaced by Appendix A, revised March 2005.

Rule 5101:3-3-20.2, Appendix A,, entitled "Medicaid Cost Report" sets forth the schedules that comprise the cost report. Nursing home providers or their representatives are required to complete and file a cost report for each cost reporting period. The Ohio Medicaid cost report, JFS 02524, is designed to provide statistical data,

financial data, and disclosure statements as required by federal and state rules. Also, included as part of the revised Appendix A are the "Instructions for completing the Ohio department of job and family services (ODJFS) calendar year medicaid cost report for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)." Rule 5101:3-3-20.2, Appendix A, revised March 2005, is being proposed for permanent amendment to comply with the five year rule review.

The following changes have been made to Appendix A schedules being proposed for amendment:

Schedule A - The type of cost report filing has been changed from "Closed Facility" to "Final" to specify usage of cost report 4.5 for providers leaving the Medicaid program as well as for providers that are closing a facility. For the Medicare provider number, a dash has been inserted to show that it should be included when reporting the Medicare number.

Schedule B-2 - For ICFs-MR only, a new account, 6700, has been added as line 48 to permit reporting of the costs for "Active Treatment Off-site Day Programming Services" as defined in the Chart of Accounts. This addition has caused changes to the "Total" lines 49 and 57 due to the new account. Also, this new account has caused a wording change to Schedule A-3 in lines 2 and 13 so the total reimbursable direct care cost continues to be captured.

Schedule C-1 - To specify that compensation paid should be reported and not hours worked, in Section B, the title above columns 3 and 4, "Worked Weekly" has been changed to "Paid Weekly." At the bottom of the page, in the sentence referencing column 7, hours "worked" has been changed to hours "paid."

Schedule C-2 - To specify that compensation paid should be reported and not hours worked, page 1 of 2, the title above columns 8 and 9, "Worked Weekly" has been changed to "Paid Weekly." At the bottom of the page, in the sentence referencing column 12, hours "worked" has been changed to hours "paid."

Schedule C-2 - To specify that compensation paid should be reported and not hours worked, page 2 of 2, the title above columns 6 and 7, "Worked Weekly" has been changed to "Paid Weekly." At the bottom of the page, in the sentence referencing column 8, hours "worked" has been changed to hours "paid."

Attachment 6 - For ICFs-MR only, a new 6700 account for "Active Treatment Off-site Day Programming Services" has been added as line 38. This addition has caused changes to the "Total" lines 39, 43, 50, 53, 54, 65, 68, 72, 73 and 74.

Should revisions to the proposed rules occur during the JCARR hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on July 01, 2005 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronic Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronic Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

Select "Ohio Health Plans - Provider" (left column)

Select "Long Term Care Manual" (right column)

Select "ICF-MR Transmittal" (left column)

Select "ICF-MRTL #" (left column)

Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, JFS 03400 may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 05-03 Order Form

ICF-MRTL 05-02A

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 05-02A

July 15, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Revised Amendment of Rule 5101:3-3-76 of the Administrative Code (Effective July 1, 2005)

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

Rule 5101:3-3-76 entitled "Resident assessment classification system (RACS): the intermediate care facility for the mentally retarded (ICF-MR) case mix payment system" sets forth the components of the Medicaid reimbursement methodology for the ICF-MR direct care payment system. This rule was originally proposed for permanent amendment to recalibrate the relative weights assigned to each Resident Assessment Classification (RAC). This rule was initially revised to reinstate appendix number 3. This rule was subsequently revised to correct the Joint Committee on Agency Rule Review's (JCARR's) rule summary fiscal analysis to be consistent with language proposed in this rule which allows ODJFS to review the relative resource weights every three years. There were no changes to the rule body in the second revision.

Instructions:

Obsolete rule 5101:3-3-76 as set forth in ICF-MRTL 05-02 and replace it with rule 5101:3-3-76 as contained in this transmittal.

For questions regarding the above referenced rule, please contact the Case Mix Section in the Bureau of Long Term Care Facilities at 614.466.9088.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/medicaid/LTC/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "ICF-MR Transmittal Letters" (left column)

4) Select "ICF-MRTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of

proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 05-02A Order Form

ICF-MRTL 05-02

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 05-02

April 22, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Amendment of Rule 5101:3-3-76 of the Administrative Code (Effective July 1, 2005)

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

This rule package sets forth the intermediate care facility for the mentally retarded (ICF-MR) case mix payment system including the resident assessment classification system (RACS). This rule was reviewed pursuant to Section 119.032 of the Ohio Revised Code (ORC), which requires the review of all state agency rules within a five-year period.

5101:3-3-76 entitled "Resident assessment classification system (RACS): the intermediate care facility for the mentally retarded (ICF-MR) case mix payment sys tem" sets forth the components of the Medicaid reimbursement methodology for the ICF-MR direct care payment system. This rule is being amended to recalibrate the relative weights assigned to each Resident Assessment Classification (RAC). The calculation of the relative weights will integrate the new Ohio wage data from calendar years 2001 through 2003, as reported on the JFS 02524 Medicaid cost report for ICFs-MR, into the case mix reimbursement system. The department is required by rule to recalibrate the relative resource weights every three years to incorporate more recent direct care wage data. The recalibration is performed using the minutes of care per job type per RAC class from the most current work measurement study and the wages per job type per hour.

In paragraph (C)(3)(h) of the proposed rule, the reference to form "FFS 02220" was corrected to "JFS 02220". In paragraph (E) of the proposed rule "ICFS-MR" was corrected to "ICFs-MR". In paragraph (F)(2) of the proposed rule "LPNS" was corrected to "LPNs". In paragraph (F)(3) of the proposed rule "OTS" was corrected to "OTs". In paragraph (F)(5) of the proposed rule "QMRPS" was corrected to "QMRPs". In paragraph (F)(6) of the proposed rule "RNS" was corrected to "RNs". In paragraph (F)(8) of the proposed rule "STS" was corrected to "STs", and "ICF-MR" was corrected to "ICFs-MR". In paragraph (G)(1) of the proposed rule "ICF's-MR" was corrected to "ICFs-MR". Paragraph (G)(4) of the proposed rule changes "shall" to "may". Paragraph (G)(4)(a) of the proposed rule deletes "At a minimum", changes "shall" to "may", and adds "no more often than". An extra word "the" was omitted from paragraph (G)(4)(a) of the proposed rule. Paragraph (G)(4)(d) of the proposed rule adds clarifying language regarding the use of the recalibrated weights in the recalculation of the quarterly case mix score and the recalculation of the annual case mix score.

Individual assessment form (IAF) alpha coding references were corrected to numeric coding references throughout the proposed rule. For example, "one" was corrected to "1" to reflect actual IAF coding values.

As a result of this review, these rules are being proposed for amendment. Should revisions to the proposed permanent rule occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions occur, the aforementioned rule will become effective July 1, 2005 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/medicaid/LTC/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

Select "Ohio Health Plans - Provider" (left column)

Select "Long Term Care Manual" (right column)

Select "ICF-MR Transmittal Letters" (left column)

Select "ICF-MRTL #" (left column)

Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If an ICF-MR provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 05-02 Order Form

ICF-MRTL 04-05

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 04-05

December 16, 2004

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rules 5101:3-3-02.3 and 5101:3-3-02.4 and Adoption of Rule 5101:3-3-02.3 of the Administrative Code (Effective on or About January 20, 2005)

Proposed Permanent Revision of Rule 5101:3-3-02.3 of the Administrative Code (Effective on or About January 20, 2005)

Changes in ODJFS Hard-Copy Rule Distribution

Enclosed are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-02.3 entitled "Eligible Providers and Provider Types" sets forth the eligible providers and provider types for Medicaid nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). This rule is being rescinded in conjunction with the adoption of a new rule by the same number. The department estimates this rescission will not increase or decrease Medicaid expenditures on an annual aggregate basis.

Rule 5101:3-3-02.4 entitled "Services Provided by an Institution Classified as a Nursing Facility (NF) or an Intermediate Care Facility for the Mentally Retarded (ICF-MR)" sets forth the services provided by an institution classified as a nursing facility (NF) or an intermediate care facility for the mentally retarded (ICF-MR). This rule is being rescinded in conjunction with the adoption of new rule 5101:3-3-02.3. The department estimates this rescission will not increase or decrease Medicaid expenditures on an annual aggregate basis.

Rule 5101:3-3-02.3 entitled "Facilities Eligible to Participate in Medicaid as Nursing Facilities (NFs) or Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled (ICFsMR/DD)" sets forth the types of long term care institutional services covered by the Medicaid program, the types of services not covered by the Medicaid program, the eligibility requirements for long term care institutional providers both in Ohio and out-of-state, and the certification and survey requirements. This rule also specifies the conditions for certification of long term care facility beds as NFs or ICFs-MR/DD. This rule is being proposed for adoption in conjunction with the rescission of former rules 5101:3-3-02.3 and 5101:3-3-02.4 and the adoption of ODMR/DD Ohio Administrative Code rule 5123:2-16-01 that requires operators applying for a new residential facility licensed by ODMR/DD and operators of existing residential facilities who previously received "development approval" to operate a facility other than an ICF-MR/DD to request and obtain a new "development approval" from ODMR/DD to operate as an ICF-MR/DD.

Rule 5101:3-3-02.3 is also being proposed for revision as a result of comments received during the public comment period. The proposed revision changed the reference "rule 3701-59-02 of the Administrative Code" to "section 3702.52.2 of the Revised Code" in paragraph (D)(3) because ORC 3702.52.2 is applicable and OAC rule 3701-59-02 is obsolete. The proposed revision also changed the reference "3701-59-02" to "3701-59-01" and added the word "care" to the phrase "long term care beds" in paragraph (D)(4) for consistency with rule 3701-59-01.

Should further revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about January 20, 2005, on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "NF Transmittal" (left column)

4) Select "NFTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

ICF-MRTL 04-05 Order Form

ICF-MRTL 04-03

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 04-03

April 29, 2004

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-25 and 5101:3-3-87.1 of the Administrative Code (Effective on or About July 1, 2004)

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-25 entitled "Payment methodology for the provision of outlier services" sets forth the calculation of the initial contract rate for an outlier facility and specifies the methodology for calculating the prospective rate. This rule is being proposed for permanent amendment to replace simple average rate with calculated statewide mean rate per diem in paragraph (D)(2) in order to establish the contracted rates subsequent to the initial rate year for providers who fail to submit all required information as set forth in paragraph (D)(3).

Rule 5101:3-3-87.1entitled "ICF-MR outlier services for behavioral redirection and medical monitoring (ICF-MR-BRMM Services)" sets forth the criteria for the ICF-MR-BRMM level of care, the requirements of the facility to provide services, and the prior authorization process. This rule is being proposed for permanent amendment to add language regarding movement of beds between the outlier and non-outlier unit of a facility in paragraph (D)(3). This rule is also being proposed for permanent amendment to delete paragraphs (H) and (I) regarding the initial contracted rate and subsequent contracted rates after the initial rate year and refer to OAC rule 5101:3-3-25 that contains the same payment methodology concepts regarding the initial contracted rate and subsequent contracted rates after the initial rate year.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about July 1, 2004 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site". The Electronic Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronic Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "ICF-MR Transmittal"(left column)

4) Select "ICF-MRTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a ICF-MR provider does not have access to Electronic Manuals Internet site through the Internet, the JFS 03400 may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 04-03 Order Form

the order form for ICF-MRTL 04-03

ICF-MRTL 04-02

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 04-02

February 5, 2004

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: No-Change Rule Filing in Compliance with Section 119.032 of the Revised Code for Rules 5101:3-3-82.1 and 5101:3-3-82.6 of the Administrative Code

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

The above captioned rules have been reviewed in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five-year period. Pursuant to this review, no changes to these rules were filed by ODJFS at this time. This review determined whether a rule should continue without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. The rules were reviewed to ensure that they are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-82.1 entitled "Method for establishing reimbursement to intermediate care facilities for the mentally retarded (ICFs-MR) for the franchise permit fee" sets forth the reimbursement method for ICFs-MR on the Medicaid program. This rule also sets forth the reimbursement method for ICFs-MR new to the medical assistance program.

Rule 5101:3-3-82.6 entitled "Enforcement of the franchise permit fee (FPF) program for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the actions ODJFS may take in regards to facilities failing to comply with the franchise permit fee program. This rule also sets for the penalty for failing to pay the FPF by the due date.

Should revisions or a re-filing to this rule occur during the hearing process administered by the Joint Committee on Agency Rule Review (JCARR), the revised rules will be published on the Electronic Manuals Internet site at that time. Should no revisions occur, the above referenced rule as published on the Electronic Manuals Internet site will continue in effect with an effective date of February 12, 2002 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site". The Electronic Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronic Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "ICF-MR Transmittal"(left column)

4) Select "ICF-MRTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a ICF-MR provider does not have access to Electronic Manuals Internet site through the Internet, the JFS 03400 may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 04-02 Order Form

to print the order form for ICF-MRTL04-02.

ICF-MRTL 04-01

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 04-01

February 5, 2004

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-82.2 5101:3-3-82.7 of the Administrative Code (Effective on or About April 12, 2004)

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-82.2 entitled "The Intermediate Care Facility for the Mentally Retarded (ICF-MR franchise permit fee (FPF)" sets forth the meaning of ICF-MR for FPF purposes and how the proceeds from the FPF collection shall be used by ODJFS. This rule is being proposed for permanent amendment to eliminate the incorporation by reference in paragraph (A).

Rule 5101:3-3-82.7 entitled "Procedure for terminating the franchise permit fee (FPF) program for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the process for terminating the FPF program if CMS determines the FPF is an impermissible health care related tax. This rule is being proposed for permanent amendment to correct the name of CMS in the first paragraph and to add language in paragraphs (B), (B)(1), (B)(2), and (B)((3) for clarification purposes.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about April 12, 2004 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facilities for the Mentally Retarded Transmittal Letters (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site". The Electronic Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronic Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "ICF-MR Transmittal"(left column)

4) Select "ICF-MRTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a ICF-MR provider does not have access to Electronic Manuals Internet site through the Internet, the JFS 03400 may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 04-01 Order Form

to print the order form for ICF-MRTL04-01.

ICF-MRTL 03-04

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 03-04

November 25, 2003

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Emergency Adoption of Rule 5101:3-3-90, and Amendment of Rule 5101:3-3-82.3 of the Administrative Code (Effective on or About September 30, 2003)

Proposed Permanent Adoption of Rule 5101:3-3-90, and Amendment of Rule 5101:3-3-82.3 of the Administrative Code (Effective on or About December 11, 2003)

Enclosed for your review are proposed rule changes made as a result of Amended Substitute House Bill 95 of the 125th General Assembly and take effect for services provided on and after July 1, 2003. The provisions of the bill also repealed Section 5111.22(A)(2) of the Revised Code which requires the department to provide copies of proposed rules.

The following rule was adopted on an emergency basis and subsequently proposed for permanent adoption.

Rule 5101:3-3-90 entitled "Intermediate care facilities for the mentally retarded (ICFs-MR) expenditure limitation" sets forth the methodology for calculating the total per diem rate expenditure limitations for ICFs-MR. This rule is being adopted on an emergency basis and proposed for permanent adoption to detail the per diem rate expenditure limits, as detailed in paragraphs (A) through (D) of this rule, of two hundred twenty-one dollars and forty-three cents for fiscal year 2004 and two hundred twenty-five dollars and eighty-six cents for fiscal year 2005.

The following rule was amended on an emergency basis and subsequently proposed for permanent amendment:

Rule 5101:3-3-82.3 entitled "Calculation, billing, collection and appeal process for the franchise permit fee (FPF)"sets forth for the ICFs-MR FPF calculation, the ICF-MR FPF billing process, the ICF-MR FPF collection process, and the ICF-MR FPF appeal process. This rule is being amended on an emergency basis and proposed for permanent amendment in paragraph (A)(1) to specify that the FPF will remain at nine dollars and sixty-three cents for fiscal years 2004 and 2005. This rule is also being amended on an emergency basis and proposed for permanent amendment in paragraph (A)(1) to state that starting July 1, 2005 and the first day of July thereafter, the FPF will be inflated by the twelve month inflation factor. This rule is also being amended on an emergency basis and proposed for permanent amendment to correct the reference to the rule specified in paragraph (C)(4) and update the zip code specified in paragraph (E)(1)(b).

Should revisions to the proposed permanent rule occur, you will be notified in a subsequent transmittal letter. Should no revisions occur, the attached rules will become effective on or about December 11, 2003 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facility (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate care facility for the mentally retarded (ICF-MR) Transmittal Letters (ICFMRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, the ICF-MR providers are now instructed to obtain proposed rules from "dynaWeb". DynaWeb is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The DynaWeb website is a follows:

http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid

At the DynaWeb home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

- Select "Ohio Health Plans - Provider"(left column)
- Select "Long Term Care Manual" (right column)
- Select "ICF-MR Transmittal"(left column)
- Select "ICF-MRTL #" (left column)
- Scroll to the desired rule number highlighted in blue, select
- desired rule number (right column)
- Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If an ICF-MR provider does not have access to DynaWeb through the Internet, the JFS 03400 may be used to request hard-copies of proposed rules referenced in the ICF-MRTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 03-04 Order Form

to print the order form for ICF-MRTL03-04.

ICF-MRTL 03-05

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICFMRTL) 03-05

November 18, 2003

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-77 and 5101:3-3-85.1 of the Administrative Code (Effective January 8, 2004)

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

This rule package sets forth the calculation of quarterly and annual intermediate care facility for the mentally retarded (ICF-MR) facility average case mix scores, and the exception review process for ICFs-MR. These rules were reviewed pursuant to Section 119.032 of the Ohio Revised Code (ORC), which requires the review of all state agency rules within a five-year period.

5101:3-3-77 entitled "Calculation of quarterly and annual intermediate care facility for the mentally retarded (ICF-MR) facility average case mix scores" sets forth the methodology for calculating average case mix scores for ICFs-MR to be used in establishing the direct care component of the ICF-MR rate. Paragraph (A)(14) of the proposed rule clarifies the definition of payment quarter. Proposed paragraph (A)(20) clarifies the definition of reporting period end date. Proposed paragraph (F)(3) contains a form name correction from JFA 02222 to JFS 02222. As a result of this review, this rule is being proposed for permanent amendment.

5101:3-3-85.1 entitled "Exception review process for intermediate care facilities for the mentally retarded" sets forth protocols for the exception review process for ICFs-MR. Proposed paragraph (B) adds the latest publication date for Title XVIII and Title XIX of the Social Security Act and the Internet website address. Proposed paragraph (C)(1) adds the latest publication date for the cited section of the CFR and the Internet website address. Proposed paragraph (Q) changes the singular and plural forms of words and acronyms and corrects punctuation. As a result of this review, this rule is being proposed for permanent amendment.

Should revisions to the proposed permanent rule occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions occur, the aforementioned rule will become effective January 8, 2004 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Intermediate Care Facility for the Mentally Retarded Letters (ICFMRTL). Recent changes in legislation have eliminated ORC Section 5111.22(A)(2) which required the issuance of proposed rules to Medicaid ICF-MR providers. In lieu of hard-copy rules, ICF-MR providers are now instructed to obtain proposed rules from "DynaWeb". DynaWeb is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The DynaWeb website is as follows:

http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid

At the DynaWeb home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "ICF-MR Transmittal" (left column)

4) Select "ICFMRTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 form "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If an ICF-MR provider does not have access to DynaWeb through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the ICFMRTL. When requesting hard-copies of proposed rules, complete all the boxes of the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the ICF-MR provider.

ICF-MRTL 03-05 Order Form

to print the order form for ICF-MRTL03-05.

ICF-MRTL 03-03

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 03-03

September 10, 2003

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: No-Change Rule Filing in Compliance with Section 119.032 of the Revised Code for Rule 5101:3-3-75 of the Administrative Code (Effective January 13, 2002)

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

The above captioned rule has been reviewed in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five-year period. Pursuant to this review, no changes to this rule will be filed by ODJFS at this time. This review determines whether a rule should continue without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. The rule was reviewed to ensure that it is clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-75 entitled "Intermediate care facilities for the mentally retarded (ICFs-MR) case mix assessment instrument: Individual Assessment Form (IAF)" sets forth the criteria for submitting an Individual Assessment Form for each resident of a Medicaid-certified ICF-MR bed, regardless of pay source or anticipated length of stay, that reflects the resident's condition on the reporting period end date, which is the last day of the calendar quarter.

Should revisions or a re-filing to this rule occur during the hearing process administered by the Joint Committee on Agency Rule Review (JCARR), the revised rule will be published on DynaWeb at that time. Should no revisions occur, the above referenced rule as published on DynaWeb will continue in effect with an effective date of January 13, 2002 on a permanent basis.

Notice

Hard-Copy Distribution Changes

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL) or in Intermediate Care Facility for the Mentally Retarded Letters (ICF-MRTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22(A)(2) which required the issuance of proposed rules to Medicaid NF and ICF-MR providers. In lieu of hard-copy rules, the NF and ICF-MR providers are now instructed to obtain proposed rules from "DynaWeb". DynaWeb is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The DynaWeb website is as follows:

http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid

At the DynaWeb home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "NF Transmittal" or "ICF-MR Transmittal" (left column)

4) Select "NFTL #" or "ICF-MRTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

NF and ICF-MR providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a NF or ICF-MR provider do not have access to DynaWeb through the Internet, the JFS 03400 may be used to request hard-copies of proposed rules referenced in the NFTL or the ICF-MRTL. When requesting hard-copies of proposed rules, complete all the boxes of the attached form and specify "Attachments of NFTL XX-XX" or "Attachments of ICF-MRTL XX-XX" in the box "Information Request". Use the NFTL number or ICF-MRTL number indicated at the top of the transmittal to specify the transmittal number for which the attachments are requested. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF or ICF-MR provider.

ICF-MRTL 03-01

Intermediate Care Facility for the Mentally Retarded Transmittal Letter (ICF-MRTL) 03-01

May 7, 2003

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-02, 5101:3-3-02.3, 5101:3-3-04, 5101:3-3-04.1, 5101:3-3-16, and 5101:3-3-23 of the Administrative Code (Effective on or About July 1, 2003)

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-02 entitled "Provider agreements: nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the payment and adjustment process for notification of an admission, discharge, or death of a resident in a NF or ICF-MR. This rule is being proposed for permanent amendment to specify "as amended through April 15, 2003" for each statutory and regulatory reference set forth in paragraphs (A)(1)(c), (A)(6), (B)(13), and (B)(14). This rule is also being proposed for permanent amendment to replace the phrase "legal philosophy" with the word "law" in paragraph (B)(2).

Rule 5101:3-3-02.3 entitled "Eligible providers and provider types" sets forth components of the Medicaid provider agreement and bed certification requirements. This rule also sets forth the types of certified facilities that may participate in medicaid, facilities where medicaid services can be provided, types of beds certification may be requested for, and distinct parts may be designated at different certified levels. This rule is being proposed for permanent amendment to add the word "and" in the list under paragraph (B).

Rule 5101:3-3-04 entitled "Payment during the Ohio department of job and family services (ODJFS) administrative appeals process for denial or termination of a provider agreement" sets forth when medicaid payments to eligible resident during administrative appeal process. This rule is being proposed for permanent amendment to reorganize the language in paragraph (A) and replace the semi colons with commas in paragraph (B)(2).

Rule 5101:3-3-04.1 entitled "Payment during the survey agency's administrative appeals process" sets forth the payment requirements for nursing facilities and intermediate care facilities for the mentally retarded during the administrative appeals process for termination or non-renewal of Medicaid certification. This rule is being proposed for permanent amendment to change "federal" to United Sates in paragraph (A)(2), replace the semi colons with commas in paragraph (D)(3)(b), and eliminate the double "the" in paragraph (E)(2).

Rule 5101:3-3-16 entitled "Resident rights in nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the rights of residents in a NF or ICF-MR and protects those residents against inappropriate discharge actions. This rule is being proposed for permanent amendment to update the reference to the Revised Code cites in paragraph (E). This rule is also being proposed for permanent amendment in paragraph (C) to specify "as amended September 23, 1992" for CFR reference 483.12, 483.13, and 483.15 and to specify "as amended June 27, 1995" for CFR reference 483.10.

Rule 5101:3-3-23 entitled "Private rooms for medicaid residents in nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth components of the Medicaid reimbursement requirements for private room accommodations for residents of NFs and ICFs-MR. This rule is being proposed for permanent amendment for grammatical purposes in the introductory paragraph.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about July 1, 2003 on a permanent basis.

ICF-MRTL 02-11

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-11

November 6, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rule 5101:3-3-80 (Effective on or About November 14, 2002)

This rule has been reviewed pursuant to Section 5111.02 and Chapter 119. of the Revised Code. The director of the Ohio department of job and family services gives notice of the department's intent to rescind rule 5101:3-3-80 of the administrative code on a proposed permanent basis, as the language contained in this rule, which was intended to amplify section 5111.263 of the Revised Code, is no longer deemed necessary. Also, in accordance with Section 5111.22 (A)(2) of the Revised Code, the department may only provide facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

5101:3-3-80 entitled "Reimbursement of therapy services in intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology for calculating the therapy services cost of the prospective reimbursement rate for intermediate care facilities for the mentally retarded. The language contained in this rule, which was intended to amplify section 5111.263 of the Revised Code, is no longer deemed necessary, and therefore proposed for permanent rescission.

ICF-MRTL 02-14

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICFMRTL) 02-14

October 23, 2002

To: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Tom Hayes, Director

SUBJECT: Proposed Permanent Adoption and Amendment of Rules 5101:3-3-20.3 and 5105:3-3-84.2 of the Administrative Code (Effective on or About December 19, 2002)

This rule package has been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period and in response to the rescission of Bureau of Long Term Care Facilities Technical Bulletins (01-12-31-98, 02-07-01-99, 03-07-01-99, 04-01-01-00, 05-07-01-00). The content of the technical bulletins is being incorporated into the Ohio Administrative Code which involves amending existing administrative rules and promulgating one new rule. The purpose of the review is to determine whether or not the applicable rules reflect the technical bulletins' purpose and scope and to ensure that the rules are clear and concise as written and that program requirements are accurate and up-to-date. This review determines whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rules's purpose and scope. The review also provides local agencies more flexibility and eliminates unnecessary paperwork.

5101:3-3-20.3 entitled "Leased staff reimbursement for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology for appropriately reporting expenses related to leased staff. This rule is being proposed for permanent adoption to define "leased staff services" and identify the criteria for determining when costs related to staff leasing are reimbursable as other/contracted costs. Services that qualify as leased nursing costs will not be reported as purchased nursing costs or subject to the purchased nursing limitations. The rule simply clarifies current practice. The department estimates this adoption does not increase or decrease Medicaid expenditures on an annual aggregate basis.

5101:3-3-84.2 entitled "Cost of ownership and efficiency incentive for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology for determining the cost of ownership and efficiency incentive for ICFs-MR. This rule is being proposed for permanent amendment to identify the criteria that must be followed by a provider for ODJFS to approve an increase in the cost of ownership payments for the provider due to downsizing to eight or fewer beds or construction of an ICF-MR of eight or fewer beds. This rule simply clarifies current practice. The department estimates this adoption does not increase or decrease Medicaid expenditures on an annual aggregate basis.

Should revisions to the proposed permanent rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur the aforementioned rule will become effective on or about December 19, 2002 on a permanent basis.

ICF-MRTL 02-13

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-13

September 5, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Tom Hayes, Director

SUBJECT: Proposed Permanent Recission of Rule 5101:3-3-20.1 (Effective on or About September 30, 2002)

Proposed Permanent Adoption of Rule 5101:3-3-20.1 and Appendix A (Effective on or About September 30, 2002)

This rule package is being reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. However, the following changes to the Medicaid long term care facility reimbursement system emerged as a result of Amended Substitute Senate Bill 261 of the 124th General Assembly and will take effect for services provided on and after July 1, 2002. Also, in accordance with Section 5111.22 (A)(2) of the Revised Code, the department may only provide facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for recission.

5101:3-3-20.1 entitled "Chart of Accounts for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the cost report chart of accounts for NFs and ICFs-MR. This rule is being proposed for permanent adoption in accordance with Am. Sub. S. B. 261 to update the description of account number 6091of the chart of accounts entitled, Franchise Permit Fee, to instruct ICF-MR providers to report one hundred percent of the ICF-MR franchise permit fee in this account; NF providers are instructed to report twenty-three and twenty-six-hundredths percent of the NF franchise permit fee, incurred in fiscal years 2003 through 2005, in this account. NF providers should report seventy-six and seventy-four-hundredths percent of the franchise permit fee, incurred in fiscal years 2003 through 2005, in account 9725, entitled "Other-Specify". NFs will report one hundred percent of the franchise permit fee in account 6091 in fiscal year 2006 and forward.

The following rule is proposed for permanent rescission.

5101:3-3-20.1 entitled "Chart of Accounts for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) sets forth the cost report chart of accounts for NFs and ICFs-MR. This rule is being proposed for permanent rescission and replaced with rule 5101:3-3-20.1 of the same name and appendix A.

The enclosed rules will become effective on or about September 30, 2002 on a permanent basis.

ICF-MRTL 02-10

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-10

June 27, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-39 and 5101:3-3-92 of the Administrative Code (Effective on or About September 1, 2002)

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-39 entitled "Payment and adjustment process for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the payment and adjustment process for notification of an admission, discharge, or death of a resident in a NF or ICF-MR. This rule is being proposed for permanent amendment to update the department name, the county name, and ODJFS form numbers. This rule is also being proposed for permanent amendment to update the address for submission of the JFS 09400 form in paragraph (C)(2) and to add new paragraph (E) to clarify the notification made by a NF to the CDJFS for NF residents who elect to receive hospice services.

Rule 5101:3-3-92 entitled "Coverage of bed-hold days for medically necessary and other limited absences in intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the criteria for payable bed-hold days, the rate of reimbursement for a bed-hold days, the number of bed-hold days allowed per calendar year for each resident, and the process for requesting bed-hold days beyond thirty days. This rule also sets forth the criteria for bed-hold days reimbursement and availability. This rule is being proposed for permanent amendment to change the department name, the county name, the numbered rule references to the correct numeric format in paragraph (G), and to change the format of the rule in paragraph (H). This rule is also being proposed for permanent amendment to add language in paragraph (D)(1) regarding the time frame for filing the JFS 09402 "Extended Bed-hold Day(s) request/payment authorization" form.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about September 1, 2002 on a permanent basis.

ICF-MRTL 02-08

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-08

June 14, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Tom Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-19, 5101:3-3-21, 5101:3-3-22, 5101:3-3-24, 5101:3-3-24.1, 5101:3-3-84, 5101:3-3-84.1, 5101:3-3-84.2, and 5101:3-3-84.3 of the Administrative Code (Effective on or About June 20, 2002)

This rule package has been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. The following rules are being proposed for permanent amendment to correct grammatical errors, correct inaccurate references, and to update the name of the agency. In addition to the above noted general changes, some rules have specific changes as detailed hereinafter:

5101:3-3-19 entitled "Relationship of other covered medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services sets forth the methodology for determining the relationship of other covered medicaid services in nursing facilities and intermediate care facilities for the mentally retarded in the prospective reimbursement rates. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-21 entitled "Audits of nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"sets forth the methodology for determining the criteria utilized when auditing nursing facilities and intermediate care facilities for the mentally retarded. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-22 entitled "Rate recalculations, interest on overpayments, penalties, repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"sets forth the methodology utilized for determining rate recalculations, interest on overpayments, penalties, repayment of overpayments for nursing facilities and intermediate care facilities for the mentally retarded. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".The paragraph ranking order was corrected from paragraph (C) throughout the subsequent paragraphs of this rule. The penalty specified in paragraph (B)(2) has been changed from two percent to the current average bank prime rate plus four percent of the last two monthly payments.

5101:3-3-24 entitled "Prospective rate reconsideration for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology utilized when determining prospective rate reconsideration for nursing facilities (NFs) and intermediate care facilities for the mentally retarded. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".In paragraph (C)(6)(e)(i) the last sentence, "The greater of reported inpatient days or ninety-five per cent of licensed bed days shall be used to compute the per diem for capital reimbursement." has been changed to "The per diem for capital reimbursement shall be computed as set forth in paragraph (V) of rule 5101:3-3-01 of the Administrative Code" in accordance with 5111.20 as amended by House Bill 94.

In paragraph (E)(5) the first sentence, "Any rate increase granted under paragraph (E)(2) of this rule shall remain in effect until the effective date of the rate calculated under rule 5101:3-3-51 or 5101:3-3-84 of the Administrative Code that includes costs incurred for a full calendar year for the bed addition, or bed

replacement, or change in provider agreement or lease." has been changed to "Any rate increase granted under paragraph (E)(2) of this rule for added or replaced beds shall remain in effect until a new rate is calculated, based on a full year of cost for the bed addition or replacement, pursuant to rules 5101:3-3-51 or 5101:3-3-84 of the Administrative Code." Cost reports filed as a result of a change in provider agreement or lease do not need to include a full year of cost to accurately reflect the rate per diem.

Paragraph (C)(1)(d) has been amended to no longer reference findings of level A deficiencies by the Ohio department of health (ODH), bankruptcy, or foreclosure, as possible factors to be considered as extreme circumstances in the case of NFs. This amendment is the result of an amendment to R.C. 5111.29 by House Bill 94.

5101:3-3-24.1 entitled "Rate adjustments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): government mandates" sets forth the methodology utilized when determining prospective rate adjustments for nursing facilities and intermediate care facilities for the mentally retarded with government mandates. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-84 entitled "Method for establishing capital reimbursement for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology utilized when determining the prospective capital reimbursement rate for intermediate care facilities for the mentally retarded. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-84.1 entitled "Capital asset and depreciation guidelines - intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth detail of capital asset and depreciation guidelines utilized in the prospective capital reimbursement rate for intermediate care facilities for the mentally retarded. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the Ohio Department of Job and Family Services".

5101:3-3-84.2 entitled "Cost of ownership and efficiency incentive for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology utilized when determining the cost of ownership and efficiency incentive for nursing facilities. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-84.3 entitled "Nonextensive renovations for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology utilized when determining nonextensive renovations for nursing facilities. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur the aforementioned rules will become effective on or about June 20, 2002 on a permanent basis.

ICF-MRTL 02-09

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-09

May 15, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Tom Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-79, 5101:3-3-80, and 5101:3-3-83 of the Administrative Code (Effective on or About June 20, 2002)

This rule package has been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. The following rules are being proposed for permanent amendment to correct grammatical errors, correct inaccurate references, and to update the name of the agency.

5101:3-3-79 entitled "Method for establishing the direct care costs component of the prospective rate for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology for calculating the direct care cost component of the prospective reimbursement rate for intermediate care facilities for the mentally retarded. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-80 entitled "Reimbursement of therapy services in intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology for calculating the therapy services cost of the prospective reimbursement rate for intermediate care facilities for the mentally retarded. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-83 entitled "Method for establishing the indirect care costs component of the prospective rate for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology for calculating the direct care cost component of the prospective reimbursement rate for intermediate care facilities for the mentally retarded. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur the aforementioned rules will become effective on or about June 20, 2002 on a permanent basis.

ICF-MRTL 02-06

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-06

May 14, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Department of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-76 of the Administrative Code (Effective July 1, 2002)

This rule package sets forth the rule changes proposed to accommodate recalibration of the relative resource weights for ICFs-MR based on three year statewide averages of wages in Ohio long term care facilities as reported on the medicaid cost reports for ICFs-MR. This calibration used cost report wage data from the most recent three calendar years available ninety days prior to the start of the fiscal year. Accordingly, calendar year cost reports for 1998, 1999, and 2000 were used to calibrate average wage rates for fiscal year 2003. This package is also being reviewed pursuant to Section 119.032 of the Ohio Revised Code (ORC), which requires the review of all state agency rules within a five-year period. The purpose of this review is to determine whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the intent of the review is to ensure that rules are clear and concise as written, program requirements are accurate and up to date, unnecessary paperwork is eliminated, and when possible local agencies are given more flexibility.

5101:3-3-76 entitled "Resident assessment classification system (RACS): the intermediate care facility for the mentally retarded (ICF-MR) case mix payment system" sets forth components of the Medicaid reimbursement methodology for the ICF-MR direct care payment system. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services" and to amend the relative weights assigned to each Resident Assessment Classification (RAC). The calculation of the relative weights will integrate the new Ohio wage data from calendar years 1998 through 2000, as reported on the JFS 02524 Medicaid cost report for ICFs-MR, into the case mix reimbursement system. The department is required by rule to recalibrate the relative resource weights every three years to incorporate more recent direct care wage data. The recalibration is performed using the minutes of care per job type per RAC class from the most current work measurement study and the wages per job type per hour.

Should revisions to the proposed permanent rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur the aforementioned rule will become effective July 1, 2002 on a permanent basis.

ICF-MRTL 02-05

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-05

May 14, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rule 5101:3-3-25 of the Administrative Code (Effective on or About June 30, 2002)

Proposed Permanent Adoption of Rule 5101:3-3-25 of the Administrative Code (Effective on or About June 30, 2002)

Proposed Permanent Amendment of Rule 5101:3-3-87.1 of the Administrative Code (Effective on or About June 30, 2002)

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. In regard to the rules proposed for rescission, Section 5111.22(A)(2) of the Ohio Revised Code requires that the department provide facilities with only the rule number and the title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

The following rule is proposed for permanent rescission.

Rule 5101:3-3-25 entitled "Payment methodology for the provision of outlier services" sets forth the calculation of the initial contract rate for an outlier facility and specifies the methodology for calculating the prospective rate. This rule is being proposed for permanent rescission in conjunction with the permanent adoption of a new rule by the same number.

The following rule is proposed for permanent adoption.

Rule 5101:3-3-25 entitled "Payment methodology for the provision of outlier services" sets forth the calculation of the initial contract rate for an outlier facility and specifies the methodology for calculating the prospective rate. This rule is being proposed for permanent adoption to clarify the initial rate and subsequent rate a facility is paid as specified in rule 5101:3-3-87.1.

The following rule is proposed for permanent amendment.

Rule 5101:3-3-87.1 entitled "ICF-MR outlier services for behavioral redirection and medical monitoring (ICF-MR-BRMM Services)" sets forth the criteria for the ICF-MR-BRMM level of care, the requirements of the facility to provide services, and the prior authorization process. This rule is being proposed for permanent amendment to change the numbered rule references to the correct numeric format throughout the rule, to correct a reference in paragraph (B)(6) and (D)(11), to include acronyms throughout the rule, and to make minor grammatical changes in paragraphs (B)(8), (B)(13), (B)(14),(E)(1), (E)(2)(a),and (E)(3).

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about June 30, 2002 on a permanent basis.

ICF-MRTL 02-07

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-07

April 24, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Jobs and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-86 of the Administrative Code (Effective July 1, 2002)

Enclosed for your review are proposed rule changes which resulted from the review of rules pursuant to the rule review provisions of Section 119.032 of the Revised Code. The purpose of the rule-review provisions under Section 119.032 of the Revised Code is to determine whether or not a rule should be amended, rescinded or adopted based upon the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. Also, in accordance with Section 5111.22 (A)(2) of the Ohio Revised Code, the department may only provide facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

5101:3-3-86 entitled "Rates for Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) which are new to the Medical Assistance Program and for ICFs-MR providers that Change Provider Agreements" set forth criteria used to set rates for providers who have no current historical costs to base a rate setting. This rule is being proposed for permanent amendment to clarify procedures to establish rates for new facilities and change of provider agreements. Pursuant to this amendment, payment rates will be established based upon the current rate under the previous provider agreement if the costs are based on the year end cost report prior to the current fiscal year, or a three month cost report within the time period of the provider immediately preceding the change. If the costs are not based upon the prior year -end cost report, or a subsequent three-month cost report, the department will assign the Median rate for the appropriate peer group. The current provider's actual case mix score will only be used when the current provider's direct care costs as reported on a three-month cost report are available. Actual case mix scores for the new provider, which results from a change in the provider agreement, will be used only when direct care costs for that provider is available. The actual case-mix score and the three-month actual cost report which determine the cost per case mix unit, should be derived from the same provider.

Should revisions to any of these rules occur during the hearing process, a copy of the revised rule or rules will be forwarded to you at that time. Should no revisions occur, the aforementioned rules will become effective July 1, 2002 on a permanent basis.

ICF-MRTL 02-04

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-04

April 30, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rule 5101:3-3-93 of the Administrative Code: (Effective on or About June 27, 2002)

Proposed Permanent Adoption of Rule 5101:3-3-93 of the Administrative Code: (Effective on or About June 27, 2002)

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. In regard to the rules proposed for rescission, Section 5111.22(A)(2) of the Ohio Revised Code requires that the department provide facilities with only the rule number and the title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

The following rule is proposed for permanent rescission.

Rule 5101:3-3-93 entitled "Personal needs allowance (PNA) and resident funds for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the personal needs allowance (PNA) account, resident's right to manage PNA account, Deposit of PNA funds, accounting and records requirements, notice of certain PNA balances, release of PNA funds upon discharge of resident, conveyance of funds upon death, assurance of financial security, limitation on charges to personal funds, services included in medicare or medicare payment, items and services that may be charged to resident's PNA, and monitoring of PNA account. This rule is being proposed for permanent rescission in conjunction with the permanent adoption of a new rule by the same number.

The following rules are proposed for permanent adoption.

Rule 5101:3-3-93 entitled "Personal needs allowance (PNA) and resident funds for intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the personal needs allowance (PNA) account, resident's right to manage PNA account, Deposit of PNA funds, accounting and records requirements, notice of certain PNA balances, release of PNA funds upon discharge of resident, conveyance of funds upon death, assurance of financial security, limitation on charges to personal funds, services included in medicare or medicare payment, items and services that may be charged to resident's PNA, and monitoring of PNA account. This rule is being proposed for permanent adoption to eliminate the non-Administrative Code references contained in the rule, update the department's name and county department's name, and to reorganize the rule language for purposes of clarification.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about June 27, 2002 on a permanent basis.

ICF-MRTL 02-03

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-03

April 30, 2002

TO: Administrators, Intermediate Care Facility for the Mentally Retarded

Directors, County Department of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rule 5101:3-3-81 of the Administrative Code (Effective July 1, 2002)

Proposed Permanent Adoption of Rule 5101:3-3-81, 5101:3-3-81.1, 5101:3-3-81.2 of the Administrative Code (Effective July 1, 2002)

The rules contained in this package have been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules every five years. The intent of the review is to determine whether a rule should be continued without amendment, should be amended, or should be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures the rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated and when possible, local agencies are given more flexibility. Also, in accordance with Section 5111.22 (A)(2) of the Revised Code, the department may only provide facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

Rule 5101:3-3-81 entitled "Compensation Cost Limits for Administrators, Owners, and Relatives of Owners in Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the compensation cost limits for administrators, owners, and relatives of owners in ICFs-MR. This rule is being proposed for permanent rescission in conjunction with the adoption of a new rule by the same number.

Rule 5101:3-3-81entitled "Compensation Cost Limits and Reasonable Costs for Compensation of Owners, Relatives of Owners, and Administrators in Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the compensation cost limits and reasonable costs for compensation of owners, relatives of owners, and administrators. This rule is being proposed for permanent adoption to specify the two components which determine the methodology for compensation cost limits and reasonable costs for compensation of administrators, owners, and relatives of owners as set forth in rules 5101:3-3-81.1 and 5101:3-3-81.2.

Rule 5101:3-3-81.1 entitled "Compensation Cost Limits and Reasonable Compensation for Owners and Relatives of Owners in Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the compensation cost limits and reasonable compensation for owners and relatives of owners in ICFs-MR. This rule is being proposed for permanent adoption to develop a method to identify "time slices" as reported by providers. This time slice methodology identifies hours worked in the facility and related facilities. Time slices are subsequently used to determine appropriate compensation cost limits and reasonable compensation costs for each owner or relative of an owner.

Rule 5101:3-3-81.2 entitled "Compensation Cost Limits and Reasonable Costs for Compensation of Administrators in Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the compensation cost limits and reasonable costs for compensation of administrators in ICFs-MR. This rule is being proposed for permanent adoption to develop a method to identify "time slices" as reported by providers. This time slice methodology identifies hours worked in the facility and related facilities. Time slices are subsequently used to determine appropriate compensation cost limits and reasonable compensation costs for each administrator.

Should revisions to any of these rules occur during the hearing process, a copy of the revised rule or rules will be forwarded to you at that time. Should no revisions occur, the aforementioned rules will become effective July 1, 2002 on a permanent basis.

For questions regarding the above mentioned rules, please contact the Reimbursement Section, of the Bureau of Long Term Care Facilities at (614) 466-8460.

ICF-MRTL 02-02

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-02

March 29, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Human Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-02.1, 5101:3-3-02.2, 5101:3-3-02.4, 5101:3-3-16.1 and 5101:3-3-17 of the Administrative Code

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. In regard to the rules proposed for rescission, Section 5111.22(A)(2) of the Ohio Revised Code, requires that the department need only to provide facilities with the rule number and the title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

The following rules are proposed for permanent amendment.

Rule 5101:3-3-02.1entitled "Length and Type of Provider Agreements" sets forth the types of provider agreements, requirements for extension of provider agreements, and provider agreement effective dates. This rule is being proposed for permanent amendment to update the department name in paragraph (C) and to clarify the effective date of a provider agreement in paragraph (A).

Rule 5101:3-3-02.2 entitled "Termination and Denial of Provider Agreement: Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)"sets forth the circumstances when a provider agreement may be terminated or denied to a ICF-MR. This rule is being proposed for permanent amendment to update the department name in paragraphs (B), (B)(2), (B)(7), and (C), change the numbered rule reference to the correct numeric format in paragraph (B)(10), and to delete definitions in paragraphs (A)(1) thru (A)(3) that are in rule 5101:3-3-01 of the Administrative Code. This rule is also being amended to include the "ODH" acronym in paragraph (B)(9) and provide the rule reference in paragraph (B)(4).

Rule 5101:3-3-02.4 entitled "Services Provided by an Institution Classified as a Nursing Facility (NF), or an Intermediate Care Facility for the Mentally Retarded (ICF-MR)" sets forth the services rendered in participating Medicaid NFs and ICFs-MR and circumstances when a provider agreements are terminated or denied for an ICF-MR. This rule is being proposed for permanent amendment to include "the following" in paragraph (C).

Rule 5101:3-3-16.1 entitled "Resource Assessment Notice" sets forth components the resource assessment notice must contain and an example of a notice. This rule is being proposed for permanent amendment to update the department name throughout the rule and to clarify paragraph (A).

Rule 5101:3-3-17 entitled "Emergency Relocation Plan" sets forth the components of the relocation plan and the time frame to notify the department and other entities. This rule is being proposed for permanent amendment to update the department name in paragraph (B).

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on a permanent basis.

ICF-MRTL 02-01

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 02-01

March 27, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Department of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rule 5101:3-3-18 of the Administrative Code

Proposed Permanent Adoption of Rule 5101:3-3-18 of the Administrative Code

The rule contained in this package has been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules every five years. The intent of the review is to determine whether a rule should be continued without amendment, should be amended, or should be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures the rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated and when possible, local agencies are given more flexibility. Also, in accordance with Section 5111.22 (A)(2) of the Revised Code, the department may only provide facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

Rule 5101:3-3-18 entitled "Aggregate Medicaid Rates and Aggregate Medicare Rates Comparison for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the aggregate Medicaid rates and aggregate Medicare rates comparison for NFs and ICFs-MR. This rule is being proposed for permanent rescission in conjunction with the adoption of a new rule by the same number.

Rule 5101:3-3-18 entitled "Inpatient Services: Application of Medicare Upper Payment Limit Calculation (MUPLC) for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the inpatient services application of Medicare Upper Payment Limit Calculation (MUPLC) for NFs and ICFs-MR. This rule is being proposed for permanent adoption to specify the provisions of the application for the Medicare Upper Payment Limit Calculation (MUPLC) as set forth in Section 447.272 (a) and (b) of the Code of Federal Regulations (CFR). These provisions changed the groups of facilities subject to the MUPLC to include state government-owned or operated facilities, non-state government-owned or operated facilities, and privately-owned and operated facilities.

Should revisions to this rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur, the aforementioned rule will become effective on a permanent basis.

For questions regarding the above mentioned rule, please contact the Planning and Research Section, of the Bureau of Long Term Care Facilities at (614) 466-9243.

ICF-MRTL 01-4A

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 01-4A

January 22, 2002

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: REFILED Proposed Permanent Adoption of Rule 5101:3-3-82.3 of the Administrative Code (Effective on or About FEBURARY 11, 2002)

Rule 5101:3-3-82.3 entitled "Calculation, Billing, Collection and Appeal Process for the Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) Franchise Permit Fee (FPF)" sets forth components of the calculation, billing, collection, and the appeal process for the FPF. This rule was originally proposed for permanent adoption in conjunction with the rescission of rules 5101:3-3-822, 5101:3-3-823 and 5101:3-3-824. This rule is being refiled for proposed permanent adoption to specify in paragraph (E)(1)(a) that ICFs-MR may not request an appeal to the franchise permit fee any later than fifteen days after the date on which the FPF assessment notice was mailed.

Instructions:

Obsolete rule 5101:3-3-82.3 as set forth in ICF-MRTL 01-04 and replace it with rule 5101:3-3-82.3 as contained in this transmittal.

For questions regarding the above referenced rule, please contact the Facility Contracting Section, in the Bureau of Long Term Care Administration at (614) 466-6467.

ICF-MRTL 01-04

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 01-04

November 13, 2001

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Human Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rules 5101:3-3-822, 5101:3-3-823, 5101:3-3-824, and 5101:3-3-825 of the Administrative Code:

Proposed Permanent Adoption of Rules 5101:3-3-82.2, and 5101:3-3-82.3 of the Administrative Code:

Proposed Permanent Amendment of Rules 5101:3-3-821, 5101:3-3-826, and 5101:3-3-827 of the Administrative Code

This rule package has been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. In accordance with Section 5111.22(A)(2) of the Ohio Revised Code, the department may provide facilities with the rule number and the title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

The following rules are proposed for permanent rescission.

Rule 5101:3-3-822 entitled "Calculation of Assessment on Beds Certified as Intermediate Care Facility Beds for the Mentally Retarded (ICFs-MR)" sets forth components of the identification of ICFs-MR subject to the franchise permit fee, the purpose for the FPF, and explains how the FPF is to be calculated. This rule is being proposed for permanent rescission in conjunction with the permanent adoption of rules 5101:3-3-82.2 and 5101:3-3-82.3.

Rule 5101:3-3-823 entitled "Schedule for Reporting Assessments for Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth components of the process for obtaining the names of ICFs-MR for billing purposes, the process for notification and payment, and the process for applying the penalty for late payment of the assessment. This rule is being proposed for permanent rescission in conjunction with the integration of this rule into new rules 5101:3-3-82.6 and 5101:3-3-82.3.

Rule 5101:3-3-824 entitled "Appeals of the Assessment on Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth components of the process for appealing the franchise permit fee. This rule is being proposed for permanent rescission in conjunction with the integration of this rule into new rule 5101:3-3-82.2.

Rule 5101:3-3-825 entitled "Method of Distribution of Funds Deposited in the Home and Community-Based Services for the Mentally Retarded and Developmentally Disabled Fund" sets forth requirements for how the monies from the franchise permit fee assessment will be allocated. This rule is being proposed for permanent rescission in conjunction with the integration of the contents of this rule into new rule 5101:3-3-82.2.

The following rules are proposed for permanent adoption.

Rule 5101:3-3-82.2 entitled "The Intermediate Care Facility for the Mentally Retarded (ICFs-MR) Franchise Permit Fee (FPF)" sets forth components of the identification of ICFs-MR subject to the franchise permit fee, the purpose for the FPF, and explains how the money from the FPF fund is to be distributed. This rule is being proposed for permanent adoption in conjunction with the proposed permanent rescission of rules 5101:3-3-822 and 5101:3-3-825.

Rule 5101:3-3-82.3 entitled "Calculation, Billing, Collection and Appeal Process for the Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) Franchise Permit Fee (FPF)" sets forth components of the calculation, billing, collection, and the appeal process for the FPF. This rule is being proposed for permanent adoption in conjunction with the proposed permanent rescission of rules 5101:3-3-822, 5101:3-3-823 and 5101:3-3-824.

The following rules are proposed for permanent amendment.

Rule 5101:3-3-821 entitled "Method for Establishing Reimbursement for Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) for the Franchise Permit Fee" sets forth the method for establishing reimbursement for the franchise permit fee for ICFs-MR. This rule is being proposed for permanent amendment to change the department name from "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services" and to change the numbered rule references to the correct numeric format.

Rule 5101:3-3-826 entitled "Enforcement of the Assessment Program for Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the enforcement process for the collection of the franchise permit fee. This rule is being proposed for permanent amendment to obtain consistency with the use of Franchise Permit Fee as the name for the FPF program, to change the department name from "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services," to address the application of the penalty for late payment or non-payment of the FPF, to update the rule title, and to change the numbered rule references to the correct numeric format.

Rule 5101:3-3-827 entitled "Procedure for Terminating the Assessment Program for Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the process for ceasing the implementation of the FPF rules if the Center for Medicare and Medicaid Services (CMS) determines that the FPF is an impermissible health care related tax. This rule is being proposed for permanent amendment to obtain consistency with the use of Franchise Permit Fee as the name for the FPF program, to change the department name from "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services," and to reflect the "United States Health Care Financing Administration's" name change to the "Center for Medicare and Medicaid Services," to update the rule title, and to change the numbered rule references to the correct numeric format.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on a permanent basis.

ICF-MRTL 01-3

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 01-3

November 13, 2001

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Department of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-75, 5101:3-3-77, and 5101:3-3-851 of the Administrative Code

The rules contained in this package have been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules every five years. The intent of the review is to determine whether a rule should be continued without amendment, should be amended, or should be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures the rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated and when possible, local agencies are given more flexibility. The following rules are being proposed for permanent amendment to correct grammatical errors, correct inaccurate references, and to update the name of the agency.

Rule 5101:3-3-75 entitled "Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) Case Mix Assessment Instrument: Individual Assessment Form (IAF)" sets forth the instrument and procedures by which ICFs-MR compile and submit resident assessment data for purposes of determining facility average resident acuity levels. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

Rule 5101:3-3-77 entitled "Calculation of Quarterly and Annual Intermediate Care Facility for the Mentally Retarded (ICF-MR) Facility Average Case Mix Scores" sets forth the methodology for determining the facility average case mix scores each quarter and annually. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services" and to correct the grammatical errors in paragraphs (A)(8) and (G).

Rule 5101:3-3-851 entitled "Exception Review Process for Intermediate Care Facilities for the Mentally Retarded" sets forth the provisions for ODJFS to verify the resident assessment data provided by the intermediate care facilities for the mentally retarded. This rule is being amended to correct the rule number, to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services", and to correct the inaccurate references in paragraph (A)(3)(a) and in Appendix A.

Should revisions to the proposed permanent rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur the aforementioned rule will become effective on a permanent basis.

For questions regarding any of the above mentioned rules, please contact the Case Mix Section, in the Bureau of Long Term Care Facilities at (614) 466-6694.

ICF-MRTL 01-2

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 01-2

October 17, 2001

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Jobs and Family Services

FROM: Thomas J. Hayes,. Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-01, 5101:3-3-02, 5101:3-3-20.1, and 5101:3-3-84.5 of the Administrative Code

Enclosed for your review are proposed rule changes which resulted from the implementation of the provisions of Am. Sub. H. B. 94, Am. Sub. H. B. 299, and the rule-review provisions of Section 119.032 of the Revised Code. Notwithstanding the legislative changes, the purpose of the rule-review provisions under Section 119.032 of the Revised Code is to determine whether or not a rule should be amended, rescinded or adopted based upon the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. In conjunction with the adoption of Am. Sub. H. B. 94, Am. Sub. H. B. 299, and the application of the aforementioned rule review provisions, the Ohio Department of Job and Family Services (ODJFS) is providing a copy of the affected rules for your review.

5101:3-3-01 entitled "Definitions" sets forth the definitions which apply to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) under Chapter 5101:3-3 of the Administrative Code. This rule is being proposed for permanent amendment in accordance with Section 63.36 of Am. Sub. H. B. 94 and Am. Sub. H. B. 299 to change the imputed occupancy percentage for indirect costs set forth in paragraph (V)(1) from eighty-five percent to eighty-two percent effective SFY 2002. This rule is also being proposed for permanent amendment to change the imputed occupancy percentage for capital costs set forth in paragraph (V)(2) from ninety-five percent to eighty-eight percent effective SFY 2002. This rule is also being proposed for permanent amendment to correct grammatical errors, rule number references, and acronym references.

5101:3-3-02 entitled "Provider Agreements: NFs and ICFs-MR" sets forth the provider agreement requirements for Medicaid NFs and ICF-MR. This rule is being proposed for permanent amendment in accordance with Section 119.032 of the Revised Code to add definitions of terminology in paragraph (A), to clarify NF and ICF-MR responsibilities for providing notification of closures or voluntary withdrawal from the Medicaid program in paragraphs (C) and (D), to delete payment time-frame requirements in paragraph (E), and to integrate new statutory requirements concerning the responsibility of the provider to admit or retain persons who are or may become Medicaid eligible in "failure to pay" circumstances in paragraph (J).

5101:3-3-20.1 entitled "Chart of Accounts for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) sets forth the cost report chart of accounts for NFs and ICFs-MR. This rule is being proposed for permanent amendment in accordance with Section 63.37 of Am. Sub. H. B. 94 and Am. Sub. H. B. 299 to clarify franchise permit fee reimbursement for NFs. Cost report account 6090 has been changed to include the "Stabilization Fund Assessment". Cost report account 6091 has been changed to clarify references to franchise permit fee rules 5101:3-3-49.2 to 5101:3-3-49.9 and 5101:3-3-82.2 to 5101:3-3-82.7 and to specify the cost reporting criteria for NFs and ICFs-MR during SFYs 2002-2003.

5101:3-3-84.5 entitled "Notice, Escrow, Recovery of Excess Depreciation Paid, Change in the Medicaid Provider Agreement, or Voluntary Termination in the Medical Assistance Program for Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) sets forth the notice, escrow, recovery of excess depreciation paid, change in the Medicaid provider agreement, or voluntary termination in the Medical assistance program for ICFs-MR. This rule is being proposed for permanent amendment in accordance with Sections 5111.251 and 5111.28 of the Revised Code to correct the rule number to include a decimal point, to change the department name throughout the rule, to replace the term "voluntary termination" with the term "closure and voluntary withdrawal" throughout the rule, to add language in paragraph (A) to identify where the definition of "closure and voluntary withdrawal" can be found in the Administrative Code, to add language in paragraph (D)

regarding the withholding of monthly vendor payments in escrow if the provider fails to notify ODJFS within the time frames required by this rule, to change the penalty in paragraph (I)(1) if an ICF-MR fails to provide notice of a change in provider agreement from the current average bank prime rate plus two percent to the current average bank prime rate plus four percent, and to add language to paragraphs (I)(3) and (I)(4) regarding the release of vendor payments held in escrow.

Should revisions to the proposed permanent rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur the aforementioned rule will become effective on a permanent basis.

ICF-MRTL 01-1

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 01-1

March 19, 2001

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Jobs and Family Services

FROM: Jo Ann Davidson, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-01 of the Administrative Code

5101:3-3-01 entitled "Definitions" sets forth the definitions which apply to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) under Chapter 5101:3-3 of the Administrative Code. This rule was recently amended as a result of the implementation of the permanent provisions of Sub. H. B. 403 as codified in Sections 5111.25 and 5111.251 of the Revised Code. Pursuant to Sub. H. B. 403, paragraph (BB) of rule 5101:3-3-01 was amended to change the definition of an arms-length transaction for the transfer or lease of a NF or an ICF-MR. This rule is now being amended to allow eligible related-party transactions which occurred prior to the implementation of the provisions of Substitute House Bill 403 to qualify for prospective reimbursement on and after the effective date of this rule if the corresponding state plan amendment is approved by the Health Care Financing Administration.

Should revisions to the proposed permanent rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur the aforementioned rule will become effective on a permanent basis.

ICF-MRTL 00-3

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 00-3

December 11, 2000

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Jobs and Family Services

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-01 and 5101:3-3-201 of the Administrative Code

The following rules are being proposed for permanent amendment to comply with the permanent provisions of Substitute House Bill 403. These rules are also being reviewed in compliance with Section 119.32 of the Ohio Revised Code (ORC), which requires the review of all agency rules every five (5) years. The purpose of this review is to determine whether or not a rule should be amended, rescinded or adopted based upon the rule's purpose and scope. The review also provides local agencies more flexibility and eliminates unnecessary paperwork.

5101:3-3-01 entitled "Definitions" sets forth the definitions which apply to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) under Chapter 5101:3-3 of the Administrative Code. This rule is being proposed for permanent amendment as a result of the implementation of the permanent provisions of Sub. H. B. 403 which amended Sections 5111.25 and 5111.251 of the Revised Code. Pursuant to Sub. H. B. 403, paragraph (BB) is being amended to change the definition of an arms- length transaction for the transfer or lease of a NF or an ICF-MR. Under this rule, transfers of ownership and leases from one party to another that are otherwise between related parties shall be considered arms-length if the transferring provider has no direct or indirect interest in the acquiring provider except as a creditor and does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default, in which case the Department must, in calculating its reimbursement rates for capital costs, treat the facility as if the transfer never occurred. Paragraph (BB) has also been amended to include specific guidelines regarding interest rates for seller financing and the submission of real estate appraisals during the sale or lease of a facility to a related party seeking to qualify for nonrelated party status. Lastly, this rule is being amended to change the agency name from the Ohio Department of Human Services (ODHS) to the Ohio Department of Job and Family Services (ODJFS).

5101:3-3-201 entitled "Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR): Chart of Accounts" sets forth the chart of accounts utilized for cost reporting purposes by NFs and ICFs-MR. This rule is being proposed for permanent amendment as a result of the implementation of the permanent provisions of Sub. H. B. 403 which amended Sections 173.55 and 173.54 of the Revised Code. These provisions require nursing facilities (NFs) to be charged a fee not to exceed four hundred dollars for annual customer satisfaction surveys. The indirect care cost center cost report account 7270 set forth in this rule has been changed to include the fee paid by the NFs for these surveys. This rule is also being amended to change references to the agency name from the Ohio Department of Human Services (ODHS) to the Ohio Department of Job and Family Services (ODJFS).

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur the aforementioned rules will become effective on a permanent basis.

ICF-MRTL 00-2

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 00-2

August 8, 2000

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Jobs and Family Services

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-01 of the Administrative Code

This rule is being proposed for permanent amendment to comply with the temporary provisions of Section Five (5) of Substitute House Bill 403. This rule is also being reviewed in compliance with Section 119.32 of the Ohio Revised Code (ORC), which requires the review of all agency rules every five (5) years. The purpose of this review is to determine whether or not a rule should be amended, rescinded or adopted based upon the rule's purpose and scope. The review also provides local agencies more flexibility and eliminates unnecessary paperwork. In conjunction with these provisions, the Ohio Department of Human Services (ODHS) is requesting your input in the completion of this review.

The following rule is proposed for adoption:

5101:3-3-01 entitled "Definitions" sets forth definitions which apply to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) for purposes of Medicaid reimbursement. This rule is being proposed for permanent amendment to change the imputed occupancy percentage for indirect costs set forth in paragraph (V)(1) from eighty-five percent to seventy-five percent, and to change the imputed occupancy percentage for capital costs set forth in paragraph (V)(2) from ninety-five percent to eighty-five percent. This proposed amendment corresponds with Sections 5 (A) and 5 (B) of Substitute House Bill 403 which become effective July 1, 2000.

Should revisions to the proposed permanent rule occur, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur, the aforementioned rule will become effective on a permanent basis.

ICF-MRTL 00-1

Intermediate Care Facility For The Mentally Retarded Transmittal Letter (ICF-MRTL) 00-1

May 24, 2000

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Human Services

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Proposed Permanent RECISSION of Rules 5101:3-3-041 and 5101:3-3-16 of the Administrative Code

Proposed Permanent Adoption of Rules 5101:3-3-041, 5101:3-3-16 and 5101:3-3-871 of the Administrative Code:

Proposed Permanent Amendment of Rules 5101:3-3-023, 5101:3-3-04 and 5101:3-3-23 of the Administrative Code

This rule package is being reviewed pursuant to Substitute House Bill 473, which requires the review of all state agency rules within a five year period. The purpose of this review is to determine whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the intent of the review is to ensure that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-023 entitled "Eligible Providers and Provider Types" sets forth components of the Medicaid provider agreement and bed certification requirements. This rule is being proposed for permanent amendment to delete references to a repealed OAC rule and to update language regarding the withdrawal of certified beds from the medical assistance program to reflect the provisions of section 5111.30 of the ORC.

Rule 5101:3-3-04 entitled "Payment During the Ohio Department of Jobs and Family Services (ODJFS) Administrative Appeals Process for Denial or Termination of a Provider Agreement" sets forth components of Medicaid reimbursement for NFs and ICFs-MR during the administrative appeals process for ODJFS denials or terminations of provider agreements. This rule is being proposed for permanent amendment to correct clerical errors and wording redundancy. The title of this rule has been shortened and the department's new name has been integrated into the rule.

Rule 5101:3-3-041 entitled "Availability of Payment During the State Survey Agency's Administrative Appeals Process for Denial, Termination or Failure to Renew a Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICF-MR) Certification" sets forth the components of the payment requirements for NFs and ICFs-MR during the administrative appeals process for termination of, or the failure to renew facility certification. This rule is being proposed for recission in conjunction with the adoption of a new rule by the same number.

Rule 5101:3-3-041 entitled "Payment During the Survey Agency's Administrative Appeals Process" sets forth the payment requirements for nursing facilities and intermediate care facilities for the mentally retarded during the administrative appeals process for termination or non-renewal of Medicaid certification. This rule is being proposed for permanent adoption to define payment requirements during the ODH administrative appeals process.

Rule 5101:3-3-16 entitled "Residents' Rights in Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the rights of residents in a NF or ICF-MR and protects those residents against inappropriate discharge actions. This rule is being proposed for recission in conjunction with the adoption of a new rule by the same number.

Rule 5101:3-3-16 entitled "Residents' Rights in Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICF-MR)" sets forth citations of the ORC and CFR which delineate the rights of

residents in nursing facilities and intermediate care facilities for the mentally retarded. This rule is being proposed for permanent adoption to identify citations of the ORC and CFR which delineate residents rights.

Rule 5101:3-3-23 entitled "Private Rooms for Medicaid Residents in Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth components of the Medicaid reimbursement requirements for private room accommodations for residents of NFs and ICFs-MR. This rule is being proposed for permanent amendment to correct spelling errors.

NF Transmittal Letters

NFTL 15-02 (Five-Year Review: OAC Rule 5160-3-19)

Nursing Facility Transmittal Letter (NFTL) 15-02

June 3, 2015

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Five-Year Review - OAC Rule 5160-3-19

Rescission of Administrative Code Rule 5160-3-19

Adoption of Administrative Code Rule 5160-3-19

The following rule changes were made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Rescinded

Rule 5160-3-19, entitled "Relationship of other covered medicaid services to nursing facility (NF) services" sets forth the covered services generally available to Medicaid recipients, and describes the relationship of those services to the services provided to Medicaid recipients who reside in a nursing facility. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule was rescinded and was replaced by new rule 5160-3-19.

Adopted

Rule 5160-3-19, entitled "Nursing facilities (NFs): relationship of NF services to other covered medicaid services" sets forth the covered services generally available to Medicaid recipients, and describes the relationship of those services to the services provided to Medicaid recipients who reside in a nursing facility. This rule was adopted to replace rule 5160-3-19, which was rescinded. The differences between this rule and the rule it replaced are:

- The rule title was modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- Language was changed throughout the rule to refer to payment rather than to reimbursement, and references to reimbursement through the facility's cost report were changed to payment through the NF per diem.
- In paragraph (A) regarding dental services, language was added to clarify that personal hygiene services provided by facility staff are related to dental services.
- Language regarding custom wheelchairs, oxygen, and medical transportation by ambulance and wheelchair van, were updated to reflect that these services are now paid for on a fee-for-service basis rather than through the NF per diem pursuant to Ohio Revised Code section 5165.01 adopted by Am. Sub. HB 59 of the 130th General Assembly. Additionally, to reflect the change in method of payment, the provisions for non-emergency oxygen were moved from paragraph (C)(1)(c), which specifies items that must be paid for through the nursing facility per diem, to new paragraph (C)(2)(d), which specifies items for which payment is made on a fee-for-service basis.
- The provisions regarding psychologist services and respiratory therapy services were broken out from paragraph (E) and moved to new paragraphs (H) and (I) in order to be easier for readers to find.
- In paragraph (F)(1)(c)(iii), the provisions regarding delegation of required physician visits were modified to require compliance with federal regulations specified in 42 C.F.R. 483.40.
- In paragraph (F)(1)(c)(iv) regarding physician delegation of tasks, the term "certified nurse practitioner" was replaced with the term "advanced practice registered nurse (APRN)" in order to be consistent with definitions in the Ohio Revised Code and with current nursing practice in

nursing facilities, and the Revised Code Chapter citation regarding APRNs was corrected. Language also was modified in paragraph (F)(1)(c)(iv)(A)(ii) to require APRNs to practice with a standard care arrangement entered into with each physician with whom an APRN collaborates in accordance with section 4723.431 of the Revised Code, and to require a copy of the standard care arrangement to be on file at each nursing facility where the APRN practices.

- In paragraph (F)(2), APRNs were added to physicians as a provider type to whom direct payment for provision of physician services may be made. In paragraph (F)(2)(b), the requirement for physicians to sign and date every entry in a resident's medical record documenting provision of physician services was extended to include APRNs.
- Language in paragraph (G) regarding podiatry services was modified to clarify that residents in a nursing facility may access podiatry services in the same amount, duration, and scope as all other Medicaid recipients, but only one podiatry visit per month may occur in a nursing facility setting.
- Ohio Administrative Code references were updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- Minor language was changed throughout the rule for clarity and better comprehension.

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Bureau of Long Term Care Services and Supports

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Columbus, OH 43218-2709

(614) 466-6742

BLTCSS@medicaid.ohio.gov

NFTL 15-01 (Nursing Facility Rule Changes Pursuant to Five-Year Review)

Nursing Facility Transmittal Letter (NFTL) 15-01

March 31, 2015

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Nursing Facility Rule Changes Pursuant to Five-Year Review

Rescission of Administrative Code Rules 5160-3-03.2, 5160-3-39.1 and 5160-3-65.1

Adoption of Administrative Code Rules 5160-3-03.2, 5160-3-39.1 and 5160-3-65.1

Amendment of Administrative Code Rules 5160-3-16.1, 5160-3-16.5, 5160-3-24, 5160-3-41, 5160-3-42.3, and 5160-3-65

The following rule changes are being made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Rescinded

Rule 5160-3-03.2, entitled "Resident protection fund (RPF) for nursing facilities (NFs) and collection of fines" sets forth the provisions for the resident protection fund, including the methods and procedures for collection of fines that are subsequently deposited into the resident protection fund, and the purposes for which the money in the fund may be used. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being rescinded and is being replaced by new rule 5160-3-03.2.

Rule 5160-3-39.1, entitled "Claim submission for nursing facilities (NFs)" sets forth the provisions for claim submission for nursing facilities. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being rescinded and is being replaced by new rule 5160-3-39.1.

Rule 5160-3-65.1, entitled "Nursing facilities (NFs): rates for providers that change provider agreements" sets forth the provisions for determining rates for nursing facilities that change provider agreements as a result of a change of operator. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being rescinded and is being replaced by new rule 5160-3-65.1.

Adopted

Rule 5160-3-03.2, entitled "Resident protection fund (RPF) for nursing facilities (NFs) and collection of fines" sets forth the provisions for the resident protection fund, including the methods and procedures for collection of fines that are subsequently deposited into the resident protection fund, and the purposes for which the money in the fund may be used. This rule is being adopted to replace rule 5160-3-03.2, which is being rescinded. The differences between this rule and the rule it is replacing are:

- The rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- The definition of fines is being revised to include assessments other than civil monetary penalties (CMPs).
- The definition of and references to the resident protection fund coordinator are being removed because the position does not exist. The phrase has been replaced with "ODM."
- The provisions regarding the methods and procedures for collection of fines are being combined and revised to reflect that CMS is responsible for imposing and collecting the CMP fines and, if CMS is unable to do so, CMS will notify ODM, who will attempt to collect. It further clarifies that ODH is responsible for issuing fines to Medicaid-only providers for noncompliance with certification requirements, and for notifying ODM, who will attempt to collect.
- In paragraph (C), language is being revised pursuant to changes in federal requirements regarding the purposes for which the resident protection fund may be used, and language is

being added regarding the requirement for CMS approval for the use of CMP funds deposited in the resident protection fund.

- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).
- Paragraph references are being updated as necessary.

Rule 5160-3-39.1, entitled "Nursing facilities (NFs): claim submission" sets forth the provisions for claim submission for nursing facilities. This rule is being adopted to replace rule 5160-3-39.1, which is being rescinded. The differences between this rule and the rule it is replacing are:

- The rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- The rule is being restructured to better delineate the requirements for submitting claims for services included and not included in the NF per diem rate, and to enhance readability and comprehension.
- Language is being added that requires nursing facility claims for services not included in the nursing facility per diem rate to be submitted in accordance with rule 5160-1-19 of the Administrative Code.
- Language is being clarified regarding use of electronic data interchange (EDI) and the Health Care Claim Institutional (837I) electronic format.
- Language is being added and modified to require electronic claim submission in EDI or the Medicaid Information Technology Systems (MITS) web portal and to require the use of the UB04 national uniform billing data specifications.
- Language is being added requiring use of the coding standards set forth in the healthcare common procedure coding system, the current procedure terminology codebook, and the international classification of diseases codebook.
- Language is being added that requires trading partners who submit EDI claim transactions to follow the requirements set forth in paragraph (H) of rule 5160-1-19 of the Administrative Code.
- Language is being updated to reference the ODM 837I Companion Guide for compliance requirements for claim submissions.
- Language is being updated to clarify that a single claim shall include days of service provided, including qualifying leave days, for a single individual within a single calendar month and shall not cross calendar months.
- Language is being modified to clarify provisions regarding lump sum payments when the County Department of Job and Family Services (CDJFS) and a Medicaid recipient in a NF determine that a lump sum shall be assigned to the NF as payment for past per diem services received by the recipient.
- Language is being modified to clarify that the date of receipt of an original claim submission shall be determined by the date the claim is received in the web portal or the date the claim is received via electronic data interchange (EDI).
- Language is being modified to clarify that when a provider identifies an underpaid claim, the provider shall submit an adjustment within 180 days of the date the underpaid claim was paid, and when a provider identifies an overpaid claim, an adjustment shall be submitted within 60 days of discovery of the overpayment. The language further clarifies that checks in lieu of claim adjustments shall not be accepted.
- Language is being modified to clarify that, if ODM identifies the need for a provider to adjust a claim, ODM shall notify the provider to make the adjustment within 60 days of notification. If the provider fails to make the adjustment, ODM shall either make the adjustment or void the claim. If an adjustment cannot be made due to lack of outgoing payments, ODM shall issue an invoice and the provider shall remit payment or seek reconsideration within 60 days. Any remaining balance shall be certified to the Ohio Attorney General for collection.
- Language is being added to clarify that claims with prior payment by Medicare or another insurance plan shall be submitted within 180 days from the date Medicare or the insurance plan paid the claim to the nursing facility.

- Language regarding delayed claim submissions has been moved to new paragraph (B)(10), "Exceptions to timely filing requirements."
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).
- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- Language applicable to dates of service prior to July 1, 2005 and between July 1, 2005 and November 30, 2005 has been removed.
- Interest provisions have been removed.

Rule 5160-3-65.1, entitled "Nursing facilities (NFs): rates for providers that change provider agreements" sets forth the provisions for determining rates for nursing facilities that change provider agreements as a result of a change of operator. This rule is being adopted to replace rule 5160-3-65.1, which is being rescinded. The differences between this rule and the rule it is replacing are:

- Old paragraphs (A) and (B) are being deleted because the provisions in them determine initial rates for entering operators that began participating in the Medicaid program between July 1, 2006 and October 31, 2006, and therefore are no longer necessary.
- In new paragraph (A), language is being added so that the quality incentive component of the nursing facility rate will equal the statewide median as calculated according to section 5165.25 of the Revised Code.
- Ohio Revised Code citations are being updated because Am. Sub. HB 59 of the 130th General Assembly created the Ohio Department of Medicaid, and subsequently relocated and reorganized many Revised Code provisions governing the Medicaid program.
- An Ohio Administrative Code reference is being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- Paragraph references are being updated as necessary.

Amended

Rule 5160-3-16.1, entitled "Nursing facilities (NFs): resource assessment notice" sets forth the provisions that govern the nursing facility resource assessment notice. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended. The changes to the rule are:

- The rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- The form number of the Medicaid Resource Assessment Notice form is being changed from JFS 04080 to ODM 04080 due to the creation of the Department of Medicaid, and the effective date of the form is being updated to 7/2014.
- An Ohio Administrative Code reference is being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).

Rule 5160-3-16.5, entitled "Nursing facilities (NFs): personal needs allowance (PNA) accounts and other resident funds" sets forth the provisions for the management and use of nursing facility personal needs allowance accounts and other resident funds. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended. The changes to the rule are:

- The rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- In the opening paragraph, the revision date of the reference to the Code of Federal Regulations is being updated.

- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) or the ODJFS office of Ohio Health Plans (OHP) to the Ohio Department of Medicaid (ODM).
- An Ohio Revised Code citation is being updated because Am. Sub. HB 59 of the 130th General Assembly created the Ohio Department of Medicaid, and subsequently relocated and reorganized many Revised Code provisions governing the Medicaid program.
- Form references are being updated and grammatical errors are being corrected.

Rule 5160-3-24, entitled "Nursing facilities (NFs): prospective rate reconsideration for possible calculation errors" sets forth the provisions for nursing facilities' requests for rate reconsiderations in cases of possible calculation errors. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended. The changes to the rule are:

- The rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).
- In paragraph (A)(1), language regarding the timeframe for filing a rate reconsideration request is being changed from "no more than thirty days after the later of the initial payment of the rate or the receipt of the rate-setting calculation" to "no more than thirty days after the later of the initial payment of the rate for which reconsideration is being requested or the date on the rate setting package notification."
- In paragraph (A)(2)(b), the address where a rate reconsideration request must be sent is being updated.

Rule 5160-3-41, entitled "Nursing facilities (NFs): placement into peer groups" sets forth the provisions for placement of nursing facilities into peer groups. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended. The changes to the rule are:

- The rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- In paragraph (A)(1), language is being changed so that for providers new to the Medicaid program, the number of licensed beds will be determined from the provider application as verified by ODH rather than from the provider agreement.
- In paragraph (B), language is being changed to clarify that peer group adjustments due to a change in bed size will be made in the fiscal year following the filing of an annual cost report that reflects the change.
- Ohio Revised Code citations are being updated because Am. Sub. HB 59 of the 130th General Assembly created the Ohio Department of Medicaid, and subsequently relocated and reorganized many Revised Code provisions governing the Medicaid program.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).

Rule 5160-3-42.3, entitled "Nursing facilities (NFs): capital asset and depreciation guidelines" sets forth the provisions for capital assets, including guidelines for the depreciation of capital assets, for nursing facilities. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended. The changes to the rule are:

- The rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- In paragraph (B), language is being added to require nursing facility providers to refer to CMS publication 15-1, Chapter 1 entitled "Depreciation" for purposes of determining if an expenditure should be capitalized.

- In paragraph (B), the threshold amount over which an asset must be capitalized and depreciated is being changed from $500 or more to $5,000 or more in order to be consistent with federal regulations.
- In paragraph (C), language is being added that requires all capital assets to be depreciated using the straight-line method of depreciation, and salvage value to be used to adjust capital asset values when calculating depreciation, in accordance with CMS publication 15-1 entitled "Depreciation."
- Language in paragraph (D) is being changed to require use of the guidelines in the American Hospital Association publication "Estimated Useful Lives of Depreciable Hospital Assets" instead of the guidelines in Appendix A of this rule when determining the useful life of a capital asset because Appendix A of this rule is being rescinded.
- Additional language in paragraph (D) is being changed to require the use of the Internal Revenue Service (IRS) publication "How to Depreciate Property" instead of Appendix A of this rule if a capital asset is not reflected in the American Hospital Association publication "Estimated Useful Lives of Depreciable Hospital Assets" because Appendix A of this rule is being rescinded.
- An Ohio Administrative Code reference is being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).

Rule 5160-3-65, entitled "Nursing facilities (NFs): rates for providers with an initial date of certification on or after July 1, 2006" sets forth the provisions for determining initial rates for nursing facilities that begin participation in the Medicaid program with a first date of licensure and subsequent certification on or after July 1, 2006. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended. The changes to the rule are:

- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).
- Ohio Revised Code citations are being updated because Am. Sub. HB 59 of the 130th General Assembly created the Ohio Department of Medicaid, and subsequently relocated and reorganized many Revised Code provisions governing the Medicaid program.
- An Ohio Administrative Code reference is being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.

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NFTL 14-05 (Nursing Facility Chart of Accounts Rule)

Nursing Facility Transmittal Letter (NFTL) 14-05

October 29, 2014

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Nursing Facility Chart of Accounts Rule

Proposed Amendment of Administrative Code Rule 5160-3-42

The following rule change is being made in accordance with sections 119.03 and 119.032 of the Ohio Revised Code, which outline the procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Proposed for Amendment

Rule 5160-3-42, entitled "Nursing facilities (NFs): chart of accounts" sets forth the Medicaid chart of accounts for nursing facilities. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended to update the Revised Code citation in paragraph (D) because Am. Sub. HB 59 of the 130th General Assembly created the Ohio Department of Medicaid, and subsequently relocated and reorganized many Revised Code provisions governing the Medicaid program.

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(614) 466-6742

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NFTL 14-04 (Nursing Facility Rule Changes Pursuant to Five-Year Review)

Nursing Facility Transmittal Letter (NFTL) 14-04

October 8, 2014

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Nursing Facility Rule Changes Pursuant to Five-Year Review

Rescission of Administrative Code Rules 5160-3-16.2, 5160-3-17.1, and 5160-3-17.3

Amendment of Administrative Code Rules 5160-3-04, 5160-3-16.3, 5160-3-17, 5160-3-57, and 5160-3-64.1

The following rule changes are being made in accordance with sections 119.03 and 119.032 of the Ohio Revised Code, which outline the procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Proposed for Rescission

Rule 5160-3-16.2, entitled "Advance directives for nursing facilities (NFs)" sets forth the provisions for advance directives for nursing facilities. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being rescinded because the provisions in it are contained in federal regulations at 42 C.F.R. 489.100 or 42 C.F.R. 489.102, or in section 1337.16 or section 2133.10 the Ohio Revised Code.

Rule 5160-3-17.1, entitled "Outlier services in nursing facilities for individuals with severe maladaptive behaviors due to traumatic brain injury (NF-TBI services)" sets forth the provisions for outlier services in nursing facilities for individuals with traumatic brain injury. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being rescinded. The Department has determined it no longer needs to have a NF-TBI program because no Medicaid payments for the provision of NF-TBI services have been made since July 1, 2008, and no nursing facility providers have expressed interest to the Department in furnishing NF-TBI services since that time.

Rule 5160-3-17.3, entitled "Out-of-state nursing facility (NF) services for individuals with traumatic brain injury (TBI)" sets forth the provisions for out-of-state nursing facility services for individuals with traumatic brain injury. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being rescinded. The Department has determined it no longer needs to have an out-of-state NF-TBI program because no Medicaid payments for the provision of out-of-state NF-TBI services have been made since August 20, 2000.

Proposed for Amendment

Rule 5160-3-04, entitled "Payment during the Ohio department of job and family services (ODJFS) administrative appeals process for denial or termination of a provider agreement" sets forth payment provisions during and after proposed termination or non-renewal of a nursing facility's provider agreement by the Department of Medicaid, and payment provisions during and after the appeals process of that proposed action. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended to update the Department's name from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).

Rule 5160-3-16.3, entitled "Private rooms in nursing facilities (NFs)" sets forth the provisions for private room accommodations in nursing facilities, including payment for such accommodations. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended. The changes to the rule are:

- The rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.

- The phrase "at the medicaid rate" in paragraph (C)(5) is being deleted for purposes of clarification.

Rule 5160-3-17, entitled "Payment methodology for the provision of outlier services in nursing facilities (NFs)" sets forth the methodology used to pay for outlier services provided in nursing facilities. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended. The changes to the rule are:

- The rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- In paragraph (C), references to the franchise fee add-on are being deleted because the franchise fee add-on became obsolete when section 5111.243 of the Revised Code was repealed with the implementation of Am. Sub. HB 153 of the 129th General Assembly, and is no longer a component of the outlier per diem rate.
- Paragraph references have been re-lettered and re-numbered as necessary due to the deletion of original paragraph (C)(1)(e), which contains the franchise fee add-on provision.
- In re-numbered paragraph (C)(1)(e), the Administrative Code citation is being replaced with a Revised Code citation because the provision in that paragraph is set forth in the Revised Code.
- Ohio Revised Code citations are being updated because Am. Sub. HB 59 of the 130th General Assembly created the Ohio Department of Medicaid, and subsequently relocated and reorganized many Revised Code provisions governing the Medicaid program.
- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).

Rule 5160-3-57, entitled "Tax cost add-on for nursing facilities (NFs)" sets forth the provisions for determining the per diem rate for tax costs for nursing facilities. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended. The changes to the rule are:

- The rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- In paragraph (B), the word "provider" is being added for clarification.
- Ohio Revised Code citations are being updated because Am. Sub. HB 59 of the 130th General Assembly created the Ohio Department of Medicaid, and subsequently relocated and reorganized many Revised Code provisions governing the Medicaid program.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).

Rule 5160-3-64.1, entitled "Nursing facility (NF) payment for cost-sharing other than medicare part A" sets forth the provisions for cost sharing for nursing facilities other than Medicare Part A. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended. The changes to the rule are:

- The rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).

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NFTL 14-03 (Five-Year Review - Institutions for Mental Diseases Rule)

Nursing Facility Transmittal Letter (NFTL) 14-03

October 8, 2014

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Five-Year Review - Institutions for Mental Diseases Rule

Amendment of Administrative Code Rule 5160-3-06.1

The following rule changes are being made in accordance with sections 119.03 and 119.032 of the Ohio Revised Code, which outline the procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Proposed for Amendment

Rule 5160-3-06.1, entitled "Institutions for mental diseases (IMDs)" sets forth the process by which the Ohio Department of Medicaid identifies nursing facilities that are at risk of becoming institutions for mental diseases (IMDs), the preventative measures to be taken by the Department when at risk facilities are identified, and the course of action to be taken by the Department if a nursing facility is determined to be an IMD. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being amended. The changes to the rule are:

- In paragraph (A), the age for individuals for whom federal financial participation (FFP) is available for inpatient psychiatric hospital services is being changed from "under age twenty-two" to "under age twenty-one and in certain circumstances under age twenty-two" in order to accurately reflect the provision in Section 1905(a)(16) of the Social Security Act.
- In paragraph (B)(3), the reference to the International Classification of Diseases (ICD) publication is being updated as part of the Department of Medicaid's implementation of ICD-10 medical coding, which was mandated by federal regulations issued in 2009 by the U.S. Department of Health and Human Services (HHS) for all entities covered by the Health Insurance Portability and Accountability Act (HIPAA). The name of the publication is being updated from "International Classification of Diseases, Ninth Edition, Modified for Clinical Applications" (ICD-9-CM) to "International Classification of Diseases, Tenth Revision, Clinical Modification," and the website where the publication is available is being added.
- Ohio Revised Code citations are being updated because Am. Sub. HB 59 of the 130th General Assembly created the Ohio Department of Medicaid, and subsequently relocated and reorganized many Revised Code provisions governing the Medicaid program.
- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).
- The name of the Ohio Department of Mental Health and Addiction Services (ODHAS) is being updated from the Ohio Department of Mental Health (ODMH).
- In paragraph (C)(2)(b)(ii), the name of the Joint Commission is being updated from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).
- In paragraph (D)(3)(c), a reference to the County Department of Human Services is being updated to County Department of Job and Family Services (CDJFS), and a CDJFS reference is being corrected in paragraph (E)(1)(b).

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Columbus, OH 43218-2709

(614) 466-6742

BLTCSS@medicaid.ohio.gov

NFTL 14-02 (Nursing Facility Rule Rescissions Pursuant to Five-Year Review)

Nursing Facility Transmittal Letter (NFTL) 14-02

August 12, 2014

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Nursing Facility Rule Rescissions Pursuant to Five-Year Review

Rescission of Administrative Code Rules 5160-3-16, 5160-3-17.2, 5160-3-42.2 and 5160-3-58

The following rule changes are being made in accordance with sections 119.03 and 119.032 of the Ohio Revised Code, which outline the procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Proposed for Rescission

Rule 5160-3-16, entitled "Resident rights for nursing facilities (NFs)" sets forth the general resident rights provisions for nursing facilities. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being rescinded because the provisions in it are contained in the Ohio Revised Code, the Ohio Administrative Code, or the Code of Federal Regulations.

Rule 5160-3-17.2, entitled "Pediatric outlier services in nursing facilities (NF-PED services)" sets forth the provisions for pediatric outlier services in nursing facilities. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being rescinded because the Department is discontinuing the NF-PED program as no Medicaid payments for the provision of NF-PED services have been made since December 29, 2009, and no nursing facility providers have expressed interest to the Department in furnishing NF-PED services since that time.

Rule 5160-3-42.2, entitled "Nursing facilities (NFs): leased staff" sets forth the provisions for staff leasing arrangements in nursing facilities. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being rescinded because it became obsolete due to elimination of the purchased nursing services disallowance when the nursing facility payment methodology for state fiscal year 2006 and beyond was modified to implement changes in Amended Substitute House Bill 66 of the 126th General Assembly.

Rule 5160-3-58, entitled "Quality incentive payment for nursing facilities (NFs)" sets forth the quality incentive criteria applicable to nursing facilities for state fiscal years 2012 and 2013, and the methodology used to calculate nursing facility quality incentive payments for state fiscal years 2012 and 2013. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being rescinded because the provisions in it are obsolete. There is no new rule to replace this rule because provisions contained in section 5165.25 of the Revised Code adopted under Senate Bill 264 of the 129th General Assembly and under Amended Substitute House Bill 59 of the 130th General Assembly now govern the NF quality incentive payment program for SFY 2014 and beyond.

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(614) 466-6742

BLTCSS@medicaid.ohio.gov

NFTL 14-01 (Updates to Nursing Facility Chart of Accounts and Cost Report)

Nursing Facility Transmittal Letter (NFTL) 14-01

January 24, 2014

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Updates to Nursing Facility Chart of Accounts and Cost Report

Proposed Amendment of Administrative Code Rule 5160-3-42

Proposed Rescission of Administrative Code Rule 5160-3-42.1 in Conjunction with Adoption of a Rule by the Same Number

These rule changes are being made in accordance with sections 119.03 and 119.032 of the Ohio Revised Code, which outline the procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Proposed for Amendment

Rule 5160-3-42, entitled "Nursing facilities (NFs): chart of accounts" is being proposed for amendment due to five-year review, and to implement provisions of Section 5165.01 of the Revised Code adopted under Amended Substitute House Bill 59 of the 130th General Assembly relating to the administration of the Medicaid program. This rule sets forth the Medicaid chart of accounts for nursing facilities. The changes to the rule are:

Rule Body

- Language is being changed to refer to the chart of accounts as set forth in Appendix A of this rule, rather than refer to the "recommended" chart of accounts.
- The Ohio Revised Code citation is being updated from 5111.26 to 5165.10 due to Am. Sub. HB 59 relocating and reorganizing many Revised Code provisions governing the Medicaid program.
- In paragraph (A)(1), language is being modified to improve readability.
- In paragraph (A)(3), language in being modified so that providers are required to capture requested information when a chart of accounts has sub-accounts.
- Also in paragraph (A)(3), clarifying language is being added to specify that sub-accounts must be used if there is a corresponding line on the cost report.
- In paragraph (A)(4), the term "payor" is being updated to "payer."

Appendix A

- On all pages, the revision date in the header is being updated to 12/2013.
- For Accounts 1030, 1090, and 5730, the acronym "LTCF" is being replaced with "nursing facility."
- For Accounts 6322 Oxygen and 7735 Custom Wheelchairs, the phrase "(only through 12/31/13)" is being added because, effective 1/1/14, costs for these items are excluded from direct care costs and ancillary/support costs.
- Account 7291 Qualified Mental Retardation Professional is being removed because it is no longer being used by NF providers.
- For Account 7631 Resident Transportation, language is being added to note that ambulance and ambulette transportation provided on or after January 1, 2014 can be billed directly to Medicaid by the transportation provider.

- Account 9720 Non-emergency Oxygen is being added under Table 7 Ancillary/Support Costs, Non-Reimbursable Expenses, along with language noting that costs for non-emergency oxygen are to be reported in this account on or after January 1, 2014.
- Under Table 7 Ancillary/Support Costs, Non-Reimbursable Expenses, language is being added to Account 9725 Other Non-Reimbursable noting that on or after January 1, 2014, costs for wheelchairs are to be reported in this account.
- For Account 9776, "Ohio Department of Job and Family Services (ODJFS)" is being changed to "Ohio Department of Medicaid."
- Ohio Revised Code citations are being updated due to Am. Sub. HB 59 relocating and reorganizing many Revised Code provisions governing the Medicaid program.
- Ohio Administrative Code references are being updated due to the creation of the Department of Medicaid by Am. Sub. HB 59 and the subsequent renumbering of rules by the Legislative Services Commission.
- Grammar, punctuation, capitalization, and phrasing are being corrected throughout as necessary to improve readability.

Proposed for Rescission

Rule 5160-3-42.1, entitled "Nursing facility (NF): medicaid cost report" is being proposed for rescission due to five-year review. It is being replaced by new rule 5160-3-42.1. This rule sets forth the Medicaid cost report for nursing facilities.

Proposed for Adoption

Rule 5160-3-42.1, entitled "Nursing facility (NF): medicaid cost report" is being proposed for adoption due to five-year review, and to implement provisions of Section 5165.01 of the Revised Code adopted under Amended Substitute House Bill 59 of the 130th General Assembly relating to the administration of the Medicaid program. It replaces rule 5160-3-42.1, which is being proposed for rescission. This rule sets forth the Medicaid cost report for nursing facilities. Differences between this rule and the rule it is replacing are:

- The phrase "Nursing facility (NF)" in the rule title is being changed to "Nursing facilities (NFs)" to be consistent with the other rules in Chapter 5160-3 of the Ohio Administrative Code.
- The acronym OAC is being deleted because it is not necessary.
- Language is being added to this rule that requires providers to use software available on the Ohio Department of Medicaid's website.
- Language referring to Appendix A of this rule is being deleted because Appendix A of this rule is being removed from the Ohio Administrative Code, and instead will be available on the Department of Medicaid's website.
- Ohio Administrative Code citations are being updated due to the creation of the Department of Medicaid by Am. Sub. HB 59 and the subsequent renumbering of Chapter 5101:3-3 rules by the Legislative Services Commission.

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NFTL 13-01 (Leave Days for Nursing Facility Residents on HCBS Waivers; Amendment of Administrative Code Rule 5101:3-3-16.4)

Nursing Facility Transmittal Letter (NFTL) 13-01

May 2, 2013

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Leave Days for Nursing Facility Residents on HCBS Waivers

Amendment of Administrative Code Rule 5101:3-3-16.4

The following rule changes are being made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Rule 5101:3-3-16.4, entitled "Coverage of bed-hold days for medically necessary and other limited absences from nursing facilities (NFs)" sets forth the provisions for leave days for nursing facilities (NFs). This rule is being amended to clarify coverage of leave days for NF residents who are on home and community-based services (HCBS) waivers, and who are not using the NF for short-term respite care as a waiver service.

The changes to the rule are: references to the Ohio Department of Job and Family Services and ODJFS are being replaced with references to the Office of Medical Assistance and OMA; new language in paragraph (A)(4) clarifies that, for purposes of this rule, a NF is not defined as a medical institution; language in paragraphs (A)(6) and (F)(3) is being modified to account for HCBS consumers in a NF who use leave days for reasons other than hospitalization; references to calendar years 2011 and 2012 in paragraph (F)(2) are being removed, and consequently the paragraph is being restructured to conform to rule drafting guidelines; in paragraph (D)(4)(a), language is being added to specify that the reimbursement provisions for hospital leave days apply to NF residents on HCBS waivers; in paragraph (D)(4)(b)(i), the acronym CDJFS is being spelled out to conform with rule drafting guidelines, and the punctuation at the end of that paragraph is being changed for consistency; paragraphs (D)(4)(b)(iii) and (D)(4)(c)(iv) are being added to include reimbursement limits specific to NF residents on HCBS waivers; paragraphs (E)(1) and (E)(2) have been replaced with new paragraph (E), which contains updated language regarding claims submission; in paragraph (J)(1)(b), language is being added regarding Medicare Part A SNF benefits and resident eligibility for leave days; new language in paragraph (J)(6) establishes eligibility for leave days for the purpose of hospitalization only for NF residents on an HCBS waiver; language is being deleted in paragraph (K)(3) because it conflicts with the policy to cover hospital leave days for NF residents on an HCBS waiver; and in paragraph (K)(3), in order to be comprehensive, six citations of Administrative Code Chapters that contain eligibility criteria for the HCBS waiver program are being added to those already listed.

NFTL 12-04 (Rule Changes to Implement ORC Section 5111.226)

Nursing Facility Transmittal Letter (NFTL) 12-04

January 22, 2013

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Rule Changes to Implement ORC Section 5111.226

Proposed Rescission of Administrative Code Rules 5101:3-3-02.1 and 5101:3-3-04.1

Proposed Adoption of Administrative Code Rules 5101:3-3-02.1 and 5101:3-3-04.1

Proposed Amendment of Administrative Code Rules 5101:3-3-02, 5101:3-3-02.2, 5101:3-3-02.3, 5101:3-3-02.7, 5101:3-3-04, 5101:3-3-16.1, 5101:3-3-20, 5101:3-3-22, 5101:3-3-30.1, 5101:3-3-30.4, 5101:3-3-32, 5101:3-3-32.1, 5101:3-3-32.2, and 5101:3-3-39

The following proposed rule changes are being made to implement provisions of Section **5111.226** of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly, and in accordance with Sections 119.03 and 119.032 of the Ohio Revised Code, which outline the procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Proposed for Rescission

Rule 5101:3-3-02.1, entitled Length and type of long term care provider agreements, sets forth provisions regarding the length and type of provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). This rule is being rescinded in conjunction with adoption of a new rule by the same number so that the new rule applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule 5101:3-3-04.1, entitled Payment to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) during the survey agency's administrative appeals process, sets forth provisions for Medicaid payment to be made to NFs and ICFs-MR during the survey agency's administrative appeals process. This rule is being rescinded in conjunction with adoption of a new rule by the same number so that the new rule applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Proposed for Adoption

Rule **5101:3-3-02.1**, entitled Length and type of long term care provider agreements, sets forth provisions regarding the length and type of provider agreements for nursing facilities. This new rule is replacing part of existing rule 5101:3-3-02.1, which is being proposed for rescission, so that this new rule applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-04.1**, entitled Payment to nursing facilities (NFs) during the survey agency's administrative appeals process, sets forth provisions for Medicaid payment to be made to NFs during the survey agency's

administrative appeals process. This new rule is replacing part of existing rule 5101:3-3-04.1, which is being proposed for rescission, so that this new rule applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Proposed for Amendment

Rule **5101:3-3-02**, entitled Provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for the execution and maintenance of provider agreements between the Ohio Department of Job and Family Services and the operators NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-02.2**, entitled Termination, denial, and non-renewal of long term care provider agreements, sets forth provisions for the termination, denial, and non-renewal of provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-02.3**, entitled Institutions eligible to participate in medicaid as nursing facilities (NFs) or intermediate care facilities for the mentally retarded (ICFs-MR), sets forth eligibility provisions for NFs and ICFs-MR to participate in the Medicaid program. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR. In paragraph (A)(10), the date referenced in the Social Security Act citation, as well as the phrase "as amended," are being removed due to rule filing guidelines.

Rule **5101:3-3-02.7**, entitled Emergency management and resident relocation plan for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for the preparation for, response to, and recovery from an emergency at a NF or ICF-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-04**, entitled Payment during the Ohio department of job and family services (ODJFS) administrative appeals process for denial or termination of a provider agreement, sets forth provisions for Medicaid payments to be made during the ODJFS administrative appeals process for denial or termination of the provider agreement of a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR). This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-16.1**, entitled Resource assessment notice for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions regarding JFS form 04080 "Medicaid Resource Assessment Notice" that are specific to NFs and ICFs-MR. This rule is being amended so that it

applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-20**, entitled Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements, sets forth provisions for Medicaid cost report filing, record retention, and disclosure requirements for NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR. In paragraph (I)(5), the phrase "as amended (through 1/1/07)" is being removed from the Social Security Act citation due to rule filing guidelines.

Rule **5101:3-3-22**, entitled Rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-30.1**, entitled Appeal of the franchise permit fee (FPF) determination and re-determination, sets forth provisions for an appeal of the franchise permit fee determination or re-determination for nursing homes or hospital long term care units in accordance with Section 3721.55 of the Revised Code, or an appeal of the franchise permit fee determination for intermediate care facilities for the mentally retarded (ICFs-MR) in accordance with Section 5112.35 of the Revised Code. This rule is being amended so that it applies only to nursing homes and hospital long term care units since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-30.4**, entitled Procedure for terminating the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), long term care hospital beds, and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the procedure for terminating the franchise permit fee for NFs, NHs, long term care hospital beds, ICFs-MR. This rule is being amended so that it applies only to nursing facilities, nursing homes, and long term care hospital beds since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-32**, entitled Debt estimation methodology for change of operator, facility closure, voluntary termination, involuntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the debt estimation methodology for change of operator, facility closure, voluntary termination, involuntary termination, and voluntary withdrawal for NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-32.1**, entitled Debt estimate and debt summary report procedure for change of operator, facility closure, voluntary termination, involuntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth the debt summary report procedure for change of operator, facility closure, voluntary termination, involuntary termination, and voluntary withdrawal for NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-32.2**, entitled Successor liability agreements for operators of nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), sets forth provisions for successor liability agreements for operators of NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR.

Rule **5101:3-3-39**, entitled Payment and adjustment process for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), is being amended due to five-year review, and to implement provisions of Section 5111.226 of the Revised Code. This rule sets forth the Medicaid payment and adjustment process for NFs and ICFs-MR. This rule is being amended so that it applies only to nursing facilities since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR. Changes being made to the rule due to five-year review are: in paragraph (A), the revision dates of the JFS 09400 and 09401 forms are being updated; in paragraph (D), an Administrative Code rule number is being updated; and in paragraph (E), the word "shall" is being added to correct a typographical error.

NFTL 12-03 (Rescission of Rule to Implement ORC Section 5111.226)

Nursing Facility Transmittal Letter (NFTL) 12-03

January 16, 2013

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Rescission of Rule to Implement ORC Section 5111.226

Proposed Rescission of Administrative Code Rule 5101:3-3-30.2

The following proposed rule changes are being made to implement provisions of Section 5111.226 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly. These changes are being made in accordance with Sections 119.03 and 119.032 of the Ohio Revised Code, which outline procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Proposed for Rescission

Rule **5101:3-3-30.2**, entitled Prohibition against billing residents for the franchise permit fee (FPF), prohibits directly billing residents of nursing facilities, nursing homes, long term care hospital units, or intermediate care facilities for the mentally retarded (ICFs-MR) for the franchise permit fee. The ICF-MR provisions of this rule are being rescinded since, pursuant to Section 5111.226 of the Revised Code, the Department of Job and Family Services has entered into a contract with the Department of Developmental Disabilities under section 5111.91 of the Revised Code that provides for the Department of Developmental Disabilities to assume the powers and duties of the Department of Job and Family Services with regard to the Medicaid program's coverage of services provided by ICFs-MR. The provisions for nursing facilities, nursing homes, and long term care hospital units are being rescinded because they are set forth in the Ohio Revised Code.

NFTL 12-02 (HB 153 and Five-Year Review Rule Changes for NFs)

Nursing Facility Transmittal Letter (NFTL) 12-02

March 21, 2012

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: HB 153 and Five-Year Review Rule Changes for NFs

Amendment of Administrative Code Rules 5101:3-3-16.4, 5101:3-3-20, 5101:3-3-22, 5101:3-3-30.1, 5101:3-3-32, 5101:3-3-32.1, 5101:3-3-42.4, 5101:3-3-58, and 5101:3-3-64 (effective March 19, 2012)

Rescission of Administrative Code Rules 5101:3-3-21 and 5101:3-3-69 (effective March 19, 2012)

The following rule changes are being made to implement provisions of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly, or in accordance with Sections 119.03 and 119.032 of the Ohio Revised Code, which outline the procedures for the adoption, amendment, and rescission of administrative rules, and the assignment of rule review dates.

Amended Rules

Rule **5101:3-3-16.4**, entitled Coverage of bed-hold days for medically necessary and other limited absences from nursing facilities (NFs), is being amended due to five year review, and to implement provisions of Section 5111.331 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth the bed-hold day provisions for nursing facilities. Changes are being made to this rule so that during calendar year 2012 and thereafter, reimbursement of nursing facility (NF) bed-hold days will be fifty per cent of the NF provider's per diem rate if the facility had an occupancy rate in the preceding calendar year exceeding ninety-five per cent. The reimbursement will be eighteen per cent of the NF provider's per diem rate if the facility had an occupancy rate in the preceding calendar year of ninety-five per cent or less.

Rule **5101:3-3-20**, entitled Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements, is being amended due to five year review, and to implement provisions of Section 5111.261 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth provisions for Medicaid cost report filing, record retention, and disclosure requirements for nursing facilities and intermediate care facilities for the mentally retarded. Changes to this rule include the following: In the opening paragraph, the date of JFS form 02524N, the Medicaid Nursing Facility Cost Report, is being updated to 09/2011; and paragraph (D) is being restructured and the language in it amended to provide that although the general rule is that a provider may amend their cost report within three years of filing it with the Department, a provider may not amend a cost report if the Department has notified the provider of an audit of that cost report or an audit of a subsequent cost reporting period.

Rule **5101:3-3-22**, entitled Rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), is being amended due to five year review, and to implement provisions of Section 5111.271 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth the provisions for rate recalculations, interest on overpayments, imposition of penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities and intermediate care facilities for the mentally retarded. Changes to this rule include the following: In paragraph (A) the reference to OAC rule 5101:3-3-21 is being replaced with reference to ORC section 5111.27 because rule 5101:3-3-21 is being

rescinded; in paragraph (A)(3), the internet address for the publication "Selected Interest Rates" is being added; in the heading to paragraph (B) the words "and fines" is being added for clarification; new paragraphs (B)(3) and (B)(4) identify the fines to be issued based on the amount of adverse findings included in the report of an audit conducted under ORC section 5111.27; new paragraph (B)(5) prohibits the Department from collecting fines issued under paragraph (B)(3) until all appeals relating to the audit report that is the basis for the fine are exhausted; language has been added in paragraph (D) so that fines collected pursuant to paragraph (B)(3) shall be deposited into the Health Care Services Administration Fund created under ORC section 5111.94; and language has been added to paragraph (D) specifying where all other penalties issued under this rule will be deposited.

Rule **5101:3-3-30.1**, entitled Appeal of the franchise permit fee (FPF) determination, is being amended due to five year review, and to implement provisions of Sections 3721.531 and 3721.532 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth provisions for appeal of the franchise permit fee (FPF) determination. Changes to this rule include the following: The addition of "and re-determination" in the rule title; re-wording of paragraph (A) for clarification; and insertion of new language in paragraph (A) regarding an appeal of the FPF re-determination in accordance with section 3721.55 of the Revised Code.

Rule **5101:3-3-32**, entitled Debt estimation methodology for change of operator, facility closure, voluntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), is being amended due to five year review, and to implement provisions of Section 5111.68 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth the debt estimation methodology for change of operator, facility closure, voluntary termination, involuntary termination, or voluntary withdrawal for nursing facilities and intermediate care facilities for the mentally retarded. This rule is being changed to add involuntary termination to the title to clarify that it is one of the cases to which the debt estimation methodology applies.

Rule **5101:3-3-32.1**, entitled Debt estimate and debt summary report procedure for change of operator, facility closure, voluntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), is being amended due to five year review, and to implement provisions of Section 5111.68 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth the debt estimate and debt summary report procedure in cases of a change of operator, facility closure, voluntary termination, involuntary termination, or voluntary withdrawal for nursing facilities and intermediate care facilities for the mentally retarded. This rule is being changed to add involuntary termination to the title to clarify that it is one of the cases to which the debt estimate and debt summary report procedure applies.

Rule **5101:3-3-42.4**, entitled Nursing facilities (NFs): nonreimbursable costs, is being amended due to five year review, and to implement provisions of Section 5111.271 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth the costs that are not reimbursable to nursing facilities through the nursing facility per diem rate. Changes to this rule include the following: Fines or penalties paid under Section 5111.271 of the Revised Code are being added as nonreimbursable costs; and the costs of physical therapy, occupational therapy, speech therapy, audiology, oxygen (other than emergency stand-by oxygen), and custom wheelchairs are being removed as nonreimbursable costs as these services are reimbursed through the nursing facility per diem effective August 1, 2009.

Rule **5101:3-3-58**, entitled Quality incentive payment for nursing facilities (NFs), is being amended due to five year review, and to implement provisions of Section 5111.244 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth provisions for the quality incentive payment for nursing facilities. This rule is being changed so that it only applies to fiscal year 2012, and three points instead of one will be awarded to a nursing facility if the nursing facility's medicaid utilization rate is above the statewide average. Additionally, because the rule is being limited to fiscal year 2012, language is being deleted that allows the quality incentive payment to be recalculated in the next fiscal year.

Rule **5101:3-3-64**, entitled Nursing facility payment for medicare part A cost sharing, is being amended due to five year review, and to implement provisions of Section 5111.225 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth payment provisions for Medicare Part A cost sharing for nursing facilities. This rule changes the medicaid maximum allowable amount from one hundred nine per cent of a nursing facility's per diem rate to one hundred per cent of the per diem rate.

Rescinded Rules

Rule **5101:3-3-21**, entitled Audits of nursing facility (NF) cost reports, sets forth the provisions governing audits of Medicaid cost reports for nursing facilities. This rule is being rescinded because the provisions in it are set forth in the Ohio Revised Code.

Rule **5101:3-3-69**, entitled Nursing facilities (NFs): method for establishing the fiscal year 2006 medicaid reimbursement rate for NFs, sets forth the method for establishing the Medicaid reimbursement rate for nursing facilities for fiscal year 2006. This rule is being rescinded because it sets forth the method for establishing the reimbursement rate for services provided in nursing facilities for the period beginning July 1, 2005 and ending June 30, 2006, and is therefore obsolete.

NFTL 12-01 (NF Chart of Accounts and Cost Report {REV. 09/2011})

Nursing Facility Transmittal Letter (NFTL) 12-01

January 11, 2011

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Nursing Facility Chart of Accounts and Cost Report

Amendment of Administrative Code Rules 5101:3-3-42 and 5101:3-3-42.1 (effective on or about January 20, 2012)

The following rule changes are being made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules, and section 119.032 of the Revised Code, which outlines procedures for the assignment of rule review dates.

Amended Rules

Rule **5101:3-3-42**, entitled **Nursing facilities (NFs): chart of accounts**, is being amended due to five year review, and to implement provisions of Sections 5111.20 and 5111.271 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth the Medicaid chart of accounts for nursing facilities. Changes to the chart of accounts are as follows:

On all 51 pages of the chart of accounts, the revision date in the header is being updated to 09/2011.

Account 2440 and throughout the chart of accounts: The revision date for CMS publication 15-1 is being removed from the account description because each section of that publication is revised independently, and there is no longer an overall date of revision for the entire publication.

Accounts 6205 Quality Assurance, 7110 Pharmaceutical Consultant, and 7291 Qualified Mental Retardation Professional: In the account descriptions, the edition dates and the website addresses for the applicable CFRs are being removed.

Account 6207 Behavioral and Mental Health Services: This is a new account number being added to direct care costs pursuant to Section 5111.20 of Am. Sub. H.B. 153, and includes new sub-accounts 6207.1 Behavioral and Mental Health Services salary and 6207.2 Behavioral and Mental Health Services contract.

Account 6322 Oxygen: The phrase "Beginning 09/01/09" is being removed from the account description because the language is no longer necessary.

Accounts 6600 through 6680.2: The notation "(only 08/01/09 forward)" is being removed from the account titles because the language is no longer necessary.

Account 7631 Resident Transportation: The phrase "For the period 08/01/09 - 08/17/09 and for 10/01/09 and forward" is being deleted from the account description because the language is no longer necessary. The sentence "Resident transportation costs for the period 08/18/09 - 09/30/09 are reimbursed on a direct bill basis if services were provided by a qualified medicaid transportation provider." is being deleted from the account description because the language is no longer necessary. Sub-accounts 7631.1 "Resident transportation salary" and 7631.2 "Resident transportation other" are being added to allow for the cost of salaries.

Account 7735 Custom Wheelchairs: The notation "(only 08/01/09 forward)" and the phrase "Beginning 08/01/09" are being removed from the account description because the language is no longer necessary.

Accounts 9600 through 9700.2: These accounts are being removed under Non-Reimbursable Expenses because, effective 8/01/09, these costs are reported using account numbers 6600 through 6645.2 under Direct Care Therapies. Accordingly, the leading paragraph under Non-Reimbursable Expenses is being modified to remove language that is no longer necessary.

Account 9720 Oxygen: This account is being removed because, effective 8/1/09, emergency stand-by oxygen is reported in account 6321 and all other oxygen is reported in account 6322.

Account 9730 Late Fees, Fines or Penalties: The language "Includes those fees, fines, or penalties" is being added to the account description for clarification. Language is also being added to the account description to include audit fines assessed pursuant to Section 5111.271 of the Ohio Revised Code.

Rule **5101:3-3-42.1**, entitled **Nursing facility (NF): medicaid cost report**, is being proposed for amendment due to five year review, and to implement provisions of Sections 5111.20 and 5111.331 of the Revised Code adopted under Amended Substitute House Bill 153 of the 129th General Assembly relating to the administration of the Medicaid program. This rule sets forth the Medicaid cost report for nursing facilities. The changes to the cost report general instructions, and schedules and attachments are as follows:

Cost Report General Instructions

The revision date for the cost report instructions is being updated from 01/2010 to 09/2011 in the footer and throughout the instructions.

The page numbers in the header of the cost report instructions are being updated because there are now 61 pages in the cost report instead of 63 due to the removal of Attachments 4 and 5, as described below.

On Page 2, under "Electronic Submission of the Medicaid Cost Report," the instructions are being modified to eliminate the option of selecting a vendor from an ODJFS approved list of vendors because such a list no longer exists.

On Page 2, under "Filing Requirements," the entity to which requests for an extension of the cost report filing deadline may be made is being updated to "Rate Setting and Cost Settling Unit, DDO, OHP."

On Page 2, under "Reasonable Cost," and on Page 18 under "Attachment 2, Adjustment to Trial Balance," the revision date for CMS publication 15-1 is being removed because each section of that publication is revised independently, and there is no longer an overall date of revision for the entire publication.

On Page 2, under "Reasonable Cost," and on Page 11 under "Religious Nonmedical Health Care Institution (RNHCI)," the revision dates for the applicable CFR citations are being removed.

On Page 4, under "Table of Cost Report Schedules," the title of Schedule E-1 is being modified to reflect the changes made to Schedule E-1 as described below. The references to Attachments 4 and 5 are being deleted to reflect the removal of those attachments from the cost report, and the page numbers for Attachments 6 through 8 are being updated accordingly.

On Page 5, under "Cost Report Instructions," the references to Attachments 4 and 5 are being deleted to reflect the removal of those attachments from the cost report, and the cost report page numbers for Attachments 6, 7, and 8 and the sequence numbers are being updated accordingly.

On Page 7, under "National Provider Identifier (NPI)," the instructions are being modified to eliminate language explaining the transition from previous health care identifiers to NPIs because all nursing facilities have made the transition.

On Page 9, under "Real Estate Investment Trust," the United States Code citation is being updated.

On Page 10, under "Nonprofit Corporation," two United States Code citations are being updated.

On Page 11, the definition of "Home for the Aging" is being removed because that care setting is no longer licensed by the Ohio Department of Health.

On Page 11, the definition of "Other Assisted Living/Nursing Home combination" is being modified to removed the reference to homes for the aging because that care setting is no longer licensed by the Ohio Department of Health.

On Page 12, under "Schedule A-1, Summary of Inpatient Days," the instructions for Column 1 are being modified to clarify that the beds certified by the Ohio Department of Health means those certified as nursing facility beds.

On Page 12, under "Schedule A-1, Summary of Inpatient Days," the definition of an inpatient day is being added to the instructions for Column 2.

On Pages 12 and 13, under "Schedule A-1, Summary of Inpatient Days," the instructions for Columns 3 and 4 are being modified to reflect the provisions of ORC 5111.331 adopted under H.B. 153 regarding hospital and therapeutic leave days, an applicable example is being added, column references are being changed to reflect changes made on Schedule A-1 as described below, and a note is being added that the calculation of inpatient days should round to two decimal places.

On Page 13, in the instructions for Column 5, column references are being changed to reflect changes made on Schedule A-1 as described below.

On Page 13, in the instructions for Columns 7, 8 and 9, the reference to Attachment 4 is being deleted because Attachment 4 is being eliminated for reasons described below.

On Page 13, in the instructions for Column 10, the definition of an inpatient day is being removed because it is being moved to Page 12.

On Page 13, language regarding the leave day limit and supplemental payment is being removed.

On Page 13, the instructions for Attachment 4, "Paid Nonmedicaid Leave Days" are being removed because Attachment 4 is being deleted as described below.

On Page 16, Attachment 5, "Nurse Aide Training Statistical Information" is being deleted because the information it collects is being collected by the Ohio Department of Health.

On Page 16, under "Schedule B-1, Tax Costs (Columns 1-4)," contract services and supplies are being removed as reportable expenses in Column 2.

On Page 18, under "Schedules B-1, B-2, C and D (Columns 4-7)," the phrase "limit the precision" is being replaced with "the allocation ratio should be calculated" in order to provide more accurate instructions.

On Page 22, under "Schedule C-2" "Page 1 of 2" and "Page 2 of 2," instructions are being added so that Social Security numbers are not required for non-profit or governmental facilities.

On Page 24, Position Code WH066 for Account 6207 "Behavioral and Mental Health Services" on Schedule B-2 is being added to the WH Code List, and Schedule B-2 line number references are being updated accordingly.

On Page 24, the notation "(only 08/01/09 forward)" is being removed from the titles for WH Codes WH030 throughWH035 and WH063 through WH065 because the notation is no longer necessary.

On Page 26, under "Schedule C-3, Cost of Services from Related Organizations," instructions are being added so that Social Security numbers are not required for non-profit or governmental facilities.

On Page 27, under "Schedule E-1, Equity Capital of Proprietary Providers," the instructions for lines 23 through 34 are being removed to reflect changes made to Schedule E-1 as described below. Accordingly, the header is being modified from "Schedule E-1, Return on Equity Capital of Proprietary Providers" to read "Schedule E-1, Equity Capital of Proprietary Providers," and the phrase "and the average equity capital amount" is being deleted from the end of the first sentence.

<u>Cost Report Schedules and Attachments</u>

The page numbers for all schedules and attachments are being updated due to the removal of Attachments 4 and 5, as described below.

Schedule A, Page 1 of 2: In the "Care Setting" box, "Home for the Aging" is being deleted because that care setting is no longer certified by the Ohio Department of Health.

Schedule A, Page 2 of 2: In the sentence under Chain Home Office Information box, the Code of Federal Regulations citation is being updated.

Schedule A-1: New columns 3b and 4b are being added for reporting hospital and therapeutic leave days that are paid at 18%, and the instructions at the top of Schedule A-1 are being updated to account for those days paid at 18%. The "Hospital Leave Days @ 50%" column is being re-numbered from 3 to 3(a), and the "Therapeutic Leave Days @ 50%" column is being re-numbered from 4 to 4(a). Also, a note is being added at the bottom of the page stating that all leave days should round to two decimal places.

Schedule A-2: In Section B, line 6, the reference to line 15 in Schedule B-2 is being changed to line 16 due to changes made to Schedule B-2 as described below.

Schedule B-2, Page 1 of 2: Account number 6207 "Behavioral and Mental Health Services" is being added, and line numbers and references are being updated accordingly. For account number 6322, the notation "(only 08/01/09 forward)" is being removed from the account title because the notation is no longer necessary. At the bottom of the page, the phrase "limit the precision" is being replaced with "the allocation ratio should be calculated" in order to provide more accurate instructions.

Schedule B-2, Page 2 of 2: Line numbers and references are being updated due to the addition of account number 6207 on Page 1 of this schedule. For the section "Direct Care Therapies," the notation "(only 08/01/09 forward)" is being removed from the section header and from the account titles on lines 38 through 49 because the notation is no longer necessary. In the sentence below line 58, the phrase "limit the precision" is being replaced with "the allocation ratio should be calculated" in order to provide more accurate instructions.

Schedule C, Page 1 of 3: At the bottom of the page, the phrase "limit the precision" is being replaced with "the allocation ratio should be calculated" in order to provide more accurate instructions.

Schedule C, Page 2 of 3: For account numbers 7631 and 7735, the notation "(only 08/01/09 forward)" is being removed from the account titles because the notation is no longer necessary. At the bottom of the page, the phrase "limit the precision" is being replaced with "the allocation ratio should be calculated" in order to provide more accurate instructions.

Schedule C, Page 3 of 3: Under "Non-Reimbursable Expenses," the following accounts are being removed because, effective 8/1/09, they are reimbursable expenses and are in Schedule B-2:

9600 Physical Therapist (only through 07/31/09)

9610 Physical Therapy Assistant (only through 07/31/09)

9620 Occupational Therapist (only through 07/31/09)

9630 Occupational Therapist Assistant (only through 07/31/09)

9640 Speech Therapist (only through 07/31/09)

9650 Audiologist (only through 07/31/09)

9660 Payroll Taxes -Therapy (only through 07/31/09)

9670 Workers' Compensation - Therapy (only through 07/31/09)

9680 Employee Fringe Benefits - Therapy (only through 07/31/09)

9690 EAP Administrator - Therapy (only through 07/31/09)

9695 Self Funded Program Admin. - Therapy (only through 07/31/09)

9700 Staff Development - Therapy (only through 07/31/09)

9720 Oxygen (only through 07/31/09)

Additionally in Schedule C, Page 3 of 3, line numbers are being updated due to the removal of the above accounts, and in one of the sentences at the bottom of the schedule, the phrase "limit the precision" is being replaced with "the allocation ratio should be calculated" in order to provide more accurate instructions.

Schedule C-2, Page 1 of 2 and Page 2 of 2: In the instructions, language is being added so that Social Security numbers are not required for non-profit and governmental facilities.

Schedule C-3, Page 1 of 3, Page 2 of 3, and Page 3 of 3: Notes have been added stating that Social Security numbers are not required for non-profit and governmental facilities.

Schedule D: At the bottom of the page, the phrase "limit the precision" is being replaced with "the allocation ratio should be calculated" in order to provide more accurate instructions.

Schedule E-1: Section B of this schedule is being deleted because the data it collects is not necessary for the administration of the Medicaid program. Accordingly, the title of this schedule is being changed from "Return

on Equity Capital of Proprietary Providers" to "Equity Capital of Proprietary Providers," and column references in line 22 are being removed.

Attachment 3: In the instructions for Exhibit 3, the revision date for CMS publication 15-1 is being removed because each section of that publication is revised independently, and there is no longer an overall date of revision for the entire publication.

Attachment 4: This attachment is being deleted because the data it collects is not necessary for the administration of the Medicaid program.

Attachment 5: This attachment is being deleted because the data it collects is also collected by the Ohio Department of Health.

Attachment 6, Page 1 of 2: Account number 6207 "Behavioral and Mental Health Services" is being added, and line numbers and references are being updated accordingly. Under the section "Direct Care Therapies," the notation "(only 08/01/09 forward)" is being removed from the account titles on lines 20 through 28 because the notation is no longer necessary.

Attachment 6, Page 2 of 2: Line numbers and references are being updated due to the addition of account number 6207 on Page 1 of this schedule. Account number 7631 "Resident Transportation" is being added under the section "Administration and General Services" to allow for the cost of salaries.

NFTL 10-06 (Successor Liability Rules for NFs)

Nursing Facility Transmittal Letter (NFTL) 10-06

September 21, 2010

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Successor Liability Rules for NFs

Proposed Adoption of Administrative Code Rules 5101:3-3-32, 5101:3-3-32.1, and 5101:3-3-32.2 (effective on or about November 29, 2010)

The following are proposed rule changes made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for Adoption

The following rules are being proposed for adoption in order to implement provisions of Amended Substitute House Bill 398 of the 128th General Assembly.

Rule **5101:3-3-32** entitled Debt estimation methodology for change of operator, facility closure, voluntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) sets forth the methodology used to estimate the actual and potential debts owed to ODJFS and CMS by the exiting operator of a NF or ICF-MR in cases of a change of operator, facility closure, voluntary termination, or voluntary withdrawal from the Medicaid program.

Rule **5101:3-3-32.1** entitled Debt estimate and debt summary report procedure for change of operator, facility closure, voluntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) sets forth the procedure used to issue the debt estimate and the debt summary reports for NFs and ICFs-MR in cases of a change of operator, facility closure, voluntary termination, or voluntary withdrawal from the Medicaid program.

Rule **5101:3-3-32.2** entitled Successor liability agreements for operators of nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) sets forth approval and signature provisions for successor liability agreements for NFs and ICFs-MR.

If no revisions occur, the above rule will become effective on or about November 29, 2010.

NFTL 10-05 (Emergency Rule: Debt Estimation Methodology)

Nursing Facility Transmittal Letter (NFTL) 10-05

September 2, 2010

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Emergency Rule: Debt Estimation Methodology

Adoption of Emergency Rule 5101:3-3-32 (effective August 31, 2010 - November 28, 2010)

The following rule change is being made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Adoption of Emergency Rule

Rule **5101:3-3-32** entitled Debt estimation methodology for change of operator, facility closure, voluntary termination, or voluntary withdrawal for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) sets forth the methodology used to estimate the actual and potential debts owed to the Ohio Department of Job and Family Services (ODJFS) and the United States Centers for Medicare and Medicaid Services (CMS) by the exiting operator of a NF or ICF-MR in cases of a change of operator, facility closure, voluntary termination, or voluntary withdrawal from the Medicaid program. This rule is being adopted on an emergency basis in order to comply with provisions required by Amended Substitute House Bill 398.

NFTL 10-04 (Provider Agreement Rules for NFs)

Nursing Facility Transmittal Letter (NFTL) 10-04

December 6, 2010

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Provider Agreement Rules for NFs

Proposed Amendment of Administrative Code Rules 5101:3-3-02.1, 5101:3-3-02.2, 5101:3-3-02.3, and 5101:3-3-02.4 (effective on or about February 15, 2011)

The following are proposed rule changes made in accordance with section 119.032 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for Amendment

Rule **5101:3-3-02.1** entitled Length and type of long term care provider agreements sets forth the length and type of provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). This rule is being proposed for amendment due to five-year review. Changes to this rule include the following: in paragraph (A)(1) the word "nursing" is being changed to the phrase "long term care" so that the definition of "reasonable assurance period" applies to ICFs-MR as well as to NFs; in paragraph (B) the phrase "developmentally disabled" is being deleted in order to conform to current federal terminology; also in paragraph (B), and throughout the rule, the acronym "ICFs-MR/DD" is being changed to "ICFs-MR" in order to conform to current federal terminology; in paragraph (B)(2)(a) the existing provision is being identified as applying in cases of initial certification of ICFs-MR; in paragraph (B)(2) language is being added that explains existing procedure requiring satisfaction of the reasonable assurance period in cases when an ICF-MR wants to re-enter the Medicaid program following involuntary termination by CMS; in paragraph (C)(4)(b) the phrase "except as specified in paragraph (D) of this rule" is being added so that the term extensions described in paragraph (D) are exceptions to the 12-month limit on time-limited agreements for ICFs-MR; in paragraph (D)(3)(a) new language is being added that explains existing policy whereby, in cases of a term extension for an ICF-MR, the time period of a subsequent provider agreement is reduced by the number of months by which the first provider agreement was extended; and citations, grammar, and punctuation are being corrected throughout the rule.

Rule **5101:3-3-02.2** entitled Termination, denial, and non-renewal of long term care provider agreements sets forth the provisions for termination, denial, and non-renewal of provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). This rule is being proposed for amendment due to five-year review. Changes to this rule include the following: in paragraph (A)(1) the phrase "developmentally disabled" is being deleted in order to conform to current federal terminology; also in paragraph (A)(1), and throughout the rule, the acronym "ICF-MR/DD" is being changed to "ICF-MR" in order to conform to current federal terminology; in paragraph (B) the phrase "pursuant to division (B) of section 5111.06 of the Revised Code" is being deleted to better clarify the authority for termination, denial, or non-renewal of provider agreements; also in paragraph (B) the phrase "or shall in certain circumstances" is being deleted in order to clarify departmental policy; in paragraph (B)(1) the phrase "According to section 5111.22 of the Revised Code" is being added in order to give the statutory authority under which ODJFS may terminate, deny, or not renew a provider agreement if ODJFS determines such an agreement is not in the best interest of the state or Medicaid residents of long term care facilities; also in paragraph (B)(1), and in paragraph (B)(2), the wording is being changed in order to more precisely express existing policy; paragraph (B)(2)(j) is being deleted because that provision is being moved to new paragraph (C)(1)(g) as one of the reasons for which ODJFS shall terminate, deny, or not renew a provider agreement; the ORC citation in paragraph (C) is being moved to paragraph (C)(1) in order to clarify the provisions to which the citation applies; language in paragraph (C)(1) is being changed so that the reasons for which ODJFS shall terminate, deny, or not renew a provider agreement are more inclusive; in paragraphs (D)(1) and (D)(2) references to the Revised Code are

being added in order to give the statutory authority under which ODJFS takes the actions described in these paragraphs; paragraph (E) is being added in order to explain existing policy regarding the reasonable assurance period; and citations, grammar, and punctuation are being corrected throughout the rule.

Rule **5101:3-3-02.3** entitled Institutions eligible to participate in Medicaid as nursing facilities (NFs) or intermediate care facilities for the mentally retarded (ICFs-MR) sets forth the eligibility provisions for institutions to participate in the Medicaid program as NFs or ICFs-MR. This rule is being proposed for amendment due to five-year review. Changes to this rule include the following: in the title and in paragraph (A)(3) the phrase "developmentally disabled" is being deleted in order to conform to current federal terminology; also in the title, and throughout the rule, the acronym "ICFs-MR/DD" is being changed to "ICFs-MR" in order to conform to current federal terminology; paragraphs (D), (E), and (F) are being restructured in order to conform to LSC rule drafting guidelines; in new paragraph (D)(1) reference to the Cincinnati Department of Health is being deleted since that department no longer licenses nursing homes; paragraph (E)(2), which lists veterans' homes operated under Chapter 5907. of the Revised Code and RNHCIs as institutions exempt from mandatory dual participation, is being deleted because this information is contained in OAC rule 5101:3-3-02.4; in paragraph (F)(1) the phrase "Ohio department of mental retardation and developmental disabilities" is being changed to "Ohio department of developmental disabilities" in order to reflect that agency's recent name change; also in paragraph (F)(1), and throughout the remainder of the rule, the acronym "ODMR/DD" is being changed to "DODD" in order to reflect the agency's name change; in paragraph (G)(2)(b) language is being added as clarification that the exception described also applies in cases of a change of operator; and citations and punctuation are being corrected throughout the rule.

Rule **5101:3-3-02.4** entitled Mandatory dual participation by nursing facilities (NFs) in the medicare program sets forth the requirements for mandatory and full participation of NFs in both the Medicare and Medicaid programs. This rule is being proposed for amendment due to five-year review. Changes to this rule include the following: in the title the word "dual" is being added in order to clarify the requirement that NFs participate in both the Medicare and Medicaid programs; in paragraph (C)(2) language is being added regarding termination or non-renewal of an operator's provider agreement for failure to ensure full participation in the Medicare program; paragraph (D) is being deleted because all non-excluded facilities have made the transition to dually and fully participating SNF/NFs in both the Medicare and Medicaid programs; in new paragraphs (D)(1), (D)(2), and (E)(1) the phrase "On or after October 1, 2005" is being deleted because the date was for transition purposes only and is no longer necessary; in new paragraph (D)(3) "CMS" is being changed to "the centers for medicare and medicaid services (CMS)" in order to follow LSC rule drafting guidelines; in paragraph (E)(2) the effective date of April 1, 2006 is being deleted because the date was for transition purposes only and is no longer necessary; the provisions in paragraphs (E)(2)(a) and (E)(2)(b) are being moved to new paragraphs (E)(2) and (E)(3) due to rule restructuring; and citations and punctuation are being corrected throughout the rule.

If no revisions occur, the above rules will become effective on or about February 15, 2011.

NFTL 10-03 (Proposed Amendment of Rules 5101:3-3-01, 5101:3-3-43.3, and 5101:3-3-43.4; Proposed Rescission and Adoption of Rules 5101:3-3-43.1, and 5101:3-3-43.2 (Effective on or About October 1, 2010))

Nursing Facility Transmittal Letter (NFTL) 10-03

August 2, 2010

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: PROPOSED AMENDMENT OF RULES 5101:3-3-01, 5101:3-3-43.3, AND 5101:3-3-43.4 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT OCTOBER 1, 2010)

PROPOSED RESCISSION AND ADOPTION OF RULES 5101:3-3-43.1, AND 5101:3-3-43.2 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT OCTOBER 1, 2010)

The following rules are being proposed for amendment, rescission, and adoption pursuant to Section 119.032 of the Revised Code.

Proposed for Amendment

Rule **5101:3-3-01** entitled Definitions, is being proposed for amendment to accommodate the October 1, 2010 implementation of the Minimum Data Set Version 3.0 (MDS 3.0) resident assessment instrument (RAI) by the Centers for Medicare and Medicaid Services (CMS). The RAI is the assessment tool used in Ohio to measure resident acuity, is the foundation for planning and delivering care to NF residents, and is used in the calculation of NF reimbursement rates. This rule defines terms in Chapter 5101:3-3 of the Administrative Code except as otherwise provided in that chapter. This rule defines terms relating to reimbursement and case mix resident acuity for services provided by nursing facilities (NFs). This rule also defines terms relating to reimbursement for services provided by intermediate care facilities for the mentally retarded (ICFs-MR). The proposed amendments to the rule are as follows:

In paragraph (B) of the proposed rule, the definition of ancillary and support costs was changed to refer to rule 5101:3-3-42 of the Administrative Code. In paragraph (D) of the proposed rule, language was added to delineate the definition of "Capital Costs" by provider type. In paragraph (H) of the proposed rule, language was added to clarify that the cost per case mix unit for NFs is determined at least once every ten years for a peer group while the cost per case mix unit for ICFs-MR is determined annually. In paragraph (I) of the proposed rule, a typographical error was corrected. In paragraph (Q) of the proposed rule, the version number was removed from the Minimum Data Set (MDS) RAI. In paragraphs (Q) and (HH) of the proposed rule, the version number was removed from the Resource Utilization Group (RUG) case mix classification system. The MDS version and the RUG version will be specified in Administrative Code rules 5101:3-3-43.1 and 5101:3-3-43.2 respectively. In paragraph (EE) of the proposed rule, NF was removed from the definition of non-extensive renovation as this only applies to ICF-MR providers.

Rule **5101:3-3-43.3** entitled Calculation of Quarterly, Semiannual and Annual Nursing Facility (NF) Average Case Mix Scores, is being proposed for amendment to comply with the five year rule review requirements of ORC section 119.032 and to accommodate the October 1, 2010 implementation of the MDS 3.0 by CMS. This rule sets forth the process for determining NF average case mix scores on a quarterly, semiannual, and annual basis. These scores are used in the calculation of NF reimbursement rates. The proposed amendments to the rule are as follows:

In paragraph (C)(1)(d) of the proposed rule, a statement was added indicating the other Medicare required assessments (OMRAs) may be excluded from calculating case mix scores due to the inability to assign an assessment record to a RUG III classification. In paragraphs (D)(4), (D)(4)(a), and (D)(4)(b) of the proposed rule, "shall" was changed to "may" for consistency. In paragraph (G)(4) of the proposed rule, "discharge and reentry tracking forms" was changed to "discharge assessments and reentry tracking forms" to add clarity. In paragraph (H) of the proposed rule, an extra week was added to the timeframe for providers to correct MDS

submissions between the first and second preliminary "Calculation of Facility Case Mix Scores" reports. References to MDS 2.0 were changed to MDS 3.0 throughout the proposed rule to accommodate the October 1, 2010 implementation of the MDS 3.0 by CMS.

Rule **5101:3-3-43.4** entitled Exception Review Process for Nursing Facilities (NFs), is being proposed for amendment to comply with the five year rule review requirements of ORC section 119.032 and to accommodate the October 1, 2010 implementation of the MDS 3.0 by CMS. This rule sets forth protocols for the exception review process for NFs. Exception review is a review of MDS assessment data conducted at a selected 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 in the calculation of NF reimbursement rates. The proposed amendments to the rule are as follows:

In paragraph (A)(7) of the proposed rule, "nursing rehabilitation/restorative care" was changed to "restorative nursing programs, current toileting program or trial, and/or bowel toileting program", and "depression" was changed to "symptoms of depression" to comport with terminology used in the most current version of the MDS. In paragraph (O)(2)(b) of the proposed rule, agency bureau and section names were updated to reflect the recent reorganization within the agency. References to the MDS version were eliminated throughout the proposed rule to accommodate the October 1, 2010 transition to MDS 3.0 by CMS.

Proposed for Rescission and Adoption

Rule **5101:3-3-43.1** entitled Nursing facility (NF) Case Mix Assessment Instrument: Minimum Data Set Version 2.0 (MDS 2.0), is being proposed for rescission and a new rule with the same number entitled Nursing facility (NF) Case Mix Assessment Instrument: Minimum Data Set Version 3.0 (MDS 3.0) is being proposed for adoption. This rule sets forth the MDS 3.0 RAI specified by the state and published by CMS. The RAI is the foundation for planning and delivering care to NF residents. The RAI data is used in the calculation of NF reimbursement rates. The new proposed rule includes MDS 3.0 item and section references and incorporates MDS 3.0 terminology. Definitions for "assessment reference date (ARD)", "care area assessment (CAA) process", "Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)", "other Medicare required assessments (OMRAs)", and "PPS assessment" were added to the proposed rule. The definition of "comprehensive assessment" was updated to include the care area assessment (CAA) process. The CAA process replaces the former resident assessment triggers, resident assessment protocols (RAPs) and resident assessment summary associated with the former MDS 2.0 RAI. The definitions for "locked" record and "MDS 2.0 correction request form" (CRF) were omitted from the new rule to eliminate obsolete terminology. New language was added to the definition of "resident identifier code" to explain how the identifier code is constructed. The proposed rule specifies the RAI data ODJFS shall use in assigning a RUG III classification and determining Medicaid payment rates for NFs, the requirements for NFs to submit encoded, accurate, and complete MDS 3.0 data for all residents of Medicaid certified NF beds, and the criteria for submission of MDS 3.0 corrections. The proposed rescission and adoption are to accommodate the October 1, 2010 implementation of the MDS 3.0 by CMS.

Rule **5101:3-3-43.2** entitled Resource Utilization Groups, Version III (RUG III): the Nursing Facility Case Mix Payment System is being proposed for rescission and a new rule with the same number and title is being proposed for adoption. This rule contains the RUG III NF case mix direct care payment system that is used to classify NF residents into forty-four resource utilization groups. Placement into RUG classifications is one of the factors used in the calculation of NF reimbursement rates. The proposed rule rescission and adoption is to accommodate the October 1, 2010 implementation of the MDS 3.0 by CMS. The new proposed rule includes MDS 3.0 item and section references and incorporates MDS 3.0 terminology.

The above rules are being proposed for amendment, rescission, or adoption as indicated above. Should revisions to the proposed rules occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions to the rules occur, the aforementioned rules will become effective on or about October 1, 2010.

NFTL 10-02 (FPF Rules for NFs)

Nursing Facility Transmittal Letter (NFTL) 10-02

August 18, 2010

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Proposed Rescission of Administrative Code Rules 5101:3-3-30, 5101:3-3-30.1, 5101:3-3-30.2, and 5101:3-3-30.3 (effective on or about October 15, 2010)

Proposed Adoption of Administrative Code Rules 5101:3-3-30.1 and 5101:3-3-30.2 in Conjunction with Rescission of Rules by the Same Number (effective on or about October 15, 2010)

Proposed Amendment of Administrative Code Rule 5101:3-3-30.4 (effective on or about October 15, 2010)

The following rules are being proposed for rescission, adoption, or amendment pursuant to section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Proposed for Rescission

The following rules are being proposed for rescission because most of the provisions in them exist in Sections 3721.50 to 3721.58, 5112.30 to 5112.35, and 5112.37 to 5112.39 of the Ohio Revised Code (ORC). Provisions in these rules that do not exist in the ORC are being moved to proposed new rules 5101:3-3-30.1 and 5101:3-3-30.2.

Rule **5101:3-3-30** entitled Beds and facilities subject to the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD) identifies beds and facilities subject to the franchise permit fee for NFs, NHs, long term care hospital beds, and ICFs-MR. This rule is being proposed for rescission because most of the provisions in it are set forth in the ORC.

Rule **5101:3-3-30.1** entitled Calculation, billing, payment remittance, and appeal process for the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD) establishes the calculation method, billing cycle, payment remittance procedure, and appeal process for the franchise permit fee for NFs, NHs, long term care hospital beds, and ICFs-MR. This rule is being proposed for rescission because most of the provisions in it are set forth in the ORC. Provisions not contained in the ORC are being moved to proposed new rules 5101:3-3-30.1 and 5101:3-3-30.2.

Rule **5101:3-3-30.2** entitled Enforcement of the franchise permit fee (FPF) program for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD) sets forth the procedures for enforcement of the franchise permit fee program for NFs, NHs, long term care hospital beds, and ICFs-MR. This rule is being proposed for rescission because the provisions in it are set forth in the ORC.

Rule **5101:3-3-30.3** entitled Distribution method for franchise permit fee (FPF) proceeds from nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD) sets forth the distribution method for franchise permit fee proceeds from NFs, NHs, long term care hospital beds, and ICFs-MR. This rule is being proposed for rescission because the provisions in it are set forth in the ORC.

Proposed for Adoption in Conjunction with Rescission of a Rule by the Same Number

Rule **5101:3-3-30.1** entitled Appeal of the franchise permit fee (FPF) determination sets forth the procedure for appealing a FPF determination that has been submitted in accordance with sections 3721.55 and 5112.35

of the Revised Code. The provisions in this rule are being moved from rule 5101:3-3-30.1, which is being proposed for rescission, and do not exist in the ORC.

Rule **5101:3-3-30.2** entitled Prohibition against billing residents for the franchise permit fee (FPF) sets forth the prohibition against directly billing or directly passing through the FPF to residents of NFs, NHs, hospitals, or ICFs-MR. The provisions in this rule are being moved from rule 5101:3-3-30.1, which is being proposed for rescission, and do not exist in the ORC.

Proposed for Amendment

Rule **5101:3-3-30.4** entitled Procedure for terminating the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), long term care hospital beds, and intermediate care facilities for the mentally retarded (ICFs-MR) sets forth the procedure for terminating the franchise permit fee for NFs, NHs, long term care hospital beds, and ICFs-MR if the Centers for Medicare and Medicaid Services (CMS) determines the FPF is an impermissible health care related tax. Changes to the rule are as follows:

In the title and in paragraph (B) the word "assessment" is being deleted in order to conform more closely to statutory language; the term "developmentally disabled" is being deleted from the title in order to conform to current federal terminology, and the acronym "ICF-MR/DD" is being changed to "ICF-MR" throughout the rule; references to Ohio Administrative Code rules proposed for rescission are being replaced throughout the rule with references to the applicable Ohio Revised Code sections; in paragraph (D)(1)(d)(i) the term "nursing homes" is being replaced with the acronym "NHs," and in paragraph (D)(1)(d)(ii) the term "nursing home" is being replaced with the acronym "NH" in order to follow rule drafting convention; also in paragraph (D)(1)(d)(i) the acronym "SN" is being replaced with "NF" in order to correct a typographical error, and the acronym "SNF/NF" is being replaced with the phrase "skilled nursing facility/nursing facility (SNF/NF)" in order to follow rule drafting convention; and in paragraph (D)(3)(a)(iii) the phrase "claims payment offsets for subsequent dates of service" is being changed to "offsets of future payments" in order to clarify departmental procedure.

If no revisions occur, the above rules will become effective on or about October 15, 2010.

NFTL 09-06 (Proposed Amendment of Rule 5101:3-3-43.1)

Nursing Facility Transmittal Letter (NFTL) 09-06

January 22, 2010

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: PROPOSED AMENDMENT OF RULE 5101:3-3-43.1 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT APRIL 3, 2010)

The following rule is being proposed for amendment pursuant to Section 119.032 of the Revised Code (ORC), which requires the review of all state agency rules within a five year period.

Rule **5101:3-3-43.1** entitled "Nursing facility (NF) case mix assessment instrument: minimum data set version 2.0 (MDS 2.0)" explains the resident assessment instrument used to assess resident acuity in nursing facilities for Medicaid reimbursement purposes. Corrections of MDS data submitted by nursing facilities will occur within 45 days instead of 80 days starting October 16, 2009 as set forth in ORC section 5111.232 of Amended Substitute House Bill 1 of the 128th General Assembly. Changes to the proposed rule are as follows:

In paragraph (B), the phrase "effective October 1, 2000 and thereafter" has been deleted; in paragraph (C), the phrase "Effective July 1, 1998" has been deleted; in paragraph (C)(2), "paragraphs (D) and (E)" has been changed to "paragraph (D)"; in paragraph (C)(3), "after the eightieth day after the RPED" has been changed to "after the forty-fifth day after the RPED"; in paragraph (C)(7), the date of the MDS 2.0 manual has been corrected from "2005" to "2002"; "eighty days" has been changed to "forty-five days" throughout the rule; website addresses have been updated throughout the rule; and dated references have been updated to reflect recently updated data.

The above rule is being proposed for amendment as indicated above. Should revisions to the proposed amendments occur as a result of a rule action taken during the hearing process, you will be notified in a subsequent transmittal letter at that time. Should no rule action occur during the hearing process, the proposed amendments will become effective on or about April 3, 2010.

NFTL 09-05 (Provider Agreements and Emergency Management Plan for NFs)

Nursing Facility Transmittal Letter (NFTL) 09-05

April 20, 2010

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Provider Agreements and Emergency Management Plan for NFs

Proposed amendment of rule 5101:3-3-02 of the Administrative Code (effective on or about June 20, 2010)

Proposed adoption of rule 5101:3-3-02.7 of the Administrative Code in conjunction with rescission of a rule by the same number (effective on or about June 20, 2010)

Proposed rescission of rule 5101:3-3-02.7 of the Administrative Code (effective on or about June 20, 2010)

Emergency Preparedness Resources

Attached are proposed rule changes made in accordance with section 119.032 of the Ohio Revised Code, which outlines the procedures for the amendment, adoption, and rescission of administrative rules.

Proposed for amendment

Rule **5101:3-3-02** **"Provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"** contains the provider agreement provisions for NFs and ICFs-MR. This rule is being proposed for amendment due to five-year review. Changes to this rule include the following: in paragraph (A) the definition of closure has been expanded for additional clarity; also in paragraph (A) the definitions of continuing care, failure to pay, and Medicaid eligible have been changed for additional clarity; in paragraph (B)(3) the provider agreement has been added as a document with which providers must comply; in paragraph (B)(8)(c)(iv) the word "persons" has been replaced with "individuals" in order to reflect current terminology; in paragraph (B)(9) reference to the July 1, 1997 effective date has been removed; in paragraphs (B)(9)(b) and (B)(9)(c)(i) the phrase "vendor payment" has been replaced with "medicaid payment" in order to reflect current terminology; in paragraph (B)(11)(a) the word "provider" has been replaced with the phrase "operator or owner and entering operator" in order to clarify who is required to give notice of a change of operator; also in paragraph (B)(11)(a) language has been added regarding the requirement for a 90-day notice when residents are relocated and penalties for lack of proper notice in cases of a change of operator; language has been inserted at (B)(11)(d) regarding assignment of an exiting operator's provider agreement to the entering operator; in paragraph (B)(14) language has been added requiring notice to ODJFS and the Attorney General's Office within thirty days of any bankruptcy or receivership pertaining to the provider; also in paragraph (B)(14) a provision requiring that notice of bankruptcy or receivership also be mailed to the Office of the Attorney General has been added; language has been inserted at (C)(4) that describes the requirements for a NF provider who voluntarily withdraws from the Medicaid program; in paragraph (D) the language regarding closure or voluntary withdrawal of an ICF-MR has been changed to provide additional clarity; in paragraph (E)(3) new language has been added to clarify the issue of pre-admission deposits for individuals whose Medicaid eligibility is pending; paragraph (I) has been revised to clarify the function of the JFS 09401; rule references and other citations throughout the rule have been updated and corrected as necessary; and corrections to grammar and punctuation have been made throughout the rule.

Proposed for adoption in conjunction with rescission of a rule by the same number

Rule **5101:3-3-02.7** **"Emergency management and resident relocation plan for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"** contains the provisions for facility management and resident relocation for NFs and ICFs-MR in case of emergencies. This rule is being

proposed for adoption due to five-year review. It replaces rescinded rule 5101:3-3-02.7. Changes include the following: new paragraph (A) sets forth the purpose of the rule; new paragraph (B) sets forth the definition of "emergency"; and subsequent paragraphs contain requirements for the preparation and communication of the written emergency relocation plan, the components of the plan, notification, compliance and reimbursement, and termination of NF services.

Proposed for rescission

Rule **5101:3-3-02.7 "Emergency management and resident relocation plan for long term care facilities"** contains the provisions for facility management and resident relocation for NFs and ICFs-MR in case of emergencies. This rule is being proposed for rescission due to five-year review. It is being replaced by new rule 5101:3-3-02.7.

If no revisions occur, the above rules will become effective on or about June 20, 2010.

Emergency Preparedness Resources

The following emergency preparedness documents are available for download from the CMS website, and may be used as resources by administrators of nursing facilities. They are available at web address **http://www.cms.hhs.gov/SurveyCertEmergPrep/03_HealthCareProviderGuidance.asp#TopOfPage:**

1. "Survey and Certification Emergency Preparedness Checklist - Recommended Tool for Effective Health Care Facility Planning"
2. "Survey and Certification Emergency Planning Checklist - Recommended Tool for Persons in Long-Term Care Facilities"

NFTL 09-03 (Rules 5101:3-3-20, 5101:3-3-42, 5101:3-3-42.1 and 5101:3-3-42.4)

Nursing Facility Transmittal Letter (NFTL) 09-03

December 21, 2009

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: PROPOSED AMENDMENT OF RULES 5101:3-3-20, 5101:3-3-42, AND 5101:3-3-42.1 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT JANUARY 31, 2010), AND RULE 5101:3-3-42.4 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT FEBRUARY 14, 2010)

The following rules are being proposed for amendment pursuant to Section 119.032 of the Revised Code.

Rule **5101:3-3-20**, entitled "Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements" sets forth the requirement for the timely filing of cost reports by NFs and ICFs-MR, the methodology for processing those reports by ODJFS, and penalties that may be applied for failure to file cost reports as required. Changes to the proposed rule are as follows:

In the leading paragraph, the revision date for the NF cost report is being changed from "rev. 01/2007" to "Rev. 1/2010".

Language is being modified to more clearly state the existing policy regarding the assessment of a penalty for the late filing of a cost report. The proposed language states that late file penalties are assessed beginning with the start of the thirty day termination period and ending when a complete and adequate cost report is filed or the provider agreement is terminated. In paragraph (D) of the proposed rule, language is being stricken to remove the requirement that in order to file there must be a change in the total per diem cost of the applicable cost center by ten cents or more per patient day. A reference to section 5111.27 of the Revised Code is being added to paragraph (D) making it clear that the ODJFS review is conducted in accordance with section 5111.27 of the Revised Code.

The proposed amendments to rules **5101:3-3-42**, **5101:3-3-42.1**, **and** **5101:3-3-42.4** bring the NF cost report and chart of accounts in line with the changes implemented in Amended Substitute House Bill 1 and Ohio Ambulance and Medical Transportation Association v. Lumpkin, Case No. 09CVH-07-11498, Franklin County Common Pleas Court. The impact of the proposed changes to these rules will not be reflected in NF rates until the affected cost reports are used to rebase NF prices.

Rule **5101:3-3-42**, entitled "Nursing facilities (NFs): chart of accounts", sets forth the chart of accounts (Appendix A) for nursing facilities. The rule text is not being revised; however, the existing Appendix A, entitled "Chart of Accounts" is being rescinded and a new Appendix A with the same title is being enacted. The changes to the "Chart of Accounts" are as follows:

Pursuant to Am. Sub. H.B. 1, section 5111.20 (H)(2), "direct care costs" now include oxygen, over-the-counter pharmacy products, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists and audiologists. The leading paragraph under Medical Supplies is being changed to add, "Beginning 08/01/09 report over-the-counter pharmacy product expenses in account 6301 or account 6311 pursuant to rule 5101:3-9-03 (J) of the Administrative Code. For those facilities participating in medicaid and not in medicare, all medical supplies are to be classified in account 6311. For those facilities participating in both the medicare and medicaid programs, medical supplies must be categorized and classified as follows:"

Account 6321 is being changed to read as follows:

6321 Oxygen - Emergency stand-by only

A new account for oxygen is being added as follows:

6322 Oxygen

Beginning 08/01/09 report all oxygen other than emergency stand-by oxygen in this account. This includes contents of oxygen cylinders or tanks, including liquid oxygen, oxygen producing machines (concentrators) for specific use by an individual recipient, and costs of equipment associated with oxygen administration, such as: carts, regulators/humidifiers, cannulas, masks, and demurrage, pursuant to rule 5101:3-3-19 of the Administrative Code.

The therapies are being added to the chart of accounts as numbers 6600, 6605, 6610, 6615, 6620, and 6630 respectively under a new section, "Direct Care Therapies". Beginning 08/01/09 use these accounts to report therapies. Account numbers 6640 through 6680.2 are being added to include such items as payroll taxes, employee fringe benefits, and staff development related to the "Direct Care Therapies".

Account number 6205 is being revised to delete the second paragraph referring to Cincinnati Municipal Code, Chapter 847, as this chapter has been repealed.

Under account number 7271, an incorrect sub-account number 7761.2 is being corrected to 7271.2.

In the description for account number 6330, reference to the version number of the minimum data set (MDS) resident assessment instrument is being deleted and replaced with a reference to the current version of the resident assessment instrument.

Account numbers 7055 and 7056 are being revised to delete the last sentence of each account description excluding "peptamen enteral nutritional therapy" and "parenteral nutritional therapy" because these services are now reimbursed to the nursing facility through the per diem payment.

Pursuant to Am. Sub. H.B. 1, section 5111.20 (B) and Ohio Ambulance and Medical Transportation Association v. Lumpkin, Case No. 09CVH-07-11498, Franklin County Common Pleas Court, "ancillary and support costs" now include "wheelchairs" and "resident transportation". To address this, account numbers 7735 and 7631 are being added as follows:

7735 Custom Wheelchairs (only 08/01/09 forward)

Beginning 08/01/09 this account includes the cost of all custom wheelchairs and related repairs. Report all expenses related to wheelchairs in this account except for those wheelchairs that meet capitalization guidelines.

7631 Resident Transportation

For the period 08/01/09 - 08/17/09 and for 10/01/09 and forward report all transportation expenses in this account except for expenses related to assets which meet capitalization guidelines and should be reported as capital assets in account 8050. Resident transportation costs for the period 08/18/09 - 09/30/09 are reimbursed on a direct bill basis.

Under the "non-reimbursable expenses" account category, account numbers 9600 through 9700.2 have been revised to indicate they are valid only through 07/31/09 and that beginning 08/01/09 "direct care therapy" account numbers 6600 through 6680.2 should be used. Account 9720 is being revised to read as follows:

9720 Oxygen - (only through 07/31/09). Beginning 08/01/09 and forward report all oxygen other than emergency stand-by oxygen in account number 6322. Emergency stand-by oxygen should be reported in account number 6321.

Two new revenue accounts are being added as follows:

5180 Resident Transportation

5190 Wheelchairs

References to the Code of Federal Regulations (CFR) are being updated throughout the chart of accounts to reflect the current CFR revision date.

Rule **5101:3-3-42.1**, entitled "Nursing Facility (NF): medicaid cost report", sets forth the medicaid cost report for nursing facilities. The existing Appendix A is being rescinded and a new Appendix A with the same title is being enacted. The changes to the NF cost report and related instructions are as follows:

General Cost Report Instructions

The revision dates for the cost report form and related cost reporting instructions are being updated from 01/2007 to 01/2010. Line number references throughout the instructions have been updated.

Lines 6, 7 and 8 are being deleted from the instructions for Schedule C-1 because the automated cost report software completes these lines automatically.

On page 24 of 63, under the heading "Position Number for Owners/Relatives of Owner", lines are being added for the five-digit "WH Code" position numbers for the "direct care therapies" and the related payroll taxes, employee fringe benefits, and staff development costs that are being added to Schedule B-2, Page 2 of 2.

Schedules and Attachments

Line numbers throughout the cost report are being renumbered to accommodate new or moved line items. Other changes to the cost report schedules and attachments are as follows:

Schedule A-1: A new column 6 is being added to accommodate "Medicaid managed care days". The heading of column 9 is being changed to read, "Medicare managed care, veteran and other days". The cost report instructions are being updated accordingly.

Schedule A-2: Reference lines on this schedule are being changed to reflect changes made on Schedules B-2 and C as described below.

Schedule A-3: Reference lines on this schedule are being changed to reflect changes made on Schedules B-2 and C as described below.

Schedule B-2, Page 1 of 2: Account number 6322 is being added for "Oxygen" beginning 08/01/09, to report all oxygen other than emergency stand-by oxygen.

Schedule B-2, Page 2 of 2: a new section, "Direct Care Therapies", Lines 37 through 49 are being added for reporting costs beginning 08/01/09 and forward for physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, audiologists and related payroll taxes, employee fringe benefits, and staff development costs.

Schedule C, Page 2 of 3: Two new chart of accounts titles are being added to this schedule for 08/01/09 and forward. Chart of accounts number 7631 for "resident transportation" is on line 51 and account number 7735 for "custom wheelchairs" is on line 71.

Schedule C, Page 3 of 3: The account titles on lines 82 through 93 and line 97 are being changed to indicate these accounts are used only through 07/31/09.

Attachment 5: Columns 1 through 4 on line 1 are being deleted since quarterly reporting is no longer required.

Attachment 6, Page 1 of 2: a new section, for "Direct Care Therapies", Lines 19 through 28 are being added, for the "Direct Care Therapies" described on Schedule B-2, Page 2 of 2 above.

Rule **5101:3-3-42.4**, entitled "Nursing facilities (NFs): nonreimbursable costs", sets forth costs which are not reimbursable to NFs through the per diem. New language is being added to paragraph (D) of the proposed rule to explain therapy costs are nonreimbursable only through July 31, 2009. Beginning August 1, 2009, these costs are reimbursable through the cost reporting mechanism in the direct care cost center. Similarly, new language is being added to paragraph (E) of the proposed rule to explain oxygen costs (excluding emergency stand-by oxygen) and custom wheelchairs are reimbursable through the cost reporting mechanism beginning August 1, 2009 and subsequent.

The above rules are being proposed for amendment as indicated above. Should revisions to the proposed amendments occur as a result of a rule action taken during the hearing process, you will be notified in a subsequent transmittal letter at that time. Should no rule action occur during the hearing

process, the proposed amendments to rules 5101:3-3-20, 5101:3-3-42, and 5101:3-3-42.1 will become effective on or about January 31, 2010, and the proposed amendments to rule 5101:3-3-42.4 will become effective on or about February 14, 2010.

NFTL 09-02

Nursing Facility Transmittal Letter (NFTL) 09-02

August 25, 2009

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: NF - Rules for Consolidated Services

Proposed adoption of rule 5101:3-3-64.1 of the Administrative Code (effective October 29, 2009)

Proposed amendment of rule 5101:3-3-19 of the Administrative Code (effective October 29, 2009)

Proposed rescission of rules 5101:3-3-46, 5101:3-3-46.1, 5101:3-3-46.2, and 5101:3-3-46.3 of the Administrative Code (effective October 29, 2009)

Attached are proposed rule changes made in accordance with Amended Substitute House Bill 1 of the 128th General Assembly.

Proposed for adoption

Rule **5101:3-3-64.1** entitled **"Nursing facility payment for cost-sharing other than medicare part A"** is being proposed for adoption in order to clarify that for Medicaid eligible NF residents, the NF per diem rate includes Medicaid payments for Medicare and other third-party insurance cost-sharing, including coinsurance or deductible payments, associated with services that are included in the NF per diem, and that neither the Medicaid eligible NF resident nor ODJFS is responsible for such cost-sharing.

Proposed for amendment

Rule **5101:3-3-19** entitled **"Relationship of other covered medicaid services to nursing facility NF) services"** sets forth covered services generally available to Medicaid recipients and describes the relationship of such services to those provided by NFs. This rule is being proposed for amendment as a result of Amended Substitute House Bill 1 of the 128th General Assembly which changed services covered by the nursing facility Medicaid cost reporting mechanism to include oxygen, custom wheelchairs and repair, physical, occupational and speech language pathology/audiology therapy, medical transportation (ambulance and ambulette), and some over-the-counter drugs. These services were previously provided by fee-for-service providers. Amended Substitute House Bill 1 changed this arrangement by making NFs responsible for providing these services to Medicaid NF residents. This rule previously addressed covered services in both NFs and in Intermediate Care Facilities for the Mentally Retarded (ICFs-MR). A new rule (5101:3-3-19.1) will now address covered services in ICFs-MR.

Proposed for rescission

Rule **5101:3-3-46** entitled **"Skilled therapy services for nursing facilities (NFs): definitions"** sets forth the definition of terms used to describe the coverage of physical, occupational, speech-language pathology therapy, respiratory care and restorative nursing care services in the NF setting. This rule is being proposed for rescission because the provision of these services in the NF setting is now addressed in amended rule 5101:3-3-19.

Rule **5101:3-3-46.1** entitled **"Skilled therapy and related services for nursing facilities (NFs): Coverage and Limitations"** sets forth the coverage and limitation criteria for physical, occupational, speech-language pathology/audiology therapy, respiratory care and restorative nursing care services in the NF setting. This rule is being proposed for rescission because the provision of these services in the NF setting is now addressed in amended rule 5101:3-3-19.

Rule **5101:3-3-46.2** entitled **"Claim submission and payment for covered skilled therapy services for nursing facilities (NFs)"** sets forth the billing and payment criteria for NF services. This rule is being proposed for rescission because the reimbursement for skilled therapy services is now set forth in amended rule 5101:3-3-19.

Rule **5101:3-3-46.3** entitled **"Payment authorization for covered skilled therapy services denied by medicare and required for certification of nursing facilities (NFs)"** sets forth the process providers of skilled therapy services must follow for reimbursement of covered services denied by Medicare. This rule is being proposed for rescission because the provision of these services in the NF setting is now addressed in amended rule 5101:3-3-19.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective October 29, 2009.

NFTL 09-01

Nursing Facility Transmittal Letter (NFTL) 09-01

May 21, 2009

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: PROPOSED AMENDMENT OF RULE 5101:3-3-02 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT AUGUST 1, 2009)

PROPOSED RESCISSION OF RULES 5101:3-3-31 AND 5101:3-3-68 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT AUGUST 1, 2009)

ODJFS RULE DISTRIBUTION

The rules are being proposed for permanent amendment, rescission, or adoption in accordance with section 119.032 of the Revised Code.

Proposed for amendment

Rule **5101:3-3-02** entitled "Provider Agreements: Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the requirements of the agreement between NF and ICF-MR providers and the Ohio Department of Job and Family Services (ODJFS). This rule is being proposed for amendment in conjunction with the ODJFS paper reduction strategy which will increase communication efficiency and cost effectiveness with NF and ICF-MR providers.

The paragraph number (D)(1) was eliminated since there was no paragraph (D)(2) in the rule. This results in existing rule language in paragraph (D)(1) moving to paragraph (D).

Paragraph (F)(3) of this rule was modified to require electronic notification from ODJFS to affected persons whenever ODJFS files proposed rules or proposed rules in revised form. ODJFS shall provide this notification by posting the full text of proposed rules on its website for viewing and printing purposes. Language requiring ODJFS to provide hard copies of proposed rules was stricken from paragraph (F)(3) of this rule. ODJFS

may also send an email notice of the rule action to all persons whose name or contact information appears on a distribution list maintained by ODJFS.

Proposed for rescission

Rule **5101:3-3-31** entitled "Capital compensation program eligibility and payment methodology" sets forth the program eligibility and payment methodology for the capital compensation program. This rule is being proposed for rescission because the capital compensation program set forth in this rule has expired.

Rule **5101:3-3-68** entitled "Fiscal year 2007 Nursing Facility (NF) Rate Change Limitation" sets forth the rate change limitation for NFs for fiscal year 2007. This rule is being proposed for rescission because the NF rate change limitation provisions are set forth in the ORC.

The above rules are being proposed for amendment, rescission, or adoption as indicated above. Should revisions to the proposed permanent rules occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions to the rules occur, the aforementioned rules will become effective on or about August 1, 2009 on a permanent basis.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Nursing Facility Transmittal Letters (NFTLs). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard copy

rules, NF providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."

2) Select "Long Term Care."

3) In the "Table of Contents" drop-down menu, scroll to and select the desired NFTL #.

4) Scroll to and select the desired rule number.

5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

NFTL 09-01 Order Form

NFTL 08-05

Nursing Facility Transmittal Letter (NFTL) 08-05

September 15, 2008

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Resident Protection Fund Rules

Proposed adoption of new rule 5101:3-3-03.2 of the Administrative Code (effective on or about January 1, 2009)

Proposed rescission of rule 5101:3-3-63 of the Administrative Code (effective on or about January 1, 2009)

Attached are proposed rule changes made in accordance with section 119.032 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for adoption

Rule 5101:3-3-03.2 **"Resident protection fund (RPF) for nursing facilities (NFs) and collection of fines"** contains the provisions for the resident protection fund for nursing facilities. This rule is being proposed for adoption as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It replaces rule 5101:3-3-63. Changes include the following: in paragraphs (B), (C), and (F), references to "vendor offset" and "vendor payments" were changed to "medicaid payment offset" and "medicaid payments"; in paragraph (B)(4), the Revised Code citation was corrected from section 132.02 to section 131.02; paragraphs (C) and (D) were broken out into sub-paragraphs; in paragraph (E)(3), the Administrative Code citation was updated from 5101:3-3-60 to 5101:3-3-16.5; and several minor grammatical corrections were made throughout the rule.

Proposed for rescission

Rule 5101:3-3-63 **"Resident protection fund (RPF) for nursing facilities (NFs) and collection of fines"** contains the provisions for the resident protection fund for nursing facilities. This rule is being proposed for rescission as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It is being replaced by new rule 5101:3-3-03.2.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about January 1, 2009.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Nursing Facility Transmittal Letters (NFTLs). Changes in legislation have eliminated Ohio Revised Code (2), which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard copy rules, NF providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."
2) Select "Long Term Care."
3) In the "Table of Contents" drop-down menu, scroll to and select the desired NFTL #.

4) Scroll to and select the desired rule number.

5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

NFTL 08-05 Order Form

NFTL 08-04

Nursing Facility Transmittal Letter (NFTL) 08-04

August 14, 2008

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: PROPOSED AMENDMENT OF RULES 5101:3-3-19 AND 5101:3-3-20 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT OCTOBER 24, 2008)

ODJFS RULE DISTRIBUTION

The following rules are being proposed for permanent amendment pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-3-19 entitled: "Relationship of other covered medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services" identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. Changes to the proposed rule are as follows:

In the introductory paragraph of the proposed rule, "the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable." was corrected to read: "the rules governing such reimbursement are set forth in Chapter 5101:3-3 of the Administrative Code." The sentence "For state operated ICFs-MR reimbursement is made in accordance with rule 5101:3-3-99 of the Administrative Code." was stricken, and the last sentence of the introductory paragraph was edited to read: "All references to "ICFs-MR" in paragraphs (A) to (I) of this rule do not include state-operated ICFs-MR for which reimbursement is made in accordance with rule 5101:3-3-99 of the Administrative Code."

In paragraph (C)(2)(d) of the proposed rule, "except that emergency stand-by oxygen is" was changed to "except emergency stand-by oxygen which is."

Paragraph (D)(2) was shortened to simply point to Chapter 5101:3-9 of the Administrative Code and provisions established by the Ohio State Board of Pharmacy for limitations on pharmaceuticals reimbursable directly to the pharmacy provider. Paragraphs (D)(2)(a), (D)(2)(b) and (D)(2)(c) were stricken for being duplicative of language found in Chapter 5101:3-9 and provisions of the Ohio State Board of Pharmacy.

In paragraph (E)(1) of the proposed rule, references to rules 5101:3-3-47, 5101:3-3-47.3, and 5101:3-3-46 were corrected to 5101:3-3-46, 5101:3-3-46.3, and 5101:3-3-46.1, respectively. In paragraph (E)(2) of the proposed rule, "rule 5101:3-3-78 of the Administrative Code" was replaced with "sections 5111.20 to 5111.33 of the Revised Code." Paragraph (E)(3) of the proposed rule was deleted as psychologist services and respiratory therapy are addressed in paragraphs (E)(1) and (E)(2) of the proposed rule for NFs and ICFs-MR respectively.

The wording of paragraph (F)(1) was changed from "services provided by a physician to a resident of a NF or ICF-MR" to "services provided to a resident of a NF or ICF-MR by a physician." In paragraphs (F)(1)(c)(iii) and (F)(1)(c)(iv)(a) of the proposed rule, "nurse practitioner" was changed to "certified nurse practitioner" to comport with current terminology. Paragraph (F)(1)(c)(iv)(a) was expanded to reference Revised Code Chapter 4730 and Administrative Code Chapter 4730-1 for physician assistants, and Revised Code Chapter 4723 and Administrative Code Chapter 4723-4 for certified nurse practitioners. Duplicative language in subsequent paragraphs of the rule was stricken where the provisions were covered in Revised Code Chapters 4730 and 4723 and Administrative Code Chapters 4730-1 and 4723-4, and paragraph references were updated accordingly.

Existing paragraphs (G) and (H) regarding psychologist services and respiratory therapy services respectively were deleted from the proposed rule, and the deleted language was included in paragraphs (E)(1) and (E)(2) to better organize the rule content. Lastly, new paragraphs (G) through (I) of the proposed rule were arranged in alphabetical order according to paragraph titles.

Rule 5101:3-3-20 entitled: "Nursing Facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements" sets forth the requirement for the timely filing of cost reports by NFs and ICFs-MR, the methodology for processing those reports by ODJFS, and penalties that may be applied for not filing cost reports as required. Changes to the proposed rule are as follows:

In the introductory paragraph of the proposed rule, the revision dates for the "Medicaid Nursing Facility Cost Report" (JFS 02524N) and the "Medicaid ICF-MR Cost Report" (JFS 02524) were both updated. In paragraph (A)(1)(b) of the proposed rule, the reporting period end date in the case of a facility closure was clarified by referencing the definition of "closure" in rule 5101: 3-3-02(A)(1) of the Administrative Code. Paragraph (A)(1)(b) of the proposed rule also clarifies that a facility closure under any circumstance would trigger submission of a final cost report. Paragraph (A)(1)(b) was also rearranged such that new language is inserted following stricken language pursuant to the LSC rule drafting manual.

In paragraph (A)(3) of the proposed rule, "the Ohio department of job and family services" was replaced with the agency's acronym, and a paragraph reference was corrected.

The last sentence of paragraph (C) was edited to remove the colon in the middle of the sentence and to read as follows: "ODJFS shall notify each NF and ICF-MR of any costs preliminarily determined not to be allowable and provide the reasons for the determination."

In paragraph (D) of the proposed rule, "…per diem cost…" was changed to "…per diem cost or rate…," in both of the first two sentences so that the rule applies to both NFs and ICFs-MR.

In paragraphs (H) and (I)(1) of the proposed rule, paragraph references were corrected. In paragraph (I)(5) of the proposed rule, an amended date was added for the cited reference to the Social Security Act.

The above rules are being proposed for permanent amendment. Should revisions to the proposed permanent rules occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions occur, the aforementioned rules will become effective on or about October 24, 2008 on a permanent basis.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Nursing Facility Transmittal Letters (NFTLs). Changes in legislation have eliminated Ohio Revised Code (2), which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard copy rules, NF providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

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2) Select "Long Term Care."
3) In the "Table of Contents" drop-down menu, scroll to and select the desired NFTL #.
4) Scroll to and select the desired rule number.
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NFTL 08-04 Order Form

NFTL 08-02

Nursing Facility Transmittal Letter (NFTL) 08-02

May 5, 2008

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Nursing Facility (NF) Outlier Rules

Proposed adoption of new rules 5101:3-3-17.1 and 5101:3-3-17.2 of the Administrative Code (effective on or about August 1, 2008)

Proposed adoption of rule 5101:3-3-17.3 of the Administrative Code in conjunction with rescission of a rule by the same number (effective on or about August 1, 2008)

Proposed rescission of rules 5101:3-3-54.1 and 5101:3-3-54.5 of the Administrative Code (effective on or about August 1, 2008)

Attached are proposed rule changes made in accordance with section 119.032 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for adoption

Rule 5101:3-3-17.1 **"Outlier services in nursing facilities for individuals with severe maladaptive behaviors due to traumatic brain injury (NF-TBI services)"** contains the provisions for traumatic brain injury outlier services in nursing facilities. This rule is being proposed for adoption as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It replaces rule 5101:3-3-54.1, which is being proposed for rescission. Changes to the rule include grammatical revisions and reorganization of the rule body for improved comprehension. In paragraph (B), the terms "individual plan (IP)" and "nursing facility (NF)" have been added, the terms "home and community-based services (HCBS)" and "open head injury" have been removed, and the term "outlier prior authorization committee" has been changed to "ODJFS outlier prior authorization committee."

Rule 5101:3-3-17.2 **"Pediatric outlier services in nursing facilities (NF-PED services)"** contains the provisions for pediatric outlier services in nursing facilities. This rule is being proposed for adoption as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It replaces rule 5101:3-3-54.5, which is being proposed for rescission. Changes to the rule include grammatical revisions and reorganization of the rule body for improved comprehension. In paragraph (B), the terms "individual plan (IP)" and "unstable medical condition" have been added, the terms "home and community-based services (HCBS)," "instability of the individual's condition," and "primary diagnosis" have been removed, and the term "outlier prior authorization committee" has been changed to "ODJFS outlier prior authorization committee."

Proposed for adoption in conjunction with rescission of rules by the same number

Rule 5101:3-3-17.3 **"Out-of-state nursing facility (NF) services for individuals with traumatic brain injury (TBI)"** contains the provisions for out-of-state nursing facility services for individuals with traumatic brain injury. This rule is being proposed for adoption in conjunction with the rescission of a rule by the same number as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It replaces rule 5101:3-3-17.3 that is being proposed for rescission. Changes to the rule include grammatical revisions and reorganization of the rule body for improved comprehension. In paragraph (B), the term "nursing facility (NF)" has been added, the term "ODJFS out-of-state TBI designated coordinator" has been removed, and the term "TBI prior authorization committee" has been changed to "ODJFS out-of-state TBI prior authorization committee."

Proposed for rescission

Rule 5101:3-3-54.1 **"Outlier long-term care services for individuals with severe maladaptive behaviors due to traumatic brain injury (NF-TBI services)"** contains the provisions for traumatic brain injury outlier services in nursing facilities. This rule is being proposed for rescission as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It is being replaced by new rule 5101:3-3-17.1.

Rule 5101:3-3-54.5 **"Pediatric outlier care in nursing facilities (NF-PED services)"** contains the provisions for pediatric outlier services in nursing facilities. This rule is being proposed for rescission as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It is being replaced by new rule 5101:3-3-17.2.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about August 1, 2008.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Nursing Facility Transmittal Letters (NFTLs). Changes in legislation have eliminated Ohio Revised Code (2), which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard copy rules, NF providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."
2) Select "Long Term Care."
3) In the "Table of Contents" drop-down menu, scroll to and select the desired NFTL #.
4) Scroll to and select the desired rule number.
5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

NFTL 08-02 Order Form

NFTL 08-01

Nursing Facility Transmittal Letter (NFTL) 08-01

April 9, 2008

TO: Ohio Medicaid Nursing Facility Providers

FROM: Helen E. Jones-Kelley, Director

SUBJECT: PROPOSED PERMANENT AMENDMENT OF RULES 5101:3-3-04 AND 5101:3-3-04.1 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT JULY 1, 2008)

Rule 5101:3-3-04 titled "Payment during the Ohio department of job and family services (ODJFS) administrative appeals process for denial or termination of a provider agreement" sets forth payment for eligible NF and ICF-MR residents during a proposed termination or non-renewal of a facility's provider agreement by ODJFS, and during the appeals process of that proposed action. Payment after termination or non-renewal of a provider agreement, and following an administrative hearing upholding ODJFS' termination or non-renewal action, as well as when ODJFS is acting under instruction from the U.S. Department of Health and Human Services, are also addressed in this rule.

This rule is proposed for permanent amendment to correct the department name in the title from "...jobs and family services" to "job and family services", correct the spelling of "pursuant" in Section (A), and change "nonrenewal" to "non-renewal" throughout the rule.

Rule 5101:3-3-04.1 titled "Payment to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) during the survey agency's administrative appeals process" sets forth requirements for ODJFS payment of eligible NF and ICF-MR residents during the appeals process for termination or non-renewal of a facility's certification proposed by the State survey agency (Ohio Department of Health). The rule contains information and requirements specific to NFs, specific to ICFs-MR, and common to both NFs and ICFs-MR, including when ODJFS acts under instruction from the U.S. Department of Health and Human Services. Payment after termination or non-renewal of certification, or following an administrative hearing upholding ODH's termination or non-renewal of certification are also addressed.

This rule is proposed for permanent amendment to correct the department name in Section (A)(3) from "jobs and family" to "job and family", change "ICF's-MR" in Section (D)(2)(b) to "ICF-MR's", add a colon to the end of the sentence in Section (E), to change "nonrenewal" to "non-renewal" throughout the rule, and to change "nonrenewed" in Section (B) to "not renewed".

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at this time. If no revisions occur, the above mentioned rules will become effective July 1, 2008.

NFTL 08-01 Order Form

NFTL 07-08

Nursing Facility Transmittal Letter (NFTL) 07-08

January 4, 2008

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Proposed Rules: Resident Rights for Nursing Facilities (NFs)

Proposed adoption of rules 5101:3-3-16, 5101:3-3-16.1, and 5101:3-3-16.2 of the Administrative Code in conjunction with rescission of rules by the same number (effective on or about March 31, 2008)

Proposed adoption of new rule 5101:3-3-16.3 of the Administrative Code (effective on or about March 31, 2008)

Proposed rescission of rules 5101:3-3-16, 5101:3-3-16.1, 5101:3-3-16.2, and 5101:3-3-23 of the Administrative Code (effective on or about March 31, 2008)

Enclosed are proposed rule changes made in accordance with section 119.03 of the Revised Code, which outlines procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for adoption in conjunction with rescission of a rule by the same number

Rule 5101:3-3-16 **"Resident rights for nursing facilities (NFs)"** contains the general provisions of resident rights for NFs. It is being proposed for adoption in conjunction with the rescission of a rule by the same number as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. NF provisions in former rule 5101:3-3-16 have been moved to this new rule. Paragraph (A) contains new definitions for the terms "nursing facility" and "nursing home." Section headings have been added and the rule body has been restructured for improved comprehension. All references to federal regulations have been updated.

Rule 5101:3-3-16.1 **"Resource assessment notice for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"** contains the provisions regarding the resource assessment notice for both NFs and ICFs-MR. It is being proposed for adoption in conjunction with the rescission of a rule by the same number as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The provisions of this rule remain substantively unchanged. Section headings have been added and the rule body has been restructured for improved comprehension.

Rule 5101:3-3-16.2 **"Advance directives for nursing facilities (NFs)"** contains the provisions regarding advance directives for NFs. It is being proposed for adoption in conjunction with the rescission of a rule by the same number as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The provisions of this rule remain substantively unchanged. Paragraph headings have been added throughout the rule for improved comprehension. Provisions regarding the establishment of written policies and procedures have been moved to paragraph (C), and provisions regarding the notification of written policies and procedures have been moved to paragraph (D).

Proposed for adoption

Rule 5101:3-3-16.3 **"Private rooms in nursing facilities (NFs)"** contains the provisions for private rooms in NFs. This is a new rule being proposed for adoption as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. NF provisions in former rule 5101:3-3-23 have been moved to this rule and remain substantively unchanged, but include a new requirement that a copy of a written request for a private room shall be kept in the resident's file. Section headings have been added and the rule body has been restructured for improved comprehension.

Proposed for rescission

Rule 5101:3-3-16 **"Resident rights in nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"** contains the general resident rights provisions for NFs and ICFs-MR. This rule is being proposed for rescission as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The NF and ICF-MR provisions are being separated and moved to two new rules, each of which addresses one provider type only. The NF provisions in this rule are being moved to new rule 5101:3-3-16.

Rule 5101:3-3-16.1 **"Resource assessment notice"** contains the provisions regarding the resource assessment notice for NFs and ICFs-MR. It is being proposed for rescission as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The provisions in this rule are being moved to new rule 5101:3-3-16.1.

Rule 5101:3-3-16.2 **"Advance directives for nursing facilities"** contains the provisions regarding advance directives for NFs. It is being proposed for rescission as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The provisions in this rule are being moved to new rule 5101:3-3-16.2.

Rule 5101:3-3-23 **"Private rooms for medicaid residents in nursing facilities (NFs) and intermediate-care facilities for the mentally retarded (ICFs-MR)"** contains the provisions for private rooms for medicaid residents in long term care facilities. This rule is being proposed for rescission as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The NF and ICF-MR provisions are being separated and moved to two new rules, each of which addresses one provider type only. The NF provisions in this rule are being moved to new rule 5101:3-3-16.3.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about March 31, 2008.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Nursing Facility Transmittal Letters (NFTLs). Changes in legislation have eliminated Ohio Revised Code (2), which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard copy rules, NF providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."
2) Select "Long Term Care."
3) In the "Table of Contents" drop-down menu, scroll to and select the desired NFTL #.
4) Scroll to and select the desired rule number.
5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

NFTL 07-06 Order Form

NFTL 07-06

Nursing Facility Transmittal Letter (NFTL) 07-06

September 11, 2007

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Proposed Bed-Hold Rules for Nursing Facilities (NFs)

Proposed adoption of new rule 5101:3-3-16.4 of the Administrative Code (effective on or about November 15, 2007)

Proposed rescission of rule 5101:3-3-59 of the Administrative Code (effective on or about November 15, 2007)

Attached are proposed rule changes made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for adoption

Rule 5101:3-3-16.4 **"Coverage of bed-hold days for medically necessary and other limited absences from nursing facilities (NFs)"** is a new rule being proposed for adoption as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It replaces rule 5101:3-3-59, which is being proposed for rescission. This rule contains the bed-hold provisions for NFs. A new provision at paragraph (B) prohibits preadmission bed-hold payments. Paragraph (E) contains new provisions regarding electronic submission of bed-hold payment requests. In paragraph (J), QMB eligible residents have been added to the categories of residents for whom NF providers may receive bed-hold payments. New paragraph (L) adds provisions regarding provider compliance with bed-hold restrictions and requirements.

Proposed for rescission

Rule **5101:3-3-59 "Coverage of bed-hold days for medically necessary and other limited absences from nursing facilities (NFs)"** is being proposed for rescission as a result of the five-year rule review and a reorganization of rules administered by the Bureau of Long Term Care Facilities. This rule contains the bed-hold provisions for NFs. It is being replaced by new rule 5101:3-3-16.4.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about November 15, 2007.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Nursing Facility Transmittal Letters (NFTLs). Changes in legislation have eliminated Ohio Revised Code (2), which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard copy rules, NF providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."
2) Select "Long Term Care."
3) In the "Table of Contents" drop-down menu, scroll to and select the desired NFTL #.

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NFTL 07-06 Order Form

NFTL 07-05

Nursing Facility Transmittal Letter (NFTL) 07-05

August 9, 2007

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Helen Jones-Kelly, Director

SUBJECT: National Provider Identifier (NPI) Implementation and the ODJFS NPI Contingency Plan

PLEASE ROUTE THIS LETTER TO YOUR:

- Billing Departments
- Systems/Information Technology Departments
- Billing Software Vendors
- Billing Associates
- Trading Partners

This transmittal letter is an update to NFTL 06-08 that we sent to you August 18, 2006. This NFTL has two primary purposes. First, this NFTL is to inform you of the Ohio Medicaid NPI Contingency Plan during the dual identifier period. A dual identifier period is the time period in which a health plan can require both the NPI and the plan's legacy (or proprietary) number on claim formats and will deny claims that are missing the plan's legacy number.

Second, this NFTL is to remind you of the importance of sharing your National Provider Identifier (NPI) with the Ohio Medicaid program's Long Term Care (LTC) Provider Enrollment Unit, and to provide you with Ohio Medicaid billing information regarding room and board and Medicare Part A claims. Instructions are provided for both the current dual identifier period tentatively scheduled to end December 31, 2007, and the period thereafter when NPIs are fully implemented. The transition to NPIs will affect your Medicaid enrollment, billing, and reimbursement.

I. The ODJFS Contingency Plan

Federal law still requires providers of health care and health plans (except for small health plans defined in CFR 45 §160.103 as a health plan with annual receipts of $5 million or less) to be in compliance with the NPI regulations on May 23, 2007. However, for a 12 month period, CMS will not impose penalties on covered health plans that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable efforts to become compliant and to facilitate the compliance of their providers and trading partners.

As a part of ODJFS' NPI contingency plan, ODJFS has extended its dual identifier period to **December 31, 2007**. During this extended period, ODJFS requires both the Medicaid legacy identifier and the national provider identifier (NPI) to be reported on claims. Failure to continue to send the Medicaid legacy identifier during the ODJFS dual identifier period will result in denial of claims.

The purpose of the dual identifier period is to give health plans and providers the opportunity to assure that the provider will get paid without interruption once NPI is fully implemented. It is in the provider's best interest to have a significant volume of claims that have both identifiers and have been submitted early enough for ODJFS to assist the provider in correcting any NPI-related billing problems prior to the end of the ODJFS dual identifier period.

Nursing facility claims for room and board and Part A co-insurance claims received by ODJFS before January 1, 2008 that contain a valid Ohio Medicaid legacy number, or both a valid NPI and valid Ohio Medicaid legacy number in the required provider fields, will continue to be accepted and processed. Claims submitted without an Ohio Medicaid legacy number (i.e., submitted only with an NPI number) prior to January 1, 2008 will be denied.* Nursing facility claims submitted to ODJFS on or after January

1, 2008 will be denied if the nursing facility's NPI number is not in the required field(s) on the claim. This information is displayed in the table below:

If EDI claims (NF Claims for room and board; Part A co-insurance) contain:	Dual Identifier Period Before and on 12/31/2007	Full NPI Implementation On and after 1/1/2008
Only a valid Ohio Medicaid legacy number	acceptable, will be processed	not acceptable, will be denied
Only a valid NPI number	not acceptable, will be denied	acceptable, will be processed only if enclosed instructions are followed
Both Ohio Medicaid legacy using the 1D qualifier and NPI numbers	preferred, will be processed	not acceptable, will be denied

* *See special instructions for paper and tape claims (below in this NFTL).*

Providers and trading partners will be notified in the event ODJFS decides that the ODJFS dual identifier period can end sooner than December 31, 2007, or if it needs to be extended to the CMS approved date of May 23, 2008. ODJFS appreciates the attention of the providers in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

II. Obtaining and Sharing the NPI with Ohio Medicaid

According to federal regulation 45 CFR § 162.404, all eligible health care providers are required to obtain a ten-digit NPI number from the National Plan and Provider Enumeration System (NPPES) and to disclose the NPI upon request. After full implementation of the NPI, the NPI will be the only acceptable provider identifier. The Ohio Department of Job and Family Services (ODJFS) Ohio Medicaid program is requesting that you share your NPI with us.

In order for ODJFS to recognize your NPI number's association with your provider agreement, your NPI must be submitted to the LTC Provider Enrollment Unit as instructed in this section. Your NPI must be verified and entered into our provider enrollment system as soon as possible so that we can identify and process your claims with your NPI number once the use of the NPI is fully implemented. Effective January 1, 2008, NPI numbers are required for use in all HIPAA related transactions such as the 837 Institutional (837I) transaction. **Failure to comply with these NPI enumeration and verification requirements could result in denied claims or delayed payments.**

Steps You Must Take to Enumerate and Share Your NPI

Although the NPI is not required for electronic claims submission until January 1, 2008, **in order to ensure that your Medicaid payment continues without interruption**, we request that you do the following:

A. Obtain an NPI number

The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. CMS has contracted with Fox Systems, Inc. to serve as the NPI Enumerator. The NPI Enumerator is responsible for dealing with health plans and providers on issues relating to unique identification. To learn more about the NPI and **to obtain an NPI number**, The NPI Enumerator may be contacted as follows:

- web address: **https://nppes.cms.hhs.gov/NPPES**
- email at customerservice@npienumerator.com or
- phone 1-800-465-3203 (NPI Toll-Free) or 1-800-692-2326 (TTY)

- mail at NPI Enumerator, PO Box 6059, Fargo, ND 58108-6059

When applying for an NPI number, be sure to reference your Medicare and Medicaid numbers in Section 3C: *Other Provider Identification Numbers* on the NPI Application/Update Form.

Please make sure your NPPES Application contains all of the following vital pieces of information:

- Provider's doing business as (DBA) or facility name
- Provider's legal name (e.g., corporation, partnership, or limited liability company)
- Provider's facility address, (street, city, state, zip code)
- Provider's nine-digit federal Employment Identification Number, (EIN)
- Provider's seven-digit Ohio Medicaid provider number (sometimes referred to as the Medicaid legacy number)
- Provider's six-digit Medicare number
- *[Note Ohio facilities' Medicare numbers usually begin with "36". Following the implementation of the NPI, the Medicare/Medicaid Provider Number will continue to be issued to certified providers and used on all survey and certification transactions and resident assessment transactions.*
- *In order to distinguish its role from that of the NPI, the Medicare Provider Number has been renamed the Centers for Medicare & Medicaid Services (CMS) Certification Number (CCN)]*
- Provider's primary taxonomy codes
- Provider's secondary taxonomy codes (if applicable).

NPPES will process your application and provide an email notice containing your ten-digit NPI number. That notice will also contain the data elements listed above, only if you provide them to NPPES on your application.

B. Report Your NPI and Verification Data to ODJFS

1. Forward the email notice that you received from NPPES that relays your assigned NPI number and associated verification data (see section A above) to **NF_NPI@odjfs.state.oh.us**. If you received a paper or fax notice from NPPES, scan the notice and send it as an attachment to this same email address.
2. In the forwarding subject line, include the heading *"NPI Reporting,"* and the name and seven-digit Ohio Medicaid number of the nursing facility to which the NPI is assigned.
3. If the NPPES confirmation letter omits the information listed in section A1, above, provide that information in the body of the email to the LTC Provider Enrollment Unit. The missing information can also be hand-written on the NPPES letter, but you must initial and date any data items added to the letter. We also highly recommend that you amend your application with NPPES to provide them with these data elements.
4. To assist in providing a smooth NPI transition, you must also supply the following information in the e-mail:

- Provider's Ohio Department of Health four-digit identification number
- Provider's Ohio Department of Health license number (if applicable)
- Provider's phone number with area code.
- Provider's trading or billing partners
- Provider type (e.g., NF, SNF/NF, ICF-MR)

5. The LTC Provider Enrollment Unit will send a confirmation notice back to the email address you use to submit your NPI.

III. Billing Instructions

As of the date of this NFTL, December 31, 2007 is the end of the "dual identifier" period. January 1, 2008 is the date when all claims submitted to Ohio Medicaid for nursing facility (NF) services must use the NPI on the 837I transaction. Do not submit your Medicaid legacy number using the qualifier 1D after the dual identifier period is over.

A. Dual Identifier Period

ODJFS is currently conducting a dual identifier period similar to Medicare's. The NPI should be submitted in addition to the Medicaid provider (legacy) number. To include both numbers on the 837I, follow these instructions:

1. Loop Occurrences

   If you submit only Loop 2010AA, *Billing Provider Information*, report the NPI, SSN or EIN, and the Medicaid provider number in this loop.

   If you submit both Loop 2010AA, *Billing Provider Information*, and Loop 2010AB, *Pay to Provider Information*, and the billing and pay to provider are the same, report the same NPI, SSN or EIN, and the Medicaid provider number in both loops.

   If you submit both Loop 2010AA, *Billing Provider Information*, and Loop 2010AB, *Pay to Provider Information*, and the billing and pay to provider are different, submit the NPI, SSN or EIN, and the Medicaid provider number of the provider to be paid in Loop 2010AB, *Pay to Provider*.

2. Segment Usage

   a. The NM1 Segment Usage:

      Use the qualifier **XX** in the primary identification qualifier location **NM108**, and use the NPI number in the primary identification location **NM109**.

   b. The REF Segment will be used twice:

      For the first occurrence of the REF segment, continue to use your Medicaid provider number with the 1D qualifier in the secondary identification qualifier location **REF01**, and the Medicaid provider number in the secondary identification location **REF02**.

      For the second occurrence of the REF segment, use your Social Security Number (SSN) or Employer Identification Number (EIN) with SY or EI in the secondary identification qualifier location **REF01**, and the EIN or SSN in the secondary identification location **REF02**.

3. Coinsurance Claims:

   a. Submitted directly to ODJFS:

      For coinsurance claims submitted directly to Ohio Medicaid, use both the NPI and your Medicaid provider number.

   b. Automatic cross-overs:

      For coinsurance claims that automatically cross over to ODJFS, the NPI of the provider that is submitted to Medicare is the NPI that will be sent to ODJFS. Continue to report the Medicaid provider number associated with the NPI submitted on the claims.

B. Post NPI Dual Identifier Period

Because Ohio Medicaid's nursing facility rates are specific for each enrolled facility, in addition to the facility's NPI, the facility's seven-digit location number (the legacy number) must be

submitted on the 837I effective January 1, 2008. This ensures that the correct rate is paid to each facility. Below are the instructions to include both numbers on the 837I - the NPI as the provider identifier and the location number as the facility identifier. Do not submit your Medicaid legacy number using the qualifier 1D after the Dual Identifier Period is over.

1. Loop Occurrences

   a. If you submit only Loop 2010AA, *Billing Provider Information*, report the NPI, SSN or EIN, and the facility location number in this loop.

   b. If you submit both Loop 2010AA, *Billing Provider Information*, and Loop 2010AB, *Pay to Provider Information*, and the billing and pay to provider are the same, report the same NPI, SSN, or EIN, and the facility location number in both loops.

   c. If you submit both Loop 2010AA, *Billing Provider Information*, and Loop 2010AB, *Pay to Provider Information*, and the billing and pay to provider are different, submit the NPI, SSN, or EIN, and the facility location number of the provider to be paid in Loop 2010AB, *Pay to Provider*.

   d. If you also submit Loop 2310E, *Service Facility Name*, submit the NPI, SSN, or EIN, and the facility location number of the provider to be paid in this loop.

Note: Loops 2010AA and 2010AB apply to all claims while Loop 2310E applies to a single claim. In the ODJFS system, the *pay to provider information* reported in Loop 2310E will overwrite the *pay to provider information* reported in 210AA and 2010AB for the claim in which it is included.

2. Segment Usage

   a. The NM1 Segment Usage:

      Use the qualifier XX in the primary identification qualifier location NM108, and report the NPI in the primary identification location NM109.

   b. The REF Segment is used two times:

      (1) In the first occurrence of the REF segment, use the **LU** qualifier in the secondary identification qualifier location REF01 to report your **facility location number (legacy number)** in the secondary identification location REF02.

      (2) In the second occurrence of the REF segment, use the SY or EI qualifier in the secondary identification qualifier location REF01, and report your Social Security Number (SSN) or Employer Identification Number (EIN) in the secondary identification location REF02.

3. Coinsurance Claims:

   a. Submitted directly to ODJFS:

      Submit coinsurance claims directly to Ohio Medicaid using both the NPI and the facility location number using the LU qualifier as indicated above.

   b. Automatic cross-overs:

      To insure that automatic coinsurance crossovers price correctly, we strongly recommend that you use the same NPI when submitting those claims that you use for Medicaid room and board billing. Report the facility location number using the LU qualifier as indicated above.

      If the NPI number you submit to Medicare is different from the one you submit to Medicaid for room and board, please provide the Medicare NPI number to LTC Provider Enrollment Unit in the manner described in section A above.

IV. Future Role of the Medicaid Provider Number (legacy number)

Post NPI implementation, the Medicaid legacy number will continue to be issued to certified NF providers and will continue to be requested for cost reports and other reporting purposes.

V. Resources

To learn more about the NPI and to obtain an NPI number, visit the NPI Enumerator website at

https://nppes.cms.hhs.gov/NPPES

To submit your NPI to the LTC Provider Enrollment unit, forward the NPPES email notice or scanned hard copy NPPES notice that relays your assigned NPI number and associated verification data to

NF_NPI@odjfs.state.oh.us

For information regarding taxonomy codes, access The Washington Publishing Company at:

http://www.wpc-edi.com/codes/taxonomy

- In the forwarding subject line, include the heading ***"NPI Reporting,"*** and the name and seven-digit Ohio Medicaid number of the nursing facility to which the NPI is assigned

For questions about the assignment of NPI numbers relating to Ohio Medicaid nursing facilities,

1) send an email to

   NF_NPI@odjfs.state.oh.us

   In the forwarding subject line, include the heading

   "NPI Assignment Question"

OR

2) call the LTCF Provider Enrollment Unit at **(614) 466-9088**.

For questions about billing the Ohio Medicaid program using the NPI, please use this email address:

NFDIRECTBILL@odjfs.state.oh.us.

Thank you for your attention to this matter. With your cooperation, we anticipate a successful transition to use of the NPI.

NFTL 07-04

Nursing Facility Transmittal Letter (NFTL) 07-04

July 5, 2007

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Personal Needs Allowance (PNA) Rules for Nursing Facilities (NFs)

Proposed adoption of new rule 5101:3-3-16.5 of the Administrative Code (effective on or about September 15, 2007)

Proposed rescission of rule 5101:3-3-60 of the Administrative Code (effective on or about September 15, 2007)

Attached are proposed rule changes made in accordance with section 119.03 of the Ohio Revised Code, which outlines the procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for adoption

Rule 5101:3-3-16.5 **"Personal needs allowance (PNA) accounts and other resident funds for nursing facilities (NFs)"** is a new rule being proposed for adoption as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. It replaces rule 5101:3-3-60, which is being proposed for rescission. This rule contains the provisions for the management of PNA accounts and other resident funds for nursing facilities. Paragraph (G)(2) contains a new provision that prohibits using PNA funds to pay an outstanding balance owed to a NF at the time of discharge. Paragraph (J)(3) contains a new provision that prohibits using PNA funds for costs associated with guardianship proceedings. The content is being restructured and section headings are being added for improved comprehension.

Proposed for rescission

Rule **5101:3-3-60 "Protection of nursing facility (NF) residents' funds and management of personal needs allowance (PNA) accounts"** is being proposed for rescission as a result of the five-year rule review and as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. This rule contains the provisions for the management of PNA accounts and other resident funds for nursing facilities. It is being replaced by new rule 5101:3-3-16.5.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about September 15, 2007.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Nursing Facility Transmittal Letters (NFTLs). Changes in legislation have eliminated Ohio Revised Code (2), which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard copy rules, NF providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."
2) Select "Long Term Care."
3) In the "Table of Contents" drop-down menu, scroll to and select the desired NFTL #.

4) Scroll to and select the desired rule number.

5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

NFTL 07-04 Order Form

NFTL 07-03A

Nursing Facility Transmittal Letter (NFTL) 07-03A

May 17, 2007

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Revised Nursing Facility (NF) Therapy Rules

Revised adoption of rules 5101:3-3-46 and 5101:3-3-46.1 of the Administrative Code (effective on or about July 1, 2007)

Rule 5101:3-3-46 **"Skilled therapy services for nursing facilities (NFs): definitions"** contains the definitions found in rules 5101:3-3-46 to 5101:3-3-46.3, which are being proposed for adoption as a result of the five-year rule review. This rule was originally proposed for adoption in conjunction with the rescission of a rule by the same number. The definitions found in rules 5101:3-3-47 and 5101:3-3-47.1, which are being proposed for rescission, have been moved to this rule, and definitions for "respiratory care" and "restorative nursing care" have been added.

This rule is being revised in order to correct terminology in paragraph (K) from "certified nurse aides" to "state tested nurse aides (STNAs)."

Rule 5101:3-3-46.1 **"Skilled therapy and related services for nursing facilities (NFs): coverage and limitations"** contains the criteria under which skilled therapy services are covered in nursing facilities. It was originally proposed for adoption as a result of a reorganization of the rules administered by the Bureau of Long Term Care Facilities. It replaces portions of rules 5101:3-3-46, 5101:3-3-47, 5101:3-3-47.1, and 5101:3-3-47.2, which have been proposed for rescission.

This rule is being revised in order to correct terminology in paragraph (C) from "certified nurse aides" to "state tested nurse aides (STNAs)."

Instructions:

Obsolete rules 5101:3-3-46 and 5101:3-3-46.1 as set forth in NFTL 07-03 and replace with rules 5101:3-3-46 and 5101:3-3-46.1 as contained in this transmittal.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Nursing Facility Transmittal Letters (NFTLs). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard copy rules, NF providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

At the eManuals home page, follow the steps below to access the proposed rules referenced in this transmittal letter.

1) Select "Ohio Health Plans - Provider."

2) Select "Long Term Care."

3) In the "Table of Contents" drop-down menu, scroll to and select the desired NFTL #.

4) Scroll to and select the desired rule number.

5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you

may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

NFTL 07-03A Order Form

NFTL 07-03

Nursing Facility Transmittal Letter (NFTL) 07-03

April 25, 2007

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Nursing Facility (NF) Therapy Rules

Proposed Adoption of Rule 5101:3-3-46 of the Administrative Code in Conjunction with Rescission of a Rule by the Same Number (Effective on or About July 1, 2007)

Proposed Adoption of New Rules 5101:3-3-46.1, 5101:3-3-46.2, and 5101:3-3-46.3 of the Administrative Code (Effective on or About July 1, 2007)

Proposed Rescission of Rules 5101:3-3-46, 51013-3-47, 5101:3-3-47.1, 5101:3-3-47.2, and 5101:3-3-47.3 of the Administrative Code (Effective on or About July 1, 2007)

Attached are proposed rule changes made in accordance with section 119.03 of the Revised Code, which outlines procedures for the adoption, amendment, and rescission of administrative rules. Notable changes include removal of language referring to prospective rate reimbursement, removal of annual service limits, and addition of provisions related to direct billing.

Proposed for adoption in conjunction with the rescission of a rule by the same number

Rule **5101:3-3-46 "Skilled therapy services for nursing facilities (NFs): definitions"** is a new rule being proposed for adoption. The definitions found in rules 5101:3-3-47 and 5101:3-3-47.1, which are being proposed for rescission as a result of the five-year rule review, are being moved to this new rule. New definitions are being added for "respiratory care" and "restorative nursing care" in order to specify the kinds of procedures and treatments that are involved in those services, and to clarify their relationship to skilled therapy.

Proposed for adoption

Rule **5101:3-3-46.1 "Skilled therapy and related services for nursing facilities (NFs): coverage and limitations"** is a new rule being proposed for adoption as a result of a reorganization of the rules administered by the Bureau of Long Term Care Facilities. It replaces portions of rules 5101:3-3-46, 5101:3-3-47, 5101:3-3-47.1, and 5101:3-3-47.2, which are being proposed for rescission. The rule contains the criteria under which skilled therapy services are covered in nursing facilities. Separate sections in paragraph (A) contain the coverage criteria for each type of skilled therapy, i.e., physical, occupational, and speech-language pathology/audiology. Paragraphs (C) and (D) contain the coverage criteria for restorative nursing care services and respiratory care services.

Rule 5101:3-3-46.2 **"Claim submission and payment for covered skilled therapy services for nursing facilities (NFs)"** is a new rule being proposed for adoption as a result of a reorganization of the rules administered by the Bureau of Long Term Care Facilities. The new rule replaces rule 5101:3-3-47.2, which is being proposed for rescission. This new rule contains the payment criteria for NF therapy services. Paragraphs (B) and (C) contain new provisions regarding national uniform billing requirements and electronic claims.

Rule 5101:3-3-46.3 **"Payment authorization for covered skilled therapy services denied by medicare and required for certification of nursing facilities (NFs)"** is a new rule being proposed for adoption as a result of a reorganization of the rules administered by the Bureau of Long Term Care Facilities. The new rule will replace rule 5101:3-3-47.3, which is being proposed for rescission. This new rule sets forth the payment process in cases where Medicare denies payment for therapy services for a dual eligible NF resident, but the provision of therapy services is required for Medicaid certification of the facility.

Proposed for rescission

Rule **5101:3-3-46 "Prospective rate reimbursement of therapy services in nursing facilities (NFs)"** is being proposed for rescission as a result of the five-year rule review and a reorganization of the rules administered by the Bureau of Long Term Care Facilities. This rule contains the provisions for prospective reimbursement of NF therapy services. It is being replaced by new rule 5101:3-3-46.1.

Rule **5101:3-3-47 "Nursing facility therapy services provider eligibility"** is being proposed for rescission as a result of the five-year rule review and a reorganization of the rules administered by the Bureau of Long Term Care Facilities. This rule contains the eligibility provisions for NF therapy service providers. It is being replaced by new rules 5101:3-3-46 and 5101:3-3-46.1.

Rule **5101:3-3-47.1 "Coverage and limitations-nursing facility therapy services"** is being proposed for rescission as a result of the five-year rule review and a reorganization of the rules administered by the Bureau of Long Term Care Facilities. This rule contains both definitions and coverage provisions for NF therapy services. It is being replaced by new rules 5101:3-3-46 and 5101:3-3-46.1.

Rule **5101:3-3-47.2 "Reimbursement for covered nursing facility (NF) therapy services"** is being proposed for rescission as a result of the five-year rule review and a reorganization of the rules administered by the Bureau of Long Term Care Facilities. This rule contains the provisions for reimbursement for NF therapy services. It is being replaced by new rules 5101:3-3-46.1 and 5101:3-3-46.2.

Rule **5101:3-3-47.3 "Payment authorization of covered therapy services denied by medicare and required for facility certification"** is being proposed for rescission as a result of the five-year rule review and a reorganization of the rules administered by the Bureau of Long Term Care Facilities. This rule explains the payment authorization process in cases where Medicare denies payment for therapy services for dual eligible NF residents, but the provision of therapy services is required for Medicaid certification of the facility. It is being replaced by new rule 5101:3-3-46.3.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about July 1, 2007.

ODJFS Rule Distribution

In conjunction with agency-wide distribution methods for proposed rules and other publications, the Bureau of Long Term Care Facilities (BLTCF) does not issue hard (paper) copies of proposed rules referenced in Nursing Facility Transmittal Letters (NFTLs). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard copy rules, NF providers can obtain proposed rules from the ODJFS eManuals website, which has been developed for the electronic publication of departmental rules and policies. The eManuals website is located at:

http://emanuals.odjfs.state.oh.us/emanuals/

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1) Select "Ohio Health Plans - Provider"

2) Select "Long Term Care"

3) From the "Table of Contents" drop down menu, scroll to and select the desired "NFTL #"

4) Scroll to and select the desired rule number

5) To print, click on the "Print Page" icon at the top or bottom of the web page.

Attached to this transmittal letter is a hard copy of the JFS 03400 entitled "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If you do not have access to the internet, you may use the JFS 03400 to obtain hard copies of proposed rules at no charge. To do so, fax or mail a completed 03400 to ODJFS according to the directions on the form.

NFTL 07-03 Order Form

NFTL 07-02

Nursing Facility Transmittal Letter (NFTL) 07-02

March 21, 2007

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Proposed Rescission of Rule 5101:3-3-30.1 of the Administrative Code (Effective on or About April 30, 2007)

Proposed Adoption of Rule 5101:3-3-30.1 of the Administrative Code (Effective on or About April 30, 2007)

The following rule is being proposed for permanent rescission due to similar provisions that exist in Sections 3721.50 to 3721.58, 5112.30 to 5112.35, and 5112.37 to 5112.39 of the Ohio Revised Code.

Rule 5101:3-3-30.1 entitled Calculation, billing, payment remittance, and appeal process for the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD).

The following rule is being proposed for permanent adoption to clarify and update language from Sections 3721.50 to 3721.58, 5112.30 to 5112.35, and 5112.37 to 5112.39 of the Ohio Revised Code.

Rule 5101:3-3-30.1 entitled Calculation, billing, payment remittance, and appeal process for the franchise permit fee (FPF) for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD). The rule sets forth franchise permit fee calculation, billing, payment remittance and appeal process for NFs, NHs, and ICFs-MR/DD.

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facilities Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals

At the Electronic Manuals Internet site home page, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider"

2) Select "Long Term Care"

3) From the "Table of Contents" drop down menu, scroll to and select the desired "NFTL #"

4) Scroll to the desired rule number highlighted in blue, select desired rule number

5) Once the desired rule appears, print or view as desired, print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete

all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL-07-02 Order Form

NFTL 07-01

Nursing Facility Transmittal Letter (NFTL) 07-01

February 2, 2007

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Proposed Amendment of Rule 5101:3-3-43.4 of the Administrative Code (Effective on or About April 1, 2007)

Changes in ODJFS Hard-Copy (Paper) Rule

Distribution

The following rule is being proposed for permanent amendment pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period:

Rule 5101:3-3-43.4 entitled "Exception review process for nursing facilities (NFs)" sets forth protocols for the exception review process for NFs. Changes to the proposed rule are as follows:

The definition of a record was added to paragraph (A)(6) of the proposed rule. This new definition defines a record as an MDS 2.0 assessment identified as a Medicaid record as set forth in paragraph (D)(2) of rule 5101:3-3-43.3. In paragraph (A)(4)(b) of the proposed rule, "quarterly facility average case mix score" was changed to "quarterly facility average Medicaid case mix score" and in paragraphs (A)(8), and (A)(8)(a) of the proposed rule, "quarterly facility average total case mix score" was changed to "quarterly facility average Medicaid case mix score".

For clarification, "facility" was changed to "provider" in paragraph (E) of the proposed rule, "facilities" was changed to "providers" in paragraph (F) of the proposed rule, "NF's" was changed to "provider's" in paragraphs (A)(4)(b), (A)(8), (A)(8)(a), (A)(9), and (A)(10) of the proposed rule, "NFs" was changed to "Providers" in paragraph (C) of the proposed rule, and "NF" was changed to "provider" in paragraphs (D)(4), (I), (J), (N), (O), (O)(3), and (P) of the proposed rule. References to appendices to rule 5101:3-3-43.4 were corrected from "appendix of this rule" to "appendix to this rule" in paragraphs (G), (H)(1)(a), (H)(1)(b), (H)(1)(c), and (H)(1)(d) of the proposed rule. Paragraph (J) of the proposed rule was modified to include the revised quarterly facility average total case mix score and the revised quarterly facility average Medicaid case mix score in the final written summary of exception review findings mailed by ODJFS to inform providers of their exception review results.

In paragraph (L) of the proposed rule "score" was corrected to "scores". Paragraph (O)(2)(d) of the proposed rule was changed to correct the style of apostrophe used in "provider's". Paragraph (P) of the proposed rule was changed to include the decimal after the reference to Chapter 119. Lastly, "Resident Census on Reporting Period End Date" was changed to "Medicaid Resident Census on Reporting Period End Date" in all table headings in appendices A and B to the proposed rule.

The above rule is being proposed for permanent amendment. Should revisions to the proposed permanent rule occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions occur, the aforementioned rule will become effective April 1, 2007 on a permanent basis.

NFTL 06-10

Nursing Facility Transmittal Letter (NFTL) 06-10

December 28, 2006

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Amendment of Rules 5101:3-3-01, 5101:3-3-22,

5101:3-3-42, and 5101:3-3-42.1 of the Administrative Code

(Effective on or About December 31, 2006)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

The rules are being proposed for permanent Amendment pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period and to implement provisions of Section 5111.20 of Am. Sub. H.B. 530 of the 126th General Assembly.

Rule 5101:3-3-01 entitled Definitions defines terms relating to reimbursement for services provided by nursing facilities and intermediate care facilities for the mentally retarded. The proposed amendment implements provisions of Section 5111.20 of Am. Sub. H.B. 530 of the 126th General Assembly, updates the date for the Code of Federal Regulations, and adds "Ancillary and Support Costs" to the rule.

Rule 5101:3-3-22 entitled Rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) provides general provisions regarding rate recalculations, penalties, and interest, repayment, and deposit of overpayments to NFs and ICFs-MR. The proposed amendment corrects a spacing error within the text of the rule.

Rule 5101:3-3-42 entitled Nursing Facilities (NFs): chart of accounts sets forth the chart of accounts for nursing facilities. The rule is being proposed for permanent amendment to change cost report numbers 6240, 6250, and 6260 to 7271, 7281 and 7291. The rule implements the provisions of Section 5111.20 of Am. Sub. H.B. 530 of the 126th General Assembly. The accounts moved from direct care costs to ancillary and support costs.

Rule 5101:3-3-42.1 entitled Nursing Facilities (NFs): medicaid cost report sets forth the cost report for nursing facilities (NFs). The rule is being proposed for permanent amendment to change cost report numbers 6240, 6250, and 6260 to 7271, 7281 and 7291. The rule implements the provisions of Section 5111.20 of Am. Sub. H.B. 530 of the 126th General Assembly. The accounts moved from direct care costs to ancillary and support costs.

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facilities Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronic Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals

1) Select "Ohio Health Plans - Provider"
2) Select "Long Term Care"

3) From the "Table of Contents" drop down menu, scroll to and select the desired "NFTL #"

4) Scroll to the desired rule number highlighted in blue, select desired rule number

5) Once the desired rule appears, print or view as desired, print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 06-09

Nursing Facility Transmittal Letter (NFTL) 06-09

October 11, 2006

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Amendment of Rule 5101:3-3-65.1 of the Administrative Code (Effective on or About November 1, 2006)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Proposed for amendment

Rule 5101:3-3-65.1 entitled, Nursing facilities (NFs): rates for providers that change provider agreements is being proposed for permanent **amendment** to change the payment methodology by which ODJFS determines rates for entering providers in transactions involving a change in provider agreement. The rule sets forth the payment methodology for entering providers that begin participation in the Medicaid program with an initial date of July 1, 2006 through October 31, 2006 and for entering providers that begin participation in the Medicaid program on and after November 1, 2006.

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facilities Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site."

The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals

At the Electronic Manuals Internet site home page, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider"

2) Select "Long Term Care"

3) From the "Table of Contents" drop down menu, scroll to and select the desired "NFTL #"

4) Scroll to the desired rule number highlighted in blue, select desired rule number

5) Once the desired rule appears, print or view as desired, Print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL-06-09 Order Form

NFTL 06-08

Nursing Facility Transmittal Letter (NFTL) 06-08

September 7, 2006

TO: Administrators of Nursing Facilities

Directors of County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: National Provider Identifier (NPI) Implementation

PLEASE ROUTE THIS LETTER TO YOUR:

- Billing Departments
- Systems/Information Technology Departments
- Billing Software Vendors
- Billing Associates
- Trading Partners

According to federal regulation 45 CFR § 162.404, all eligible health care providers are required to obtain a ten-digit National Provider Identifier (NPI) number from the National Plan and Provider Enumeration System (NPPES). **Effective May 23, 2007, all claims submitted to the Ohio Department of Job and Family Services (ODJFS) for nursing facility (NF) services must use the NPI.**

It is very important to understand that the NPI will affect Medicaid billing and reimbursement. This transmittal letter contains information regarding NPI enumeration and reporting in order to ensure successful Medicaid billing and reimbursement. It also includes specific information for nursing facilities that use the NPI on claims submitted prior to May 23, 2007.

NPI Enumeration

Currently, Medicaid NF providers are identified by unique Medicaid provider numbers that are tied directly to specific reimbursement rates for each NF. ODJFS will continue to assign seven-digit Medicaid provider numbers to NFs upon their enrollment in Medicaid. Effective May 23, 2007, NPI numbers will replace the Medicaid provider numbers used in HIPAA related transactions, and Medicaid reimbursement rates will be tied directly to the NPI number, NOT the Medicaid provider number. For this reason, **a separate NPI number is required for each NF**, whether or not it is part of a chain that operates multiple NFs.

Steps You Must Take

Although the NPI is not required for electronic claims submission until May 23, 2007, i**n order to ensure that your Medicaid payment continues without interruption,** we request that you do the following:

A. Obtain an NPI number from NPPES **before November 1, 2006**;

B. Report it via e-mail to ODJFS; and

C. Report it when submitting electronic claims to ODJFS via the 837I.

A. Obtain an NPI number

To learn more about the NPI and **to obtain a NPI number**, please contact NPPES at **http://nppes.cms.hhs.gov,** or by phone at 1-800-465-3203 (1-800-692-2326 (TTY)). When applying for an NPI number, be sure to reference your Medicare and Medicaid numbers in Section 3C: *Other Provider Identification Numbers* on the NPI Application/Update Form.

B. Report NPI to ODJFS

To ensure successful Medicaid billing and reimbursement, you must report your NPI number to ODJFS. To do so, forward the e-mail notice that you received from the NPI

Enumerator that shows your assigned NPI number to **nf_npi@odjfs.state.oh.us.** Include "*NPI Reporting,*" and the name and seven-digit Medicaid number of the nursing facility to which the NPI is assigned, in the forwarding subject line. If you received a paper notice from the NPI Enumerator, please scan the notice and send it as an attachment to this same email address.

C. Report NPI in Electronic Claims Submissions

Since January 1, 2006, ODJFS has accepted the NPI on electronic claims if those claims also include the Medicaid provider number.

The NM1 Segment Usage:

- When submitting electronic claims via the 837I using both the NPI and the Medicaid provider number, use the qualifier XX in the primary identification qualifier location **NM108**, and use the NPI number in the primary identification location **NM109**.

The REF01 Segment will be used twice:

- For the first occurrence of the REF01 segment, continue to use your Medicaid provider number with the 1D qualifier in the secondary identification qualifier location **REF01**, and the Medicaid provider number in the secondary identification location **REF02**.
- For the second occurrence of the REF01 segment, use your Social Security Number (SSN) or Employer Identification Number (EIN) with SY or EI in the secondary identification qualifier location **REF01**, and the EIN or SSN in the secondary identification location **REF02**.

Loop Occurrences:

- If you submit Loop 2010AA, *Billing Provider Information,* **report the NPI, SSN or EIN, and the Medicaid provider number in this loop.**
- If you submit both Loop 2010AA, *Billing Provider Information,* and Loop 2010AB, *Pay to Provider Information,* and **<u>the billing and pay to provider are the same</u>**, report the same NPI, SSN or EIN, and the Medicaid provider number in both loops.
- If you submit both Loop 2010AA, *Billing Provider Information,* and Loop 2010AB, *Pay to Provider Information,* and **<u>the billing and pay to provider are different</u>**, **submit the NPI, SSN or EIN, and the Medicaid provider number of the provider to be paid in Loop 2010AB, Pay to Provider.**

Coinsurance Claims:

- The NPI number that is submitted on coinsurance claims that automatically cross over to ODJFS is the NPI of the provider that will be paid by ODJFS.

<u>Resources</u>

For questions about the assignment of NPI numbers relating to Ohio Medicaid nursing facilities, please send e-mail to **nf_npi@odjfs.state.oh.us** and include *"NPI Assignment Question"* in the e-mail subject line, or call the Bureau of Long Term Care Facilities, Facility Contracting Section, Provider Enrollment Unit at (614) 466-9088.

For questions about billing with the NPI, please send e-mail to **nf_npi@odjfs.state.oh.us** and include *"NPI Billing Question"* in the e-mail subject line.

Thank you for your attention to this matter. With your cooperation, we anticipate a successful transition to NPI.

NFTL 06-07

Nursing Facility Transmittal Letter (NFTL) 06-07

July 24, 2006

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Amendment of Rule 5101:3-3-43.1 of the Administrative Code (Effective on or About October 1, 2006)

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

The following rule is being proposed for permanent amendment pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period:

Rule 5101:3-3-43.1 entitled "Nursing facility (NF) case mix assessment instrument: minimum data set version 2.1 (MDS 2.0)" sets forth the resident assessment instrument (RAI) specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS). The RAI is the foundation for planning and delivering care to nursing home residents. Changes to the proposed rule are as follows:

First, paragraph (B) of the rule is being proposed for permanent amendment to require the submission of a single MDS 2.0 assessment when the time frames for completing the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) assessment and the Medicare assessment coincide. This change will prevent submission of duplicative assessments for the same resident resulting in inaccurate case mix scores.

Second, new language has been added to paragraphs (C)(7)(b), (C)(9)(b), and (D)(3)(a) of the proposed rule because assessment records may be used for determining the quarterly facility average Medicaid case mix score provided the record is identified as a Medicaid record for case mix purposes pursuant to the calculation methodology in rule 5101:3-3-43.3. If the assessment record is not identified as a Medicaid record, then it will not be used in the calculation of the facility's average Medicaid case mix score.

The above rule is being proposed for permanent amendment. Should revisions to the proposed permanent rule occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions occur, the aforementioned rule will become effective October 1, 2006 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider"
2) Select "Long Term Care"
3) From the "Table of Contents" drop down menu, scroll to and select the desired "NFTL #"
4) Scroll to the desired rule number highlighted in blue, select desired rule number
5) Once the desired rule appears, print or view as desired

Print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL- 06-07 Order Form

NFTL 06-06

Nursing Facility Transmittal Letter (NFTL) 06-06

September 28, 2006

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of New Rule 5101:3-3-58 of the Administrative Code (Effective on or About September 28, 2006)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Proposed for adoption

The rule being proposed for adoption is in accordance with Section 5111.244 (C) of the Am. Sub. H.B. 530 of the 126th General Assembly.

Rule 5101:3-3-58 entitled, "Quality incentive payment for nursing facilities (NFs)" sets forth the methodology by which ODJFS will calculate the quality incentive payment for NFs, on the basis of points awarded to each NF for meeting the quality criteria specified in Section 5111.244 (C) of Am. Sub. H.B. 530.

This rule replaces the rule that was emergency filed with an effective date of June 30, 2006. Subsequent to the proposed rule filing a possible discrepancy with the statute as amended by H.B. 530 was identified. The filing of the rule on an emergency basis eliminated the potential discrepancy.

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facilities Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals

At the Electronic Manuals Internet site home page, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider"
2) Select "Long Term Care"
3) From the "Table of Contents" drop down menu, scroll to and select the desired "NFTL #"
4) Scroll to the desired rule number highlighted in blue, select desired rule number
5) Once the desired rule appears, print or view as desired, Print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL- 06-06 Order Form

NFTL 06-05

Nursing Facility Transmittal Letter (NFTL) 06-05

June 14, 2006

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of NEW Rule 5101:3-3-31 of the Administrative Code (Effective on or About August 10, 2006)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Proposed for adoption

The rule being proposed for adoption is in accordance with Section 606.18.06 of the Am. Sub. H.B. 530 of the 126th General Assembly.

Rule 5101:3-3-31 entitled, "Capital compensation program eligibility and payment methodology" sets forth the eligibility criteria for providers and the payment methodology for the capital compensation program. Specifically the rule describes capital projects that are eligible for compensation, the timeframes that must be met in order to receive payments, the calculation methodology to be used in determining payments, and the methodology to be used to proportionally reduce payments in order to avoid exceeding the $10 million cap. A process by which providers can seek administrative review of a calculation is also included.

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facilities Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals

At the Electronic Manuals Internet site home page, follow these steps to access proposed rules contained in each transmittal letter:

1. Select "Ohio Health Plans - Provider"
2. Select "Long Term Care"
3. From the "Table of Contents" drop down menu, scroll to and select the desired "NFTL #"
4. Scroll to the desired rule number highlighted in blue, select desired rule number
5. Once the desired rule appears, print or view as desired, Print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

Attachment

NFTL 06-04

Nursing Facility Transmittal Letter (NFTL) 06-04

June 2, 2006

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Recission of Rule 5101:3-3-18 of the Administrative Code (Effective on or About October 1, 2006)

Changes in ODJFS HARD COPY Rule Distribution

The following rule is being proposed for permanent rescission due to similar provisions that exist in Section 447.272 of Title 42 of the Code of Federal Regulations and Section 5111.021 (A) of the Ohio Revised Code:

Rule 5101:3-3-18 entitled Inpatient Services: Application of Medicare Upper Payment Limit Calculation (MUPLC) for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR).

For questions regarding the above-referenced rule, please contact the Planning and Research Section, in the Bureau of Long Term Care Facilities, at (614) 466-9243.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronic Manuals Internet site home page, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider"
2) Select "Long Term Care"
3) From the "Table of Contents" drop down menu, scroll to and select the desired "NFTL #"
4) Scroll to the desired rule number highlighted in blue, select desired rule number
5) Once the desired rule appears, print or view as desired

Print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 06-03

Nursing Facility Transmittal Letter (NFTL) 06-03

May 5, 2006

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of Rules 5101:3-3-02.7, 5101:3-3-17, 5101:3-3-24, 5101:3-3-41, 5101:3-3-57, 5101:3-3-58, 5101:3-3-65, and 5101:3-3-65.1 of the Administrative Code (Effective on or About July 1, 2006)

Proposed Amendment of Rule 5101:3-3-21 of the Administrative Code (Effective on or About July 1, 2006)

Proposed Recission of Rules 5101:3-3-17, 5101:3-3-25, and 5101:3-3-26 of the Administrative Code (Effective on or About July 1, 2006)

CHANGES IN ODJFS HARD COPY RULE DISTRIBUTION

The following rules are being proposed for permanent adoption, amendment, or rescission pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. The department is providing facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

The following rules are being proposed for **adoption**:

Rule 5101:3-3-02.7 entitled Emergency management and resident relocation plan for long term care facilities sets forth the requirements for emergency relocation of residents in long term care facilities.

This rule is being proposed for adoption as part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. The provisions in this rule are being moved from former rule 5101:3-3-17 which is proposed for rescission. Minor grammatical changes have been made, and the title has been changed.

Rule 5101:3-3-17 entitled Payment methodology for the provision of outlier services in nursing facilities (NFs) is being proposed to implement Section 5111.258 of Am. Sub. H.B. 66 of the 126th General Assembly for fiscal year 2007 and beyond. This rule sets forth the methodology by which ODJFS will establish the contracted rate for outlier providers. The rule sets forth the components of the per diem rate and details the information that must be submitted by providers to ODJFS for establishment of the contracted outlier rate. This new rule is being proposed for adoption to align

reimbursement for outlier providers with the reimbursement methodology prescribed in Am. Sub. H.B. 66 for FY07 and beyond. Some of the provisions in this rule are being moved from former rule 5101:3-3-25 which is proposed for rescission.

Rule 5101:3-3-24 entitled Prospective rate reconsideration for nursing facilities (NFs) for possible calculation errors is being proposed to implement Section 5111.29 of Am. Sub. H.B. 66 of the 126th General Assembly. This rule sets forth the process by which a facility, group, or association may request a reconsideration of a prospective rate on the basis of a possible error in calculation and states the process and time frame to be followed by ODJFS in response to the request for reconsideration.

Rule 5101:3-3-41 entitled Nursing facilities (NFs) placement into peer groups sets forth the language that amplifies Sections 5111.231, 5111.24, and 5111.25 of Am. Sub. H.B. 66 of the 126th General Assembly by describing how ODJFS determines facility bed size for existing providers, new providers, and providers that have undergone a change of operator.

Rule 5101:3-3-57 entitled Tax cost add-on for nursing facilities (NFs) sets forth the language that amplifies Section 5111.242 of Am. Sub. H.B. 66 of the 126th General Assembly by establishing the methodology by which ODJFS will determine a rate for tax costs for providers not having a filed calendar year cost report.

Rule 5101:3-3-58 entitled Quality incentive payment for nursing facilities (NFs) implements changes made to Section 5111.244 of Am. Sub. H.B. 530 of the 126th General Assembly. This rule sets forth the methodology by which ODJFS will calculate the quality incentive payment for NFs, as well as the basis for awarding points to each NF for meeting the quality criteria specified in Section 5111.244 (C) of Am. Sub. H.B. 530.

Rule 5101:3-3-65 entitled Nursing Facilities (NFs): Rates for providers with an initial date of certification on or after July l, 2006 amplifies Section 5111.254 of Am. Sub. H.B. 66 of the 126th General Assembly. This rule sets forth the application of case-mix scores in determination of initial rates for providers with an initial date of certification on or after July 1, 2006 and the methodology by which ODJFS will adjust the case-mix calculation for replacement facilities, if necessary, to reflect any differences in the number of beds in the replaced and replacement nursing facilities.

Rule 5101:3-3-65.1 entitled Nursing Facilities (NFs): Rates for providers that change provider agreements amplifies Section 5111.254 of Am. Sub. H.B. 66 of the 126th General Assembly by establishing the methodology to determine an initial rate for an entering operator following a change of provider transaction and for establishing rates for the provider in subsequent fiscal years.

The following rule is being proposed for **amendment**:

Rule 5101:3-3-21 entitled Audits of nursing facility (NF) cost reports sets forth the process for the conducting of audits by ODJFS or outside contractors, time frames for provider submission of amended cost reports, and preparation of written summaries of audit disallowances. The proposed amendment implements changes in the rule pursuant to Section 5111.27 of Am. Sub. H.B. 66 of the 126th General Assembly, adds a website for the American Institute of Certified Public Accountants, and makes various grammatical changes to the rule.

The following rules are being proposed for **rescission**:

Rule 5101:3-3-17 entitled Emergency relocation plan.

Rule 5101:3-3-25 entitled Payment methodology for the provision of outlier services.

Rule 5101:3-3-26 entitled Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): implementation of timely rates.

For questions regarding the above-referenced rules, please contact the Reimbursement Section, in the Bureau of Long Term Care Facilities, at (614) 752-8196.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

- Select "Ohio Health Plans - Provider" (left column)
- Select "Long Term Care Manual" (right column)
- Select "NF Transmittal" (left column)
- Select "NFTL #" (left column)
- Scroll to the desired rule number highlighted in blue, select desired rule number (right column)
- Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-

copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

Attachment

NFTL 06-02A

Nursing Facility Transmittal Letter (NFTL) 06-02A

May 22, 2006

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Revision of Rules 5101:3-3-43.1, and 5101:3-3-43.4 of the Administrative Code (Effective on or About July 1, 2006)

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

The following rules are being revised:

Rule 5101:3-3-43.1 entitled "Nursing facility (NF) case mix assessment instrument: minimum data set version 2.1 (MDS 2.0)" sets forth the resident assessment instrument (RAI) specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS). This rule was originally proposed for adoption to comply with the provisions of section 5111.232 of Amended Substitute House Bill 66 of the 126th General Assembly. This rule is now being revised to correct paragraph references contained within this rule. An incorrect reference to Administrative Code rule 5101:3-3-43.3, paragraph (D)(3) was corrected to paragraph (D)(4). This correction was made to paragraphs (C)(3), (C)(4), (D)(3)(c), (D)(3)(d), (D)(3)(e), and (D)(4) of this rule.

In paragraph (C)(7)(b) of this rule, an incorrect reference to paragraph (C)(6)(a) of this rule was corrected to paragraphs (C)(1) and (C)(2). In paragraph (D)(4) of this rule, an incorrect reference to paragraphs (D)(4)(a) and (D)(4)(b) of this rule were corrected to paragraphs (D)(3)(a) and (D)(3)(b) respectively.

Rule 5101:3-3-43.4 entitled "Exception review process for nursing facilities (NFs)" sets forth protocols for the exception review process for NFs. This rule was originally proposed for adoption to comply with the provisions of Section 5111.27 of Amended Substitute House Bill 66 of the 126th General Assembly. This rule is now being revised to correct rule references and paragraph references contained within this rule. In paragraph (A)(6) of this rule, an incorrect reference to Administrative Code rule 5101:3-3-43.3 was corrected to Administrative Code rule 5101:3-3-43.2. In paragraph (N) of this rule, incorrect references to paragraphs (P) and (Q) of this rule were corrected to paragraphs (O) and (P) respectively.

The above rules are being revised. Should further revisions to the rules occur, you will be notified in a subsequent transmittal letter at that time. Should no further revisions occur, the aforementioned rules will become effective July 1, 2006 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

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At the Electronic Manuals Internet site home page, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider"

2) Select "Long Term Care"

3) From the "Table of Contents" drop down menu, scroll to and select the desired "NFTL #"

4) Scroll to the desired rule number highlighted in blue, select desired rule number

5) Once the desired rule appears, print or view as desired

Print individual or multiple pages by clicking the "Entire eManual" link (at the top or bottom of an eManual) and identify the print range.

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 06-02A Order Form

NFTL 06-02

Nursing Facility Transmittal Letter (NFTL) 06-02

May 5, 2006

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Recission of Rules 5101:3-3-40, 5101:3-3-41, and 5101:3-3-52.1 (Effective on or About July 1, 2006)

Proposed Adoption of Rules 5101:3-3-43.1, 5101:3-3-43.2, 5101:3-3-43.3, 5101:3-3-43.4, and 5101:3-3-68 of the Administrative Code (Effective on or About July 1, 2006)

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

The following rules are being proposed for permanent **rescission** pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period:

Rule 5101:3-3-40 entitled "Nursing facility (NF) case mix assessment instrument: minimum data set version 2.0 (MDS 2.0)."

Rule 5101:3-3-41 entitled "Resource utilization groups, version III (RUG III): the nursing facility case mix payment system."

Rule 5101:3-3-52.1 entitled "Exception review process for nursing facilities (NFS)."

The following rules are being proposed for permanent **adoption**:

Rule 5101:3-3-43.1 entitled "Nursing facility (NF) case mix assessment instrument: minimum data set version 2.0 (MDS 2.0)" sets forth the resident assessment instrument (RAI) specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS). The RAI is the foundation for planning and delivering care to nursing home residents. This rule is being proposed for permanent adoption to comply with the provisions of Section 5111.232 of Amended Substitute House Bill 66 of the 126th General Assembly. This rule is part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. This rule replaces rule 5101:3-3-40.

Rule 5101:3-3-43.2 entitled "Resource utilization groups, version III (RUG III): the nursing facility case mix payment system" sets forth components of the Medicaid reimbursement methodology for the nursing facility direct care payment system, based on a core set of items included in the uniform resident assessment instrument (RAI) specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS). This rule is being proposed for permanent adoption to comply with the provisions of Section 5111.232 of Amended Substitute House Bill 66 of the 126th General Assembly. This rule is part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. This rule replaces rule 5101:3-3-41.

Rule 5101:3-3-43.3 entitled "Calculation of quarterly, semiannual and annual nursing facility (NF) average case mix scores" sets forth the process for determining nursing facility average case mix scores on a quarterly, semiannual and annual basis. This rule is being proposed for permanent adoption to comply with the provisions of Sections 5111.231 and 5111.232 of Amended Substitute House Bill 66 of the 126th General Assembly. This rule is part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. This rule replaces rule 5101:3-3-42.

Rule 5101:3-3-43.4 entitled "Exception review process for nursing facilities (NFs)" sets forth protocols for the exception review process for NFs. These protocols include the facility selection process and the components of a risk analysis profile. This rule is being proposed for permanent adoption to comply with the provisions of Section 5111.27 of Amended Substitute House Bill 66 of the 126th General Assembly. This rule is part of a reorganization of rules administered by the Bureau of Long Term Care Facilities. This rule replaces rule 5101:3-3-52.1.

Rule 5101:3-3-68 entitled "Fiscal year 2007 nursing facility (NF) rate change limitation" sets forth limits on the amount that fiscal year 2007 NF rates can differ from June 30, 2006 rates. The rule also states that these limits shall be applied to any NF rate determined for NF services provided during fiscal year 2007, including rates that have been adjusted for any reason. The rule amplifies section 206.66.23 of Amended Substitute House Bill 66 of the 126th General Assembly.

The above rules are being proposed for permanent rescission and adoption. Should revisions to the proposed permanent rules occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions occur, the aforementioned rules will become effective July 1, 2006 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/medicaid/LTC/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)
2) Select "Long Term Care Manual" (right column)
3) Select "NF Transmittal" (left column)
4) Select "NFTL #" (left column)
5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)
6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

Attachment

NFTL 05-12A

Nursing Facility Transmittal Letter (NFTL) 05-12A

February 6, 2006

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: REFILED Proposed Permanent Adoption of Rules 5101:3-3-42 and 5101:3-3-42.1 of the Administrative Code (Effective on or About FEBRUARY 13, 2006)

Changes in ODJFS HARD COPY Rule Distribution

Rule 5101:3-3-42 entitled NFs: Chart of Accounts sets forth the chart of accounts for nursing facilities (NFs). This rule was originally proposed for permanent adoption in conjunction with the rescission of rule 5101:3-3-20.1. This rule is being refiled for proposed permanent adoption to reinstate Medicaid nursing facility cost report accounts 1350.1, 1350.2, 1350.3, 1350.4, 8500, 8570, and 8580 which were inadvertently omitted during the original filing. This rule is also being refiled to change omitted cost report account numbers 8500, 8570, and 8580 to 8085, 8086, and 8087 respectively.

Rule 5101:3-3-42.1 entitled NF Medicaid Cost Report sets forth the cost report for nursing facilities (NFs). This rule was originally proposed for permanent adoption in conjunction with the rescission of rule 5101:3-3-20.2. This rule is being refiled for proposed permanent adoption to reinstate cost report accounts 1350, 5020, 5030, 5040, 5050, 5060, 8085, 8086, and 8087 that were omitted from the Medicaid nursing facility cost report during the development of separate cost reports for nursing facilities and intermediate care facilities for the mentally retarded pursuant to Am. Sub. H.B. 66.

Instructions:

Obsolete rule 5101:3-3-42 and its appendix and rule 5101:3-3-42.1 and its appendix as set forth in NFTL 05-12 and replace the rules and appendices as contained in this transmittal.

For questions regarding the above-referenced rules, please contact the Reimbursement Section, in the Bureau of Long Term Care Facilities, at (614) 752-8196.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)
2) Select "Long Term Care Manual" (right column)
3) Select "NF Transmittal" (left column)
4) Select "NFTL #" (left column)
5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)
6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 05-12A Order Form

NFTL 05-12

Nursing Facility Transmittal Letter (NFTL) 05-12

December 16, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of Rules 5101:3-3-42, 5101:3-3-42.1, 5101:3-3-42.2, 5101:3-3-42.3, and 5101:3-3-42.4 of the Administrative Code (Effective on or About FEBRUARY 9, 2006)

Proposed Amendment of Rule 5101:3-3-20 of the Administrative Code (Effective on or About FEBRUARY 9, 2006)

Proposed Recission of Rules 5101:3-3-20.1, 5101:3-3-20.2, 5101:3-3-20.3, 5101:3-3-42, 5101:3-3-51.1, and 5101:3-3-56 of the Administrative Code (Effective on or About FEBRUARY 9, 2006)

CHANGES IN ODJFS HARD COPY RULE DISTRIBUTION

These rules are being proposed for permanent adoption, amendment, or rescission pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five-year period. The following changes to the Medicaid long term care facility reimbursement system emerged as a result of House Bill 66 of the 126th General Assembly and will take effect for services provided on and after July 1, 2005. In accordance with Section 5111.22 of the Revised Code, the department is providing facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

These rules are being proposed for permanent **Adoption** pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five-year period.

Rule 5101:3-3-42 entitled NFs: Chart of Accounts sets forth the chart of accounts for nursing facilities (NFs). In order to implement Section 5111.26 of Am. Sub. H.B. 66 of the 126th General Assembly, the charts of accounts for nursing facilities and intermediate care facilities for the mentally retarded must be separated. This rule replaces in part Ohio Administrative Code rule 5101:3-3-20.1. The major changes to this chart of accounts, include the addition of new cost centers for the reporting of Ancillary and Support Services and Taxes, as well as the redistribution of cost accounts within the Direct Care and Ancillary and Support Services cost centers. Accounts were renumbered throughout all of the cost centers in order to accommodate these changes.

Rule 5101:3-3-42.1 entitled NF Medicaid Cost Report sets forth the cost report for nursing facilities (NFs). This rule is proposed for adoption on a permanent basis in accordance with Section 5111.26 of Am. Sub. H.B. 66 of the 126th General Assembly. Significant changes to the cost report, labeled Appendix A, include: (1) the addition of new cost centers for reporting Taxes and Ancillary and Support services costs, the addition of a box for the reporting of National Provider Identifier on Schedule A, the addition of fields to Schedule A to permit reporting of additional provider information, including Type of Control for the facility and Chain Home Office Information, the addition of Attachment 8, Employee Retention Rate, as required under Section 5111.244 of Am. Sub. H. B. 66 of the 126th General Assembly, and the addition of Section C on Attachment 5 entitled, Nurse Aide Training and/or Competency Evaluation Program Prohibitions, (2) the removal of cost centers for reporting Other Protected and Indirect Care costs, the removal of renovations from schedules D and D-1, the removal of the return on equity calculation section in Schedule E-1, removal of cost report types 4.4 Rate Reconsideration and 4.7 Capital, and removal of the Government Mandate cost account, (3) separation of the NF cost report from the ICF-MR cost report which will be proposed for adoption as rule 5101:3-3-71, and the rearranging of accounts under Taxes, Direct Care, and Ancillary and Support Services cost centers.

Rule 5101:3-3-42.2 entitled Nursing facilities (NFs): Leased staff sets forth the definition of leased staff services, the conditions under which leased staff services are reimbursable to NFs as other/contracted costs, and the manner in which staff leasing arrangements are reimbursable through the medicaid cost reporting mechanism. This rule amplifies Section 5111.26 of Am. Sub. H.B. 66 of the 126th General Assembly and replaces in part former rule 5101:3-3-20.3, which is being rescinded.

Rule 5101:3-3-42.3 entitled Capital asset and depreciation guidelines - nursing facilities (NFs) sets forth capital asset and depreciation guidelines for NFs, the guidelines for determining if an expenditure should be capitalized, the method of depreciation to be used, and a table for determining the useful life of a capital asset contained in appendix A of the rule. The rule also sets forth the conditions for reporting disposal of assets, and the records that must be maintained by providers to support the reporting of capital asset depreciation. This rule amplifies Section 5111.25 of Am. Sub. H.B. 66 of the 126th General Assembly and replaces former rule 5101:3-3-51.1, which is being rescinded.

Rule 5101:3-3-42.4 entitled Nursing facilities (NFs): nonreimbursable costs identifies costs which are not reimbursable to NFs through the prospective cost reporting mechanism. This rule implements Sections 5111.20, 5111.26, 5111.263, 5111.265, and 5111.266 of Am. Sub. H.B. 66 of the 126th General Assembly and replaces former rule 5101:3-3-56, which is being rescinded.

This rule is being proposed for permanent **Amendment** pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-3-20 entitled Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements sets forth the requirement for the timely filing of cost reports by NFs and ICFs-MR, the methodology for processing those reports by ODJFS, and penalties that may be applied for not filing cost reports as required. The rule is being amended to implement Sections 5111.26, 5111.27, and 5111.28 of Am. Sub. H.B. 66 of the 126th General Assembly. Changes include the elimination of language describing the nursing facility reimbursement formula that is no longer valid based on these sections. Former paragraph (A) is deleted because it required that rates be calculated each fiscal year based on the prior calendar year cost report. Language in former paragraph (C), allowing rate reconsiderations for disputed costs has been deleted. Language regarding desk reviews has been updated based on Section 5111.27 of Am. Sub. H.B. 66 of the 126th General Assembly. Former paragraph (K) has been changed to require providers to provide, on request, all contracts of ten thousand dollars or more during a twelve month period rather than twenty five thousand. Former paragraph (M)(3) was updated to show that maintenance and repair costs of transport vehicles should now be reported by NFs as Ancillary and Support costs. The proposed amendment also updates or eliminates references to Ohio Administrative Code rules that are being rescinded to implement Am. Sub. H.B. 66 of the 126th General Assembly, and various grammatical changes appear throughout the body of the rule.

These rules are being proposed for permanent **Rescission** pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-3-20.1 entitled Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): Chart of accounts.

Rule 5101:3-3-20.2 entitled Nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR): medicaid cost report.

Rule 5101:3-3-20.3 entitled Leased staff reimbursement for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-42 entitled Calculation of quarterly and annual nursing facility (NF) average case mix scores.

Rule 5101:3-3-51.1 entitled Capital asset and depreciation guidelines - nursing facilities (NFs).

Rule 5101:3-3-56 entitled Nursing facilities (NFs): nonreimbursable costs.

Should revisions to the proposed rules occur during the JCARR hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules would become effective on February 9, 2006 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A) (2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "NF Transmittal" (left column)

4) Select "NFTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 05-12 Order Form

NFTL 05-11

Nursing Facility Transmittal Letter (NFTL) 05-11

December 8, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of Rule 5101:3-3-69 of the Administrative Code (Effective on or About FEBRUARY 2, 2006)

Proposed Amendment of Rules 5101:3-3-01, 5101:3-3-19, 5101:3-3-22, 5101:3-3-25, 5101:3-3-40, 5101:3-3-41, 5101:3-3-52.1 of the Administrative Code (Effective on or About FEBRUARY 2, 2006)

Proposed Recission of Rules 5101:3-3-24, 5101:3-3-24.1, 5101:3-3-43, 5101:3-3-44, 5101:3-3-45, 5101:3-3-48, 5101:3-3-48.1, 5101:3-3-48.2, 5101:3-3-49, 5101:3-3-49.1, 5101:3-3-50, 5101:3-3-50.1, 5101:3-3-51, 5101:3-3-51.2, 5101:3-3-51.3, 5101:3-3-51.4, 5101:3-3-51.5, 5101:3-3-51.6, 5101:3-3-53, 5101:3-3-57 and 5101:3-3-58 of the Administrative Code (Effective on or About FEBRUARY 2, 2006)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

These rules are being proposed for permanent adoption, amendment, or rescission pursuant to Am. Sub. H.B. 66 of the 126th General Assembly, and Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five-year period. The following changes to the Medicaid long term care facility reimbursement system emerged as a result of Am. Sub. House Bill 66 of the 126th General Assembly and will take effect for services provided on and after July 1, 2005. In accordance with Section 5111.22 of the Revised Code, the department is providing facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

This rule is being proposed for permanent **Adoption**:

Rule 5101:3-3-69 entitled Nursing facilities (NFs): method for establishing the fiscal year 2006 Medicaid reimbursement rate for NFs is being proposed to implement Section 206.66.22 of Am. Sub. H.B. 66 of the 126th General Assembly. The rule sets forth the method for establishing the reimbursement rate for NFs for the period beginning July 1, 2005 and ending June 30, 2006. The rule also sets forth the method of establishing the reimbursement rate for a provider that undergoes a change in operator, a provider that obtains certification as a NF and begins participation in the medicaid program, or a provider that adds one or more certified beds during the period from July 1, 2005 to June 30, 2006. The rule also states that the rate for those NFs that were not required to pay the franchise fee in fiscal year 2005 but are required to pay the fee in fiscal year 2006 will be increased by $4.30 per day to reflect the franchise fee assessment rate. The rule also states that the NFs rate established under this rule is not subject to adjustments except to reflect an adjustment resulting from an audit of a 2003 cost report. ODJFS estimates that from state fiscal year 2005 to state fiscal year 2006, this reimbursement change will result in an increase in aggregate payments to nursing facilities of approximately $40 million. If this change were not adopted, aggregate payments to nursing facilities would be an estimated $440 million higher in state fiscal year 2006 than they will be after this change.

These rules are being proposed for permanent **Amendment** pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-3-01 entitled Definitions defines terms relating to reimbursement for services provided by nursing facilities and intermediate care facilities for the mentally retarded. The proposed amendment eliminates references to Ohio Administrative Code rules that are being rescinded to implement Am. Sub. H.B. 66 of the 126th General Assembly. The amendment also eliminates references to the Ohio Revised Code and sections

describing the nursing facility reimbursement formula that are no longer valid based on Am. Sub. H.B. 66 of the 126th General Assembly.

Rule 5101:3-3-19 entitled Relationship of other covered medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. The proposed amendment eliminates references to Ohio Administrative Code rules that are being rescinded to implement Am. Sub. H.B. 66 of the 126th General Assembly. In (D)(1) and (D)(2) of the rule, reference to Ohio Medicaid Drug Formulary was changed to appendix A of rule 5101:3-9-12 of the Administrative Code. Paragraph (E) subparagraphs (1), (2), and (3), have been revised to specify the reimbursement method for therapy services rendered to residents of NFs and ICFs-MR. In (F)(1)(c)(iv)(a)(i)(A), reference to the American Nurses' Association has been changed to American Nurses Association, and reference to the National Board of Pediatric Nurse Practitioners and Associates has been changed to Pediatric Nursing Certification Board. In (F)(1)(c)(iv)(a)(ii)(B)(3), reference to American Medical Association's Committee on Allied Health Education and Accreditation has been changed to American Medical Association's Commission on Accreditation of Allied Health Education Programs. Various grammatical changes appear throughout the body of the rule.

Rule 5101:3-3-22 entitled Rate recalculations, interest on overpayments, penalties, repayment of overpayments and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) identifies the provisions for rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). The proposed amendment eliminates references to Ohio Administrative Code rules that are being rescinded to implement Am. Sub. H.B. 66 of the 126th General Assembly. The amendment also changes "sale of the facility" to "facility closure, voluntary termination, or voluntary withdrawal" to be consistent with Section 5111.28 of Am. Sub. H.B. 66 of the 126th General Assembly.

Rule 5101:3-3-25 entitled Payment methodology for the provision of outlier services sets forth provisions under which outlier services are reimbursed. This rule is being proposed for permanent amendment to comply with the provisions of Section 5111.258 of Amended Substitute House Bill 66 of the 126th General Assembly. The proposed amendment eliminates references to Ohio Administrative Code rules that are being rescinded to implement reimbursement system changes included in this bill. Changes include the elimination of language in paragraphs (B)(3), (B)(5), (C)(1), (C)(2), and (D)(2) describing the nursing facility reimbursement formula that is no longer valid based on Section 5111.258 of Am. Sub. H.B. 66 of the 126th General Assembly. Paragraph (A)(3) was deleted from the proposed rule as it referenced calculation of a prospective rate for cost centers that have been realigned for nursing facilities. Paragraph (B)(5) eliminates the phrase prior to July 1 and replaces it with the phrase after June 30 in accordance with 5111.258 (A)(2) of Amended Substitute House Bill 66 of the 126th General Assembly. Paragraph (C)(1) eliminates the phrase ICFS-MR and replaces it with ICFs-MR. Paragraphs (C)(2) and (D)(2) eliminates the phrase in accordance with paragraph (E) of this rule, which has been amended. Paragraph (D)(2) also eliminates language which describes payment of per diem rate for outlier services if the required information is not submitted, also in accordance to changes mandated by Section 5111.258 of Am. Sub. H.B. 66 of the 126th General Assembly. Paragraph (D)(3)(a) eliminates the word Sheets and replaces it with the word Sheet and eliminates the phrase ICF-IMR and replaces it with the phrase ICF-MR. Paragraph (D)(3)(d)(ii) eliminates the word march and replaces it with the word March. Paragraph (E) of the former rule, which described the determination of per diem rates for outlier services, has been eliminated as it describes the nursing facility reimbursement formula that is no longer valid based on Section 5111.258 of Am. Sub. H.B. 66 of the 126th General Assembly. Therefore, what was formerly Paragraph (F) has now become Paragraph (E).

Rule 5101:3-3-40 entitled Nursing facility (NF) case mix assessment instrument: minimum data set version 2.0 (MDS 2.0), sets forth the resident assessment instrument (RAI) specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS). This rule is being proposed for permanent amendment to comply with the provisions of Section 5111.232 of Am. Sub. H.B. 66 of the 126th General Assembly. The following changes all relate to language describing the nursing facility reimbursement formula that is no longer valid based on Sections 5111.231 and 5111.232 of Am. Sub. H.B. 66 of the 126th General Assembly. Paragraph (A)(1) was deleted from the proposed rule as it referenced calculation of annual facility

average case mix score and also referenced rule 5101:3-3-42 which is being proposed for rescission to implement Section 5111.26 of Am. Sub. H.B. 66 of the 126th General Assembly requiring that the charts of accounts for nursing facilities and intermediate care facilities for the mentally retarded be separated. Paragraph (A)(6) of the proposed rule was deleted as it defined the calculation of cost per case mix unit and the determination of the NFs rate for direct care costs that are no longer valid. Language referencing rate setting was also deleted from paragraph (A)(10) of the proposed rule and language referencing the calculation of the quarterly facility average case mix score was deleted from paragraph (A)(16) of the proposed rule. Paragraph (A)(8) of the proposed rule was deleted as it defined direct care peer groups that are no longer valid. Quarterly rate setting was deleted from paragraph (C)(2) of the proposed rule, and replaced with determining the quarterly facility score. Paragraph (C)(3) of the proposed rule was deleted. The reference to an assigned quarterly average case mix score was deleted from paragraph (C)(4) of the proposed rule. Rate setting was deleted from paragraph (C)(6) of the proposed rule and was replaced with determining the quarterly facility score. Rate setting was deleted from paragraph (C)(7)(b) of the proposed rule and was replaced with determining the quarterly facility score. Rate setting was deleted from paragraph (C)(9)(b) of the proposed rule and was replaced with determining the quarterly facility score. For rate setting purposes was deleted from paragraphs (D)(1)(b), (D)(1)(d)(i), and (D)(1)(d)(ii) of the proposed rule. Reference to paragraph (C)(9) was corrected to (C)(8) in paragraph (D)(1)(d)(ii) of the proposed rule. Rate setting purposes was deleted from paragraph (D)(2)(a) of the proposed rule and replaced by determining the quarterly facility score. Used for rate setting was deleted from paragraph (E) of the proposed rule.

The following procedural changes and grammatical corrections were also made. The verbiage or an annual average was deleted from paragraph (A)(2) of the proposed rule. Language regarding the eighty day correction period was deleted from paragraph (A)(10) of the proposed rule as the correction period is not relevant to the definition of filing date. Paragraph (A)(15) was deleted from the proposed rule. References to paragraphs (C)(7) and (C)(9) were corrected to (C)(6) and (C)(8) respectively in paragraph (A)(21) of the proposed rule. A web site referenced in paragraph (A)(26) of the proposed rule was corrected. Reference to paragraph (C)(7)(a) was corrected to (C)(6)(a) in paragraph (C)(7)(b) of the proposed rule. The last sentence of paragraph (D)(2)(b) was deleted from the proposed rule. The last sentence of paragraph (D)(2)(d) was deleted from the proposed rule. Paragraph (D)(3) was deleted from the proposed rule. Reference to paragraph (C)(4) was corrected to (C)(3) in paragraph (E) of the proposed rule. The department estimates the annual aggregate Medicaid payments will not increase or decrease as a result of this amendment.

Rule 5101:3-3-41 entitled Resource utilization groups, version III (RUG III): the nursing facility case mix payment system, sets forth components of the Medicaid reimbursement methodology for the nursing facility direct care payment system, based on a core set of items included in the uniform resident assessment instrument (RAI) specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS). This rule is being proposed for permanent amendment to comply with Section 5111.232 of Am. Sub. H.B. 66 of the 126th General Assembly. The second sentence of the introductory paragraph referencing establishment of each facility's rate for direct care costs was deleted from the proposed rule as it is no longer valid based on Section 5111.231 of Am. Sub. H.B. 66 of the 126th General Assembly. Acronyms for registered nurses, licensed practical nurses, and nurse aides were corrected from the singular to the plural form (RNs, LPNs, and NAs, respectively) in paragraph (G) of the proposed rule. The department estimates the annual aggregate Medicaid payments will not increase or decrease as a result of this amendment.

Rule 5101:3-3-52.1 entitled Exception review process for nursing facilities (NFs), sets forth protocols for the exception review process for NFs. This rule is being proposed for permanent amendment to comply with the provisions of Section 5111.27 and 5111.28 of Am. Sub. H.B. 66 of the 126th General Assembly. Paragraphs (A)(2), (N), (N)(1), (N)(2), (N)(3), and (P) were deleted from the proposed rule as they were no longer valid based on Sections 5111.231 and 5111.232 of Am. Sub. H.B. 66 of the 126th General Assembly. The reference to paragraph (P) was deleted from paragraph (O) accordingly. Paragraph (A)(1) of the proposed rule changes at selected nursing facilities (NFs) to the singular at a selected nursing facility (NF) and used to calculate the direct care rate was deleted from the first sentence. Exceeds was corrected to exceed in paragraph (C)(2) of the proposed rule. References to MDS2.0 were corrected to MDS 2.0 throughout the proposed rule. The department estimates the annual aggregate Medicaid payments will not increase or decrease as a result of this amendment.

These rules are being proposed for permanent **Rescission** pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-3-24 entitled Prospective rate reconsideration for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).

Rule 5101:3-3-24.1 entitled Rate adjustments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): government mandates.

Rule 5101:3-3-43 entitled Nursing facilities (NFs): method for establishing the total prospective rate.

Rule 5101:3-3-44 entitled Method for establishing the direct care cost component of the prospective rate for nursing facilities (NFs).

Rule 5101:3-3-45 entitled Purchased nursing services reimbursement for nursing facilities (NFs).

Rule 5101:3-3-48 entitled Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for owners, relatives of owners, and administrators in nursing facilities (NFs).

Rule 5101:3-3-48.1 entitled Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for owners and relatives of owners in nursing facilities (NFs).

Rule 5101:3-3-48.2 entitled Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for administrators in nursing facilities (NFs).

Rule 5101:3-3-49 entitled Nursing facilities (NFs): method for establishing the other protected costs component of the prospective rate.

Rule 5101:3-3-49.1 entitled Nursing facilities (NFs): method for establishing reimbursement for the franchise permit fee reported in account 6091.

Rule 5101:3-3-50 entitled Method for establishing the indirect care costs component of the prospective rate for nursing facilities (NFs).

Rule 5101:3-3-50.1 entitled Method for establishing the out-of-facility meal cost limits for nursing facilities (NFs).

Rule 5101:3-3-51 entitled Method for establishing capital reimbursement for nursing facilities (NFs).

Rule 5101:3-3-51.2 entitled Cost of ownership and efficiency incentive for nursing facilities (NFs).

Rule 5101:3-3-51.3 entitled Nonextensive renovations for nursing facilities (NFs).

Rule 5101:3-3-51.4 entitled Nursing facilities (NFs): return on equity.

Rule 5101:3-3-51.5 entitled Reimbursement for leased nursing facilities (NFs).

Rule 5101:3-3-51.6 entitled Notice, escrow, and recovery of excess depreciation paid, change in the medicaid provider agreement, closure or voluntary withdrawal from the medical assistance program for nursing facilities (NFs).

Rule 5101:3-3-53 entitled Nursing facilities (NFs): Rates for providers new to the medical assistance program and providers that change provider agreements.

Rule 5101:3-3-57 entitled Nursing facilities (NFs) expenditure limitation.

Rule 5101:3-3-58 entitled Nursing facilities (NFs) stabilization fund: method of establishing payment(s) from the stabilization fund.

Should revisions to the proposed rules occur during the JCARR hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on February 2, 2006 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated

Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "NF Transmittal" (left column)

4) Select "NFTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 05-11 Order Form

NFTL 05-10

Nursing Facility Transmittal Letter (NFTL) 05-10

October 26, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Recission of Rules 5101:3-3-49.2, 5101:3-3-49.3, 5101:3-3-49.7, 5101:3-3-49.8, and 5101:3-3-49.9 of the Administrative Code (Effective on or About December 30, 2005)

PROPOSED ADOPTION OF NEW RULES 5101:3-3-30, 5101:3-3-30.1, 5101:3-3-30.2, 5101:3-3-30.3, AND 5101:3-3-30.4 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT DECEMBER 30, 2005)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Enclosed are proposed rule changes made in accordance with section 119.03 of the Revised Code, which outlines procedures for the adoption, amendment, and rescission of administrative rules.

Proposed for rescission

Rule 5101:3-3-49.2 entitled "Identification of nursing facility (NF) and hospital beds subject to the franchise permit fee (FPF)" identifies NF and hospital beds subject to, and those exempt from, the FPF assessment. This rule is being proposed for rescission as a result of provisions in HB66 relating to the administration of the Medicaid program. It is being replaced by new rule 5101:3-3-30, which explains the FPF assessment criteria for both NF and ICF-MR/DD provider types.

Rule 5101:3-3-49.3 entitled "Calculation, billing, collection and appeal process for the franchise permit fee (FPF)" sets forth the FPF calculation formula, payment process, and calculation appeal process for NFs and hospitals. This rule is being proposed for rescission as a result of provisions in HB66 relating to the administration of the Medicaid program. It is being replaced by new rule 5101:3-3-30.1, which sets forth the calculation method, billing cycle, payment remittance procedure, and calculation appeal process for both NF and ICF-MR/DD provider types.

Rule 5101:3-3-49.7 entitled "Method of distribution of franchise permit fee (FPF) proceeds" sets forth the distribution method for FPF proceeds from NFs and hospitals. This rule is being proposed for rescission as a result of provisions in HB66 relating to the administration of the Medicaid program. It is being replaced by new rule 5101:3-3-30.3, which sets forth the distribution method for FPF proceeds from both NF and ICF-MR/DD provider types.

Rule 5101:3-3-49.8 entitled "Enforcement of the franchise permit fee (FPF) program for nursing facilities (NFs) and hospitals" sets forth procedures for the enforcement of the FPF program for NFs and hospitals. This rule is being proposed for rescission as a result of provisions in HB66 relating to the administration of the Medicaid program. It is being replaced by new rule 5101:3-3-30.2, which sets forth the procedures for enforcement of the FPF program for both NF and ICF-MR/DD provider types.

Rule 5101:3-3-49.9 entitled "Procedure for terminating the franchise permit fee (FPF) program for nursing facilities (NFs) and hospitals" sets forth the procedure for terminating the FPF program if the Centers for Medicare and Medicaid Services (CMS) determines the FPF is an impermissible health care related tax. This rule is being proposed for rescission as a result of provisions in HB66 related to the administration of the Medicaid program. It is being replaced by new rule 5101:3-3-30.4, which sets forth the termination procedure for both NF and ICF-MR/DD provider types.

Proposed for adoption

Rule 5101:3-3-30 entitled "Beds and facilities subject to the franchise permit fee (FPF) - for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally

retarded/developmentally disabled (ICFs-MR/DD)" identifies beds and facilities subject to, and those exempt from, the FPF. This is a new rule being proposed for adoption to implement provisions in HB66 relating to the administration of the Medicaid program. It replaces rule 5101:3-3-49.2, and combines provisions for both NF and ICF-MR/DD provider types. Rule references have been updated as necessary. Paragraphs (G), (H), and (I), which address FPF exemptions for nursing homes that provide charity care, have been deleted.

Rule 5101:3-3-30.1 entitled "Calculation, billing, payment remittance, and appeal process for the franchise permit fee (FPF) - for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" sets forth the FPF calculation method, billing cycle, payment remittance procedure, and calculation appeal process. This is a new rule being proposed for adoption to implement provisions in HB66 relating to the administration of the Medicaid program. It replaces rule 5101:3-3-49.3, and combines provisions for both NF and ICF-MR/DD provider types. Rule references have been updated as necessary, and FPF rates and applicable dates have been updated.

Rule 5101:3-3-30.2 entitled "Enforcement of the franchise permit fee (FPF) program - for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" sets forth the procedures for enforcement of the FPF program. This is a new rule being proposed for adoption to implement provisions in HB66 relating to the administration of the Medicaid program. It replaces rule 5101:3-3-49.8, and combines provisions for both NF and ICF-MR/DD provider types. Rule references have been updated as necessary. Paragraph (B) has been expanded to list the specific enforcement measures available to ODJFS.

Rule 5101:3-3-30.3 entitled "Distribution method for franchise permit fee (FPF) proceeds from nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" sets forth the distribution method for FPF proceeds. This is a new rule being proposed for adoption to implement provisions in HB66 relating to the administration of the Medicaid program. It replaces rule 5101:3-3-49.7, and combines provisions for both NF and ICF-MR/DD provider types. Rule references have been updated as necessary. The percentage of FPF proceeds deposited into the home- and community-based services for the aged fund has been changed from thirty and three-tenths per cent to sixteen percent. Paragraphs that describe the use of FPF proceeds for Medicaid cost report audits and Ohio access success project benefits have been deleted.

Rule 5101:3-3-30.4 entitled "Procedure for terminating the franchise permit fee (FPF) assessment - for nursing facilities (NFs), nursing homes (NHs), hospitals, and intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" sets forth the procedure for terminating the FPF program if the Centers for Medicare and Medicaid Services (CMS) determines that the FPF is an impermissible health care related tax. This is a new rule being proposed for adoption to implement provisions in HB66 relating to the administration of the Medicaid program. It replaces rule 5101:3-3-49.9, and combines provisions for both NF and ICF-MR/DD provider types. Rule references have been updated as necessary. A definition for "effective FPF termination date" (EFTD) has been added in paragraph (A). Explanations have been clarified for FPF claim reconciliation and adjustment procedures.

Should revisions of the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. If no revisions occur, the above rules will become effective on or about December 30, 2005.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

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At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

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- Select "Long Term Care Manual" (right column)
- Select "NF Transmittal" (left column)
- Select "NFTL #" (left column)
- Scroll to the desired rule number highlighted in blue, select desired rule number (right column)
- Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 05-10 Order Form

NFTL 05-09

Nursing Facility Transmittal Letter (NFTL) 05-09

August 12, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: NEW JFS forM 04080 (Effective on or About October 1, 2005)

Revised JFS forM 09405 (Effective on or About August 1, 2005)

inSTRUCTIONS for DOWNLOADinG and PRinTinG JFS forMS

Enclosed are summaries of new JFS form 04080 entitled "Medicaid Resource Assessment Notice", and revised JFS form 09405 entitled "Personal Needs Allowance Account Remittance Notice."

New **JFS 04080** "Medicaid Resource Assessment Notice"

This document was previously Appendix A of OAC rule 5101:3-3-16.1, and was entitled "Resource assessment notice". The notice has been removed from rule, redesigned as a one page PDF document for enhanced functionality, and reworded for easier comprehension. Spaces at the bottom of the form have been added for the resident's name, signature, and date of request.

Revised **JFS 09405** "Personal Needs Allowance Account Remittance Notice"

This form has been redesigned as a PDF document to allow online completion. The instruction section that summarizes relevant sections of OAC rules 5101:3-3-60 and 5101:3-3-93, and that explains how to complete the form, has been revised. Additionally, the mailing address for the Ohio Attorney General's office has been updated.

Instructions for Downloading and Printing JFS Forms

These forms may be downloaded to your computer from the ODJFS online forms website at **http://www.odjfs.state.oh.us/forms/inter.asp.**

To print a form you have filled out online, use the "Print" icon in the Adobe Reader toolbar, just above the document window. *If you are viewing the application in your web browser's window, do not use your web browser's print command; this will almost always result in garbled output*.

JFS forms 04080 and 09405 are letter size, and in portrait mode. You will need to change the Print Setup in order for the documents to print correctly, as follows:

1. After clicking on the "Print" icon, select "Setup...".
2. In the Print Setup dialog box, set Paper Size to *US Letter* and set Orientation to *Portrait*.
3. Click "OK" to dismiss the Print Setup dialog box.
4. Click "OK" to print out the form.

Please remember that, due to a limitation in Adobe Reader, you can fill out the form online and print the result, but you cannot save the completed document to your computer after it has been filled out. You must have Adobe Writer on your computer in order to save the completed document.

NFTL 05-09 Order Form

JFS 04080 - Medicaid Resources Assessment Notice

Click here to view the JFS 04080 - Medicaid Resources Assessment Notice

JFS 09405 - Personal Needs Allowance Account Remittance Notice

Click here to view the JFS 09405 - Personal Needs Allowance Account Remittance Notice

NFTL 05-08A

Nursing Facility Transmittal Letter (NFTL) 05-08A

August 17, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Revised Adoption of Rules 5101:3-3-02.2 and 5101-3-3-02.3 of the Administrative Code (Effective on or About October 1, 2005)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Rule 5101:3-3-02.2 entitled "Termination, denial, and non-renewal of long term care provider agreements" sets forth the conditions for termination, denial, and non-renewal of Medicaid provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded and developmentally disabled (ICFs-MR/DD). This rule was originally adopted in conjunction with the rescission of a rule by the same number in order to expand the explanation of situations requiring mandatory termination, denial, or non-renewal of the Medicaid provider agreement, and to add a new paragraph on adjudication orders.

This rule was revised pursuant to House Bill 66 to add paragraph (B)(2)(m), which allows the Ohio Department of Job and Family Services (ODJFS) to terminate a provider agreement for failure to pay the full franchise permit fee (FPF) installment when due.

Rule 5101:3-3-02.3 entitled "Institutions eligible to participate in Medicaid as nursing facilities (NFs) or intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" sets forth the eligibility requirements for participation of long term care facilities in the Medicaid program. This rule was originally adopted in conjunction with the rescission of a rule by the same number in order to add definitions and to specify mandatory dual participation of nursing facilities in both the Medicare and Medicaid programs.

This rule was revised in order to update paragraph (A)(11), which specifies the accrediting organization for religious non-medical health care institutions (RNHCIs). RHNCIs sponsored by the Church of Christ, Scientist were previously certified by the Mother Church in Boston, the First Church of Christ, Scientist. They are now accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

Instructions:

Obsolete rules 5101:3-3-02.2 and 5101:3-3-02.3 as set forth in NFTL 05-08 and replace them with rules 5101:3-3-02.2 and 5101:3-3-02.3 as contained in this transmittal.

For questions regarding the above referenced rule, please contact the Facility Contracting Section in the Bureau of Long Term Care Facilities at (614) 466-6467.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

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At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

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2.) Select "Long Term Care Manual" (right column)

3.) Select "NF Transmittal" (left column)

4.) Select "NFTL #" (left column)

5.) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6.) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 05-08A Order Form

NFTL 05-08

Nursing Facility Transmittal Letter (NFTL) 05-08

July 21, 2005

TO: Administrators, Intermediate Care Facilities for the Mentally Retarded

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of New Rules 5101:3-3-02.1, 5101:3-3-02.2, 5101:3-3-02.3, and 5101:3-3-16.1 of the Administrative Code in CONJUNCTION with RECISSION of Rules by the SAME NUMBER (Effective on or About October 1, 2005)

PROPOSED ADOPTION OF NEW RULE 5101:3-3-02.4 OF THE ADMINISTRATIVE CODE (EFFECTIVE ON OR ABOUT OCTOBER 1, 2005)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Enclosed are proposed rule changes made in accordance with section 119.03 of the Revised Code, which outlines procedures for the adoption of administrative rules.

Rule 5101:3-3-02.1 entitled "Length and type of long term care provider agreements" sets forth the length and type of long term care provider agreements for Medicaid nursing facilities (NFs) and intermediate care facilities for the mentally retarded and developmentally disabled (ICFs-MR/DD). This rule is being adopted in conjunction with the rescission of a rule by the same number. Definitions are added for the terms "reasonable assurance period", "state survey agency", and "time-limited agreement". Explanations of effective dates, term limits, and term extensions are expanded and refined in paragraphs (B), (C), and (D). Paragraph (E) explains conditional agreements, cancellation clauses, and post-survey revisits for ICFs-MR/DD.

Rule 5101:3-3-02.2 entitled "Termination, denial, and non-renewal of long term care provider agreements" sets forth the conditions for termination, denial, and non-renewal of Medicaid provider agreements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded and developmentally disabled (ICFs-MR/DD). This rule is being adopted in conjunction with the rescission of a rule by the same number. Paragraph (C) has expanded explanations of situations that require mandatory termination, denial, or non-renewal of the Medicaid provider agreement. Paragraph (D) is new, and addresses adjudication orders.

Rule 5101:3-3-02.3 entitled "Institutions eligible to participate in Medicaid as nursing facilities (NFs) or intermediate care facilities for the mentally retarded/developmentally disabled (ICFs-MR/DD)" sets forth the eligibility requirements for participation of long term care facilities in the Medicaid program. This rule is being adopted in conjunction with the rescission of a rule by the same number. Definitions are added for the terms "certification", "distinct part", "dually participating long term care facility", "long term care facility", "religious non-medical health care institution" (RNHCI), and "state survey agency". Paragraph (E) is new, and specifies mandatory dual participation of nursing facilities in both the Medicare and Medicaid programs.

Rule 5101:3-3-02.4 entitled "Mandatory participation by nursing facilities (NFs) in the medicare program" sets forth the requirements for mandatory and full participation of NFs in both the Medicare and Medicaid programs. This is a new rule that is being adopted in order to establish the administrative and enforcement procedures for ensuring that on or before January 1, 2007, all nursing facilities participate in both the Medicare and Medicaid programs, and that all nursing facility beds are both Medicare-certified and Medicaid-certified. Paragraph (B) states the exceptions to mandatory participation.

Rule 5101:3-3-16.1 entitled "Resource assessment notice" sets forth the requirements of the resource assessment notice for nursing facilities (NFs) and intermediate care facilities for the mentally retarded and developmentally disabled (ICFs-MR/DD). This rule is being adopted in conjunction with the rescission of a rule by the same number. A substantial portion of the language in this rule is deleted because of duplication in rule 5101:1-39-35 of the Revised Code, which specifically explains the requirements of the resource assessment notice. Appendix A of this rule, entitled "Resource Assessment Notice", is removed from rule and assigned form number JFS 04080.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

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3) Select "NF Transmittal" (left column)

4) Select "NFTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 05-08 Order Form

NFTL 05-07

Nursing Facility Transmittal Letter (NFTL 05-07)

June 15, 2005

TO: Ohio Medicaid Nursing Facility Providers

FROM: Barbara E. Riley, Director

SUBJECT: ODJFS 837 Institutional Companion Guide

This Nursing Facility Transmittal Letter (NFTL) contains information regarding the ODJFS 837 Institutional (837I) Companion Guide. This Companion Guide contains the data elements related to the July 1, 2005 (date of service) implementation of direct claims submission by nursing facility providers.

Nursing facilities are required to submit a complete 837I as indicated in the Companion Guide. However, please make note of the following when reviewing the Companion Guide. These ODJFS User Notes instructions are new and/or are highlighted here as essential to nursing facility claims processing:

- **Page 53 - DMG:** The User Notes indicate that nursing facilities are required to report a resident's date of birth on each claim.
- **Page 57-CLM:** The User Notes indicate the appropriate bill types to use on nursing facility claims.
- **Page 65-DTP:** The User Notes indicate that nursing facilities are required to report the resident's date of admission on each claim.
- **Page 66-CL1:** The User Notes indicate the appropriate admission source, or patient status codes to use on nursing facility claims.
- **Page 69-AMT:** The User Notes indicate to use this AMT segment to report patient liability.
- **Page 82-NTE:** The User Notes indicate to use this segment for nursing facility room and board claims when it is needed to report the date of a delayed eligibility or hearing decision.
- **Page 100-HI:** The User Notes indicate that for nursing facility claims, this segment is required by HIPAA to report diagnosis codes. These codes are not used in adjudication.
- **Page 139-HI:** The User Notes indicate to use this segment on nursing facility room and board claims to report the date a prior payer acted on the claim if it is submitted between 365 of the date of the service and 180 days of the prior payer's action using valid occurrence codes.
- **Page 148-HI:** The User Notes indicate to use this segment and value code 31, patient liability, on nursing facility room and board claims to report per month lump sum payments due to Medicaid.
- **Page 157-HI:** The User Notes indicate to use this segment and the specified claim change reason codes to submit adjustments to nursing facility room and board claims.
- **Page 165- QTY:** The User Notes indicate to use this segment on nursing facility claims to report the number and identify the type of days reported on the claim.
- **Page 190-SBR:** The User Notes indicate to use this segment on nursing facility crossover claims.
- **Page 198-AMT:** The User Notes indicate to use this segment on nursing facility claims to report Medicare paid amount.
- **Page 223-DTP:** The User Notes indicate to use this segment on nursing facility claims to report the date of Medicare paid amount on crossover claims.
- **Page 230-SV2:** The User Notes indicate to use this segment and specified revenue codes on nursing facility claims.
- **Page 232-SV2:** The User Notes indicate to use this segment to report the covered charge amount on nursing facility room and board claims in SV 203 or to report zeros in the covered charge amount when reporting charges for non-covered days.

- **Page 232-SV2:** The User Notes indicate to use this segment to report the number of units (days) associated with each occurrence of a revenue code in SV205.
- **Page 232-SV2:** The User Notes indicate to use this segment to report the rate associated each occurrence of a revenue code in SV206. The rate is required but not used in adjudication.
- **Page 233-SV2:** The User Notes indicate to use this segment to report the non-covered charge amount on nursing facility room and board claims, and to report zeros in the covered charge amount when reporting charges for non-covered days.
- **Page 234-DTP:** The User Notes indicate to use this segment to report the begin date for each occurrence of a revenue code.

The ODJFS 837I Companion Guide can be accessed on our web site at **"http://hipaa.oh.gov/odjfs/"**

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**. The web address for the Office of Ohio Health Plans front page is **www.jfs.ohio.gov/ohp/** Information regarding nursing facility payment policies may be accessed from the department's web page by going to **www.jfs.ohio.gov/ohp/bltcf**. This NFTL can be accessed at the Electronic Manuals Internet website: http://emanuals.odjfs.state.oh.us/emanuals/. Questions pertaining to this NFTL should be addressed to: Theresa Woodward, Ohio Department of Job and Family Services, Office of Ohio Health Plans, Bureau of Long Term Care Facilities, 30 East Broad Street, 33rd Floor, Columbus, OH 43215-3414, (614) 466-9243

NFTL 05-06

Nursing Facility Transmittal Letter (NFTL) 05-06

April 20, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Adoption of NEW Rule 5101:3-3-64 of the Administrative Code (Effective on or About July 1, 2005)

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Enclosed are proposed rule changes made in accordance with Section 119.03 of the Revised Code, which outlines procedures for the adoption of administrative rules.

Rule 5101:3-3-64 entitled "Nursing facility payment for Medicare Part A cost sharing" sets forth the Medicaid payment policy for cost sharing for nursing facility (NF) services provided as a Medicare Part A benefit. This rule will establish that the Ohio Department of Job and Family Services (ODJFS) will pay as cost sharing the lesser of the coinsurance amount or the Medicaid maximum allowable reimbursement rate for the identified services minus the Medicare Part A plan's payment to the nursing facility for the same services. If the Medicare Part A plan's payment is more than the Medicaid maximum, ODJFS will pay nothing for the services.

Should further revisions to the proposed ODJFS rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur, the attached rule will become effective on or about July 1, 2005.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2), which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/medicaid/LTC/

At the Electronic Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "NF Transmittal" (left column)

4) Select "NFTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete

all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 05-06 Order Form

NFTL 05-05A

Nursing Facility Transmittal Letter (NFTL) 05-05A

July 21, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: REFILED Permanent Amendment of Rule 5101:3-3-39.1 of the Administrative Code Effective July 1, 2005

CHANGES IN ODJFS HARD-COPY RULE DISTRIBUTION

Rule 5101:3-3-39.1 entitled "Claims submission for nursing facilities (NFs)" sets forth the claims submission requirements for NFs under the direct bill. This rule was refiled for permanent adoption to revise the calculation in paragraph (A)(6) by removing original (A)(6)(a)(ii) that required the vendor payment first be reduced by three percent. This refiled rule also revises paragraph (F) by removing original paragraph (F)(3) that required transferring nursing facilities to notify admitting facilities of the amount of remaining patient liability.

Instructions:

Obsolete rule 5101:3-3-39.1 as set forth in NFTL 05-05 and replace it with rule 5101:3-3-39.1 as contained in this transmittal.

For questions regarding the above referenced rule, please contact the Policy Unit in the Bureau of Long Term Care Administration at (614) 466-9364.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A) (2), which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

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NFTL 05-05A Order Form

NFTL 05-05

Nursing Facility Transmittal Letter (NFTL) 05-05

April 27, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Amendment of Rules 5101:3-3-02, 5101:3-3-20, 5101:3-3-39, 5101:3-3-49.3, 5101:3-3-51.6, 5101:3-3-54.1, 5101:3-3-54.5, 5101:3-3-59, 5101:3-3-63 and Adoption NEW Rule 5101:3-3-39.1 of the Administrative Code (Effective on or About July 1, 2005)

Changes in ODJFS Hard-Copy Rule Distribution

In accordance with section 119.03 of the Ohio Revised Code that outlines the process for amendment and adoption of rules, enclosed are proposed rule changes. These rules set forth Medicaid policy to implement direct bill for nursing facilities (NFs) by which NFs will submit claims directly to the department for payment by Medicaid.

Rule 5101:3-3-02 entitled "Provider agreements: nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the execution and maintenance of a provider agreement between the Ohio department of job and family services (ODJFS) and the operator of a NF or ICF-MR. The proposed amendment to this rule specifies that NFs use the 9400 process for dates of service preceding July 1, 2005 to initiate, terminate or adjust vendor payment, and the 837I claim, as required in rule 5101:3-3-39.1, for dates of service on or after July 1, 2005 to initiate, terminate or adjust payment Also, "vendor payment" is amended to read "payment."

Rule 5101:3-3-20 entitled "Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements" sets forth the process by which each nursing facility (NF) and intermediate care facility for the mentally retarded (ICFs-MR) files a cost report with the Ohio department of job and family services (ODJFS). The proposed amendment modifies "medicaid vendor payment" to read "medicaid payment."

Rule 5101:3-3-39 entitled "Payment and adjustment process for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the payment and adjustment process for NFs and ICF/MRs. The proposed amendment to this rule specifies that NFs use the form 9400, Nursing Facility Payment and Adjustment Authorization for dates of service proceeding July 1, 2005 for the reimbursement of services. The amendment also clarifies that the for dates of service preceding July 1, 2005, the CDJFS shall stop vendor payment within ten days of receipt of the JFS 09401, Facility/CDJFS Transmittal, in the case of death, discharge or hospice enrollment.

Rule 5101:3-3-39.1 entitled "Claims submission for nursing facilities (NFs)" is being adopted to set forth the claims submission requirements for NFs under the direct bill.

Rule 5101:3-3-49.3 entitled "Calculation, billing, collection and appeal process for the franchise permit fee (FPF)" sets forth the formula for calculating the franchise permit fee and the related appeals process. The proposed amendment modifies "medicaid vendor payment" to read "medicaid payment."

Rule 5101:3-3-51.6 entitled "Notice, escrow, and recovery of excess depreciation paid, change in the medicaid provider agreement, closure or voluntary withdrawal from the medical assistance program for nursing facilities (NFs)" sets forth the process for a closure or voluntary withdrawal of a NF from the medical assistance program. The proposed amendment modifies "vendor payment" to read "medicaid payment."

Rule 5101:3-3-54.1 entitled "Outlier long-term care services for individuals with severe maladaptive behaviors due to traumatic brain injury (NF-TBI services)" sets forth the process to identify a sub-population of those individuals determined to require a nursing facility (NF) level of care (LOC) for the purpose of providing prior authorized intensive rehabilitation services to individuals with severe maladaptive behaviors due to traumatic

brain injury (TBI). The proposed amendment modifies "medicaid vendor payment" to read "medicaid payment."

Rule 5101:3-3-54.5 entitled "Pediatric outlier care in nursing facilities (NF-PED services)" sets forth the process to identify a sub-population of those individuals determined to require a nursing facility (NF) level of care (LOC) for the purpose of providing prior authorized NF-PED services. The proposed amendment modifies "medicaid vendor payment" to read "medicaid payment."

Rule 5101:3-3-59 entitled "Coverage of bed-hold days for medically necessary and other limited absences in nursing facilities (NFs)" sets forth the identification of leave days. The proposed amendment modifies "medicaid vendor payment" to read "medicaid payment." The amendment also specifies that for dates of service preceding July 1, 2005, the NF shall report the use of bed-hold days on the form 9400, Nursing Facility Payment and Adjustment Authorization, and for dates of service on or after July 1, 2005, to submit the number of bed-hold days on the 837I claim as specified in rule 5101:3-3-39.1.

Rule 5101:3-3-63 entitled "Resident protection fund (RPF) for nursing facilities (NFs) and collection of fines" sets forth the process and circumstances by which fines are assessed and collected to be deposited in the RPF. The proposed amendment modifies "vendor offset" to "medicaid payment offset" and "vendor payment" to "medicaid payment."

Should further revisions to the proposed rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about July 1, 2005, on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

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NFTL 05-05 Order Form

NFTL 05-04

Nursing Facility Transmittal Letter (NFTL) 05-04

April 27, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Amendment of Rules 5101:3-3-20.1 and 5101:3-3-20.2 of the Administrative Code (Effective July 01, 2005)

Changes in ODJFS Hard-Copy Rule Distribution

Rule 5101:3-3-20.1 entitled "Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): Chart of accounts" sets forth the methodology for filing costs reports according to the chart of accounts included with this rule. The Ohio Department of Job and Family Services requires that all facilities file cost reports annually to comply with Section 5111.26 of the Ohio Revised Code. Rule 5101:3-3-20.1 and its appendix are being proposed for permanent amendment due to the five year rule review. The changes to the rule are: changing the example that is given for reporting petty cash and other cash accounts in paragraph (B)(2), hyphenating a word in (C)(4), and adding account 6700, for ICFs-MR to be used to report the costs for "Active Treatment Off-site Day Programming Services" as defined in the Chart of Accounts.

Rule 5101:3-3-20.1, Appendix A, entitled "Chart of Accounts," effective September 30, 2002, is being proposed for rescission to be replaced with the Appendix A, "Chart of Accounts," with the changes to the appendix that are detailed below.

Rule 5101:3-3-20.1, Appendix A, entitled "Chart of Accounts" is being proposed for enactment for use by nursing facilities and intermediate care facilities for the mentally retarded to establish the minimum level of detail to allow for cost report preparation. The word "administrator" has been inserted in references to accounts 6057, 6535, and 7075, to complete the title of the EAP individual for each category. Account 6090 has been revised to specify items that are not to be reported as government mandated assessments or fees. A website reference has been included in accounts 6200, 6205, and 7110. For account 6205, reference to the Cincinnati Municipal Code has been updated by adding the chapter title and revising the section number. For account 7100, the reference to "plus MDS+" has been replaced by "version 2.0 (MDS 2.0)." Account 7270 has been revised to delete language no longer applicable due to an amendment of section 5111.20 of the Ohio Revised Code. Under account 6615, "Non-Reimbursable Expenses - NFs Only," the word "salary" has been added to 6615.1, to distinguish salary from contract. New language has been inserted in account 8065, to specify that leases effective after 12/01/92 for assets acquired prior to 7/01/93 are to be reported in account 8065, and that for leases executed before 2/01/92, the costs are to be reported in account 7400. For ICFs-MR only, account 6700 is being added to capture the costs of "Active Treatment Off-site Day Programming Services."

Rule 5101:3-3-20.2 entitled "Nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR): Medicaid cost report" sets forth the Medicaid Cost Report for NFs and ICFs-MR. Each nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR) shall file a cost report as a condition of participation in the Title XIX Medicaid program, as specified in rules 5101:3-3-20 and 5101:3-3-20.1 of the Administrative Code. Rule 5101:3-3-20.2 is being proposed for permanent amendment due to the five year rule review.

Rule 5101:3-3-20.2, Appendix A, entitled "Medicaid Cost Report" sets forth the schedules that comprise the cost report. Nursing home providers or their representatives are required to complete and file a cost report for each cost reporting period. Rule 5101:3-3-20.2, Appendix A, revised October 2002, is being proposed for permanent rescission to be replaced by Appendix A, revised March 2005.

Rule 5101:3-3-20.2, Appendix A, entitled "Medicaid Cost Report" sets forth the schedules that comprise the cost report. Nursing home providers or their representatives are required to complete and file a cost report for each cost reporting period. The Ohio Medicaid cost report, JFS 02524, is designed to provide statistical data,

financial data, and disclosure statements as required by federal and state rules. Also, included as part of the revised Appendix A are the "Instructions for completing the Ohio department of job and family services (ODJFS) calendar year medicaid cost report for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)." Rule 5101:3-3-20.2, Appendix A, revised March 2005, is being proposed for permanent amendment to comply with the five year rule review.

The following changes have been made to Appendix A schedules being proposed for amendment:

Schedule A - The type of cost report filing has been changed from "Closed Facility" to "Final" to specify usage of cost report 4.5 for providers leaving the Medicaid program as well as for providers that are closing a facility. For the Medicare provider number, a dash has been inserted to show that it should be included when reporting the Medicare number.

Schedule B-2 - For ICFs-MR only, a new account, 6700, has been added as line 48 to permit reporting of the costs for "Active Treatment Off-site Day Programming Services" as defined in the Chart of Accounts. This addition has caused changes to the "Total" lines 49 and 57 due to the new account. Also, this new account has caused a wording change to Schedule A-3 in lines 2 and 13 so the total reimbursable direct care cost continues to be captured.

Schedule C-1 - To specify that compensation paid should be reported and not hours worked, in Section B, the title above columns 3 and 4, "Worked Weekly" has been changed to "Paid Weekly." At the bottom of the page, in the sentence referencing column 7, hours "worked" has been changed to hours "paid."

Schedule C-2 - To specify that compensation paid should be reported and not hours worked, page 1 of 2, the title above columns 8 and 9, "Worked Weekly" has been changed to "Paid Weekly." At the bottom of the page, in the sentence referencing column 12, hours "worked" has been changed to hours "paid."

Schedule C-2 - To specify that compensation paid should be reported and not hours worked, page 2 of 2, the title above columns 6 and 7, "Worked Weekly" has been changed to "Paid Weekly." At the bottom of the page, in the sentence referencing column 8, hours "worked" has been changed to hours "paid."

Attachment 6 - For ICFs-MR only, a new 6700 account for "Active Treatment Off-site Day Programming Services" has been added as line 38. This addition has caused changes to the "Total" lines 39, 43, 50, 53, 54, 65, 68, 72, 73 and 74.

Should revisions to the proposed rules occur during the JCARR hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on July 01, 2005 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

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3) Select "NF Transmittal" (left column)

4) Select "NFTL #" (left column)

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6) Once the desired rule appears, print or view as desired

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NFTL 05-04 Order Form

NFTL 05-03A

Nursing Facility Transmittal Letter (NFTL) 05-03A

July 15, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Revised Amendment of Rule 5101:3-3-41 of the Administrative Code (Effective July 1, 2005)

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

Rule 5101:3-3-41 entitled "Resource utilization groups, version III (RUG III): the nursing facility case mix payment system" sets forth components of the Medicaid reimbursement methodology for the nursing facility direct care payment system, based on a core set of items included in the uniform resident assessment instrument (RAI) specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS). This rule was originally proposed for permanent amendment to recalibrate the relative weights assigned to each Resource Utilization Group version III (RUG III). This rule was initially revised to reinstate original appendix number 5. This rule was subsequently revised to correct the Joint Committee on Agency Rule Review's (JCARR's) rule summary fiscal analysis to be consistent with language proposed in this rule which allows ODJFS to review the relative resource weights every three years. There were no changes to the rule body in the second revision.

Instructions:

Obsolete rule 5101:3-3-41 as set forth in NFTL 05-03 and replace it with rule 5101:3-3-41 as contained in this transmittal.

For questions regarding the above referenced rule, please contact the Case Mix Section in the Bureau of Long Term Care Facilities at 614.466.9088.

Changes in ODJFS hard-copy (paper) rule distribution

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NFTL 05-03A Order Form

NFTL 05-03

Nursing Facility Transmittal Letter (NFTL) 05-03

April 22, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Amendment of Rule 5101:3-3-41 of the Administrative Code (Effective July 1, 2005)

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

This rule package sets forth the nursing facility (NF) case mix payment system including the resource utilization groups, version III (RUG III). This rule was reviewed pursuant to Section 119.032 of the Ohio Revised Code (ORC), which requires the review of all state agency rules within a five-year period.

5101:3-3-41 entitled "Resource utilization groups, version III (RUG III): the nursing facility case mix payment system" sets forth components of the Medicaid reimbursement methodology for the nursing facility direct care payment system, based on a core set of items included in the uniform resident assessment instrument (RAI) specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS). This rule is being amended to recalibrate the relative weights assigned to each Resource Utilization Group version III (RUG III). The calculation of the relative weights will integrate the new Ohio wage data from calendar years 2001 through 2003, as reported on the JFS 02524 Medicaid cost report for NFs, into the case mix reimbursement system. The department is required by rule to recalibrate the relative resource weights every three years to incorporate more recent direct care wage data. The recalibration is performed using the minutes of care per job type per RUG III group from the most current work measurement study and the wages per job type per hour.

The reference to Section U of the MDS 2.0 is being deleted from paragraph (A)(1) of the proposed rule as this section is no longer required.

Paragraph (C)(1)(a)(iii) of the proposed rule adds new language "during entire 7 days" to mirror language on the MDS 2.0. Also, in the same paragraph, "set up" was changed to "setup" and "one-person" was changed to "one person" to mirror MDS 2.0 language.

Paragraph (C)(1)(a)(iv) of the proposed rule adds new language "during entire 7 days" to mirror language on the MDS 2.0. Also, in the same paragraph, "activity did not occur" was changed to "ADL activity itself did not occur during entire 7 days" to mirror MDS 2.0 language.

Paragraph (C)(1)(b)(iii) of the proposed rule adds new language "during entire 7 days" to mirror language on the MDS 2.0. Also, in the same paragraph, "cc's" was corrected to "CCs" and "2 or more" was corrected to "2", "3", "4", or "5" to reflect valid MDS 2.0 coding values.

In paragraph (D)(3)(a)(ii) of the proposed rule "days/week" was corrected to "days per week". In paragraphs (D)(3)(e)(iii)*(a)* and (D)(3)(g)(iii)*(a)* of the proposed rule "readmission assessment" was corrected to "readmission/return assessment" to reflect MDS 2.0 language.

The word "therapy" was inserted to correct paragraph (D)(3)(g)(iii)*(d)* of the proposed rule. In paragraph (D)(3)(i)(iv)*(a)* of the proposed rule "readmission assessment" was corrected to "readmission/return assessment" to reflect MDS 2.0 language.

In paragraph (D)(4)(a)(ii) of the proposed rule "presentitem" was corrected to "present in item". In paragraph (D)(4)(a)(iii) of the proposed rule "CC'S" was corrected to "CCs", and "2 or more" was corrected to "2", "3", "4", or "5" to reflect valid MDS 2.0 coding values. In paragraph (D)(4)(b)(iii) of the proposed rule "2 or more" was corrected to "2", "3", "4", or "5" to reflect valid MDS 2.0 coding values. In paragraph (D)(4)(c) of the proposed rule "adl" was corrected to uppercase (ADL).

In paragraph (D)(6)(b) of the proposed rule "during entire 7 days" was added to mirror language on the MDS 2.0. In paragraph (D)(6)(j) of the proposed rule "CC'S" was corrected to "CCs" and "2 or more" was corrected

to "2", "3", "4", or "5" to reflect valid MDS 2.0 coding values. In paragraph (D)(8)(a) of the proposed rule "adl" was corrected to uppercase (ADL). Paragraph (D)(8)(a) of the proposed rule adds new language "during entire 7 days" to mirror language on the MDS 2.0.

Paragraph (D)(8)(b) of the proposed rule corrects "section g" to uppercase (section G), corrects MDS 2.0 item "1ha" to item "1hA", deletes two unnecessary characters "A" and "a", and adds new language "during entire 7 days" to mirror language on the MDS 2.0.

Paragraph (E) of the proposed rule adds clarifying language "of this rule". Paragraph (H) of the proposed rule deletes "and cost". Paragraph (H)(4) of the proposed rule changes "shall" to "may". Paragraph (H)(4)(b) of the proposed rule deletes "At a minimum", changes "shall" to "may", and adds "no more often than". Paragraph (H)(4)(d) of the

proposed rule adds clarifying language regarding the use of the recalibrated weights in the recalculation of the quarterly case mix score and the recalculation of the annual case mix score. References to "MDS2.0" were corrected to "MDS 2.0" throughout the proposed rule. MDS 2.0 alpha coding references were corrected to numeric coding references throughout the proposed rule. For example, "one" was corrected to "1" to reflect actual MDS 2.0 coding values.

As a result of this review, these rules are being proposed for amendment. Should revisions to the proposed permanent rule occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions occur, the aforementioned rule will become effective July 1, 2005 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

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NFTL 05-03 Order Form

NFTL 05-02

Nursing Facility Transmittal Letter (NFTL) 05-02

April 22, 2005

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Barbara E. Riley, Director

SUBJECT: Proposed Amendment of Rule 5101:3-3-40 of the Administrative Code (Effective July 1, 2005)

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

This rule package sets forth the nursing facility (NF) case mix assessment instrument: minimum data set version 2.0 (MDS 2.0). This rule was reviewed pursuant to Section 119.032 of the Ohio Revised Code (ORC), which requires the review of all state agency rules within a five-year period.

5101:3-3-40 entitled "Nursing facility (NF) case mix assessment instrument: minimum data set version 2.0 (MDS 2.0)" sets forth the resident assessment instrument (RAI) specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS). The RAI is the foundation for planning and delivering care to nursing home residents. This rule is being proposed for permanent amendment to further paperwork reduction efforts by giving providers the option of submitting the MDS medicare prospective payment assessment form (MPAF) in lieu of the MDS 2.0 for a resident's quarterly review assessment. Providers choosing this option should code MPAF item AA8a as "05" (zero five) to indicate a quarterly review assessment. Giving providers this option aligns with federal provisions set forth in the "CMS Revised Long Term Care Resident Assessment Instrument User's Manual version 2.0". In addition, we are also proposing to delete Section S items on the MDS 2.0 with the exception of item S12. MDS 2.0 item S12 is the alternate resident identifier for those residents without a social security number.

Paragraph (A)(7) of the proposed rule defines default group and the definition has been expanded to define missing or inaccurate data including inconsistencies in date fields or missing or inaccurate resident identifiers. Paragraph (A)(10) of the proposed rule contains a definition of filing date and has been clarified to indicate assessment data submitted by the submission deadline will be used to calculate the facility average case mix score. Paragraph (A)(10) also includes new language indicating facilities have eighty (80) days to transmit appropriate assessment submissions to the state for final rate setting purposes. Reference to the processing quarter has been deleted from paragraph (A)(15) of the proposed rule. The definition of processing quarter (formerly paragraph (A)(16)) has been removed from the proposed rule. Paragraph (A)(18) of the proposed rule contains the definition of record and the reference to paragraph (B)(3) has been corrected to paragraph (B)(5) of the proposed rule. Paragraph (A)(22) of the proposed rule defines the resident assessment instrument (RAI), and the edition date and Internet address for 42 code of federal regulations (CFR) were corrected. The parentheses around the acronym "RAPs" were also deleted. Paragraph (A)(26) of the proposed rule contains new language to define resident identifier code as an alternate resident identifier for those residents without a social security number.

The reference to "MDS2.0" in paragraph (B) of the proposed rule was corrected to "MDS 2.0", and appendix E was also added to paragraph (B) to accommodate acceptance of the MDS medicare PPS (prospective payment system) assessment form (MPAF). Paragraph (B)(1) of the proposed rule corrects the edition date and Internet address for 42 CFR section 483.20. Clarifying language has been added to paragraph (B)(2) of the proposed rule indicating NFs may use the Ohio-specified MDS 2.0 including sections S and T for their quarterly review assessments. Accordingly, language requiring the Ohio-specified MDS 2.0 including sections S and T was removed from this paragraph for all quarterly review assessments. Paragraph (B)(3) of the proposed rule contains a correction to the edition date and Internet address for 42 CFR section 483.20. Sentence structure was corrected in paragraph (B)(5) of the proposed rule and the Internet address for CMS Revised Long-Term Care Resident Assessment Instrument User's Manual version 2.0 was also corrected. Paragraph (B)(5) also contains clarifying language explaining that NFs may use the MPAF for quarterly review assessments.

Paragraph (C)(1) of the proposed rule deletes the incorrect reference to paragraph (B)(3) and inserts the correct reference to paragraph (B)(5). Paragraphs (C)(1) and (C)(2) of the proposed rule correct the edition date and Internet address for 42 CFR section 483.20. Paragraph (C)(4) of the proposed rule contains examples of submissions that cannot be processed by the department. This paragraph deletes the example of a blank submission and inserts the examples of rejection of all data files in a submission, and a data file submitted as a test file. Paragraph (C)(5)(b) of the proposed rule clarifies the type of NF, and removes irrelevant language regarding what setting a resident was admitted from. Irrelevant language regarding what setting a resident was transferred from was also removed from the proposed rule (formerly paragraph (C)(5)(c)). Paragraph (C)(7)(a) of the proposed rule corrects the edition date and the Internet addresses for 42 CFR section 483.20 and corrects the Internet address for the MDS 2.0 manual. Paragraphs (C)(8)(a) and (C)(8)(b) of the proposed rule clarify the correct acceptable coding for MDS 2.0

items AA8a and R3 (08 for a resident discharged prior to completion of the initial assessment; and 1 through 9 for the discharge status, respectively).

Paragraphs (D), (D)(1)(a), (D)(1)(c), and (D)(1)(d) of the proposed rule correct the Internet address for the "State Operations Manual" (SOM) issued by CMS.

Language requiring approval for electronic submission of MDS 2.0 data and the requirement for written requests for filing extensions were removed from the proposed rule (formerly in paragraph (E)).

As a result of this review, these rules are being proposed for amendment. Should revisions to the proposed permanent rule occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions occur, the aforementioned rule will become effective July 1, 2005 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/medicaid/LTC/

At the Electronics Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "NF Transmittal" (left column)

4) Select "NFTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 05-02 Order Form

NFTL 04-07

Nursing Facility Transmittal Letter (NFTL) 04-07

December 16, 2004

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rules 5101:3-3-02.3 and 5101:3-3-02.4 and Adoption of Rule 5101:3-3-02.3 of the Administrative Code (Effective on or About January 20, 2005)

Proposed Permanent Revision of Rule 5101:3-3-02.3 of the Administrative Code (Effective on or About January 20, 2005)

Changes in ODJFS Hard-Copy Rule Distribution

Enclosed are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-02.3 entitled "Eligible Providers and Provider Types" sets forth the eligible providers and provider types for Medicaid nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). This rule is being rescinded in conjunction with the adoption of a new rule by the same number. The department estimates this rescission will not increase or decrease Medicaid expenditures on an annual aggregate basis.

Rule 5101:3-3-02.4 entitled "Services Provided by an Institution Classified as a Nursing Facility (NF) or an Intermediate Care Facility for the Mentally Retarded (ICF-MR)" sets forth the services provided by an institution classified as a nursing facility (NF) or an intermediate care facility for the mentally retarded (ICF-MR). This rule is being rescinded in conjunction with the adoption of new rule 5101:3-3-02.3. The department estimates this rescission will not increase or decrease Medicaid expenditures on an annual aggregate basis.

Rule 5101:3-3-02.3 entitled "Facilities Eligible to Participate in Medicaid as Nursing Facilities (NFs) or Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled (ICFsMR/DD)" sets forth the types of long term care institutional services covered by the Medicaid program, the types of services not covered by the Medicaid program, the eligibility requirements for long term care institutional providers both in Ohio and out-of-state, and the certification and survey requirements. This rule also specifies the conditions for certification of long term care facility beds as NFs or ICFs-MR/DD. This rule is being proposed for adoption in conjunction with the rescission of former rules 5101:3-3-02.3 and 5101:3-3-02.4 and the adoption of ODMR/DD Ohio Administrative Code rule 5123:2-16-01 that requires operators applying for a new residential facility licensed by ODMR/DD and operators of existing residential facilities who previously received "development approval" to operate a facility other than an ICF-MR/DD to request and obtain a new "development approval" from ODMR/DD to operate as an ICF-MR/DD.

Rule 5101:3-3-02.3 is also being proposed for revision as a result of comments received during the public comment period. The proposed revision changed the reference "rule 3701-59-02 of the Administrative Code" to "section 3702.52.2 of the Revised Code" in paragraph (D)(3) because ORC 3702.52.2 is applicable and OAC rule 3701-59-02 is obsolete. The proposed revision also changed the reference "3701-59-02" to "3701-59-01" and added the word "care" to the phrase "long term care beds" in paragraph (D)(4) for consistency with rule 3701-59-01.

Should further revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about January 20, 2005, on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site." The Electronics Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

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3) Select "NF Transmittal" (left column)

4) Select "NFTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form." If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 04-07 Order Form

NFTL 04-05 (Part C Nursing Home Billing Instructions)

Nursing Facility Transmittal Letter (NFTL 04-05)

December 1, 2004

TO: Ohio Medicaid Nursing Facility Providers

FROM: Thomas J. Hayes, Director

SUBJECT: Nursing Facility Billing Instructions for Medicare HMO Crossover Claims

This Nursing Facility Transmittal Letter (NFTL) contains billing instructions for Medicare HMO (Part C) crossover claims. As the department continues to implement HIPAA-related changes and moves toward the implementation of direct claims submission by long term care facility providers, additional transmittals will be published and the nursing facility billing instructions will be revised.

Nursing Facility billing instructions to provide instructions for billing nursing facility claims for Medicaid consumers enrolled in Medicare HMO plans have been developed. Please make note of the following form locators when reviewing the billing instructions. The instructions included in these form locators are new and/or are highlighted here as essential to Medicare HMO crossover claims processing:

- **Form Locators 9 - Co-insurance Days.** Nursing facilities are responsible for reporting co-insurance days, when applicable. Absence of this information, if applicable, will impact reimbursement.
- **Form Locator 32 through 35 - Occurrence Codes and Dates.** For paper claims submission and electronic submissions using Flat File formats, occurrence code 57 is required and must include the date of payment by the Medicare HMO plan. The date must match the date on the remittance advice from the Medicare HMO plan.
- **Form Locators 39 through 41 - Value Codes and Dollar Amounts.** For Medicare HMO crossover claims submitted on paper or electronically using Flat File formats, applicable value codes E1, E2, E3, or E7 must be used for services provided under a non-capitated arrangement with the Medicare HMO Plan. For Medicare HMO crossover claims submitted on paper or electronically using Flat File formats, applicable value codes F1, F2, F3, or F7 must be used for services provided under a capitated arrangement with the Medicare HMO Plan. Value code dollar amounts should be obtained from the Medicare HMO remittance advice.
- **Form Locator 54 - Prior Payments.** The actual payment from the Medicare HMO plan as it appears on the Medicare HMO remittance advice is required to be reported in this form locator, and should correspond to the payer code in Form Locator 50.

This Nursing Facility Transmittal Letter, related billing instructions, and OAC rules can be accessed on our web site at http://emanuals.odjfs.state.oh.us/emanuals/medicaid/.

Medicaid providers are responsible for accurate and valid reporting of Medicaid claims submitted for payment. Upon our request, providers that submit Medicare Part C crossover claims must provide documentation to support that the information provided on the claim submitted to the department for payment matches information found on the Part C plan's remittance advice.

Department Web Page

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is **www.jfs.ohio.gov**. The web address for the Office of Ohio Health Plans front page is **www.jfs.ohio.gov/ohp/** Information regarding nursing facility payment policies may be accessed from the department's web page by going to **www.jfs.ohio.gov/ohp/bltcf** and selecting the option for provider payment policies and relative weight tables.

Questions pertaining to this NFTL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Long Term Care Facilities
30 East Broad Street, 33rd Floor
Columbus, OH 43215-3414
(614) 466-9243

Attachment - Part C Nursing Home Billing Instructions

Click here to view Part C Nursing Home Billing Instructions.

NFTL 04-05 Order Form

NFTL 04-04

Nursing Facility Transmittal Letter (NFTL) 04-04

April 29, 2004

TO: Administrators, Nursing Facility

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-17.3, 5101:3-3-25, 5101:3-3-54.1, and 5101:3-3-54.5 of the Administrative Code (Effective on or About July 1, 2004)

CHANGES IN ODJFS HARD-COPY (PAPER) RULE DISTRIBUTION

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-17.3 entitled "Out-of-state placement for recipients with traumatic brain injury (TBI)" sets forth the TBI level of care criteria, the requirements for out-of-state facilities, the prior authorization process, and the reimbursement methodology for out-of-state TBI services. This rule is being proposed for permanent amendment to setup the "LOC" acronym for level of care in paragraph (A)(1).

Rule 5101:3-3-25 entitled "Payment methodology for the provision of outlier services" sets forth the calculation of the initial contract rate for an outlier facility and specifies the methodology for calculating the prospective rate. This rule is being proposed for permanent amendment to replace simple average rate with calculated statewide mean rate per diem in paragraph (D)(2) in order to establish the contracted rates subsequent to the initial rate year for providers who fail to submit all required information as set forth in paragraph (D)(3).

Rule 5101:3-3-54.1 entitled "Outlier long-term care services for recipients with sever maladaptive behaviors due to traumatic brain injury (NF-TBI services)" sets forth the TBI level of care criteria, the facility requirements to provide services, and the prior authorization process. This rule is being proposed for permanent amendment to add language regarding movement of beds between the outlier and non-outlier unit of a facility in paragraph (D)(4). This rule is also being proposed for permanent amendment to delete paragraphs (H) and (I) regarding the initial contracted rate and subsequent contracted rates after the initial rate year and refer to OAC rule 5101:3-3-25 that contains the same payment methodology concepts regarding the initial contracted rate and subsequent contracted rates after the initial rate year.

Rule 5101:3-3-54.5 entitled "Pediatric outlier care in nursing facilities (NF-PED services)" sets forth the criteria for NF-PED level of care, the requirements of the facility to provide services, and the prior authorization process. This rule is being proposed for permanent amendment to add language regarding movement of beds between the outlier and non-outlier unit of a facility in paragraph (D)(3). This rule is also being proposed for permanent amendment to delete paragraphs (H) and (I) regarding the initial contracted rate and subsequent contracted rates after the initial rate year and refer to OAC rule 5101:3-3-25 that contains the same payment methodology concepts regarding the initial contracted rate and subsequent contracted rates after the initial rate year.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about July 1, 2004 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of

proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site". The Electronic Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet site website is as follows:

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1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "NF Transmittal"(left column)

4) Select "NFTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

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NFTL 04-04 Order Form

NFTL 04-03

Nursing Facility Transmittal Letter (NFTL) 04-03

March 11, 2004

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-44 and 5101:3-3-50 of the Administrative Code (Effective on or About May 20, 2004)

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

This rule package is being reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules every five years. However, the following changes have emerged as a result of OMB Bulletin No. 03-04, issued June 6, 2003 by the federal Office of Management and Budget.

The following rules are to be amended and subsequently proposed for permanent amendment.

Rule 5101:3-3-44 entitled "Method for establishing the direct care cost component of the prospective rate for nursing facilities (NFs)" sets forth the methodology for calculating the per resident per day rate for direct care costs for each facility. On June 6, 2003, the federal Office of Management and Budget (OMB) issued Bulletin No. 03-04 regarding revised definitions of metropolitan statistical areas (MSAs), micropolitan statistical areas, and combined statistical areas (CSAs). Pursuant to OAC 5101:3-3-44, the Ohio Department of Job and Family Services is required to determine if the changes presented in OMB Bulletin No. 03-04 have an effect on Ohio's long term care prospective reimbursement methodology for direct care costs. Rule 5101:3-3-44 is being amended and proposed for permanent amendment to change when the Ohio Department of Job and Family Services plans to redefine the new peer group direct care classifications for nursing facilities (NFs), as a result of the changes to statistical areas as defined by the Office of Management and Budget in Bulletin No. 03-04.

The Ohio Department of Job and Family Services (ODJFS), after conducting a study of the changes described in OMB Bulletin No. 03-04, issued June 6, 2003, has determined that new geographic direct care peer groupings for nursing facilities (NFs) will be implemented effective with the prospective reimbursement system beginning July first of state fiscal year 2006. This change is detailed in paragraph (F)(2) of rule 5101:3-3-44. The peer groups will remain as defined in (F)(1)(a)(b) and (c) of rule 5101:3-3-44 through state fiscal year 2005. No change has been made to any other section of the rule. However, rates are subject to any adjustments required or authorized by Chapter 5111 of the Revised Code.

Rule 5101:3-3-50 entitled "Method for establishing the indirect care costs component of the prospective rate for nursing facilities (NFs)" sets forth the methodology for calculating the per resident per day rate for indirect care costs for each facility. On June 6, 2003, the federal Office of Management and Budget (OMB) issued Bulletin No. 03-04 regarding revised definitions of metropolitan statistical areas (MSAs), micropolitan statistical areas, and combined statistical areas (CSAs). Pursuant to OAC 5101:3-3-50, the Ohio Department of Job and Family Services is required to determine if the changes presented in OMB Bulletin No. 03-04 have an effect on Ohio's long term care prospective reimbursement methodology for indirect care costs. Rule 5101:3-3-50 is being amended and proposed for permanent amendment to change when the Ohio Department of Job and Family Services plans to redefine the new peer group indirect care classifications for nursing facilities (NFs), based upon the bed size of the facility and geographic location of the county in which the facility resides, as a result of the changes to statistical areas as defined by the Office of Management and Budget in Bulletin No. 03-04.

The Ohio Department of Job and Family Services (ODJFS), after conducting a study of the changes described in OMB Bulletin No. 03-04, issued June 6, 2003, has determined that the new geographic indirect care peer groupings for nursing facilities (NFs) will be implemented effective with the prospective reimbursement system beginning effective July first of state fiscal year 2006. This change is detailed in paragraph (D)(3) of rule 5101:3-3-50. The peer groups will remain as defined in (D)(2)(a)(b) and (c) of rule

5101:3-3-50 through state fiscal year 2005. No change has been made to any other section of the rule. However, rates are subject to any adjustments required or authorized by Chapter 5111 of the Revised Code.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur the aforementioned rules will become effective on or about May 20, 2004 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the internet. The internet website developed by ODJFS for the electronic publication of departmental rules and policies is as follows:

http://emanuals.odjfs.state.oh.us/emanuals

Follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "NF Transmittal" (left column)

4) Select "NFTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

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NFTL 04-03 Order Form

NFTL 04-02

Nursing Facility Transmittal Letter (NFTL) 04-02

February 5, 2004

TO: Administrators, Nursing Facility

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: No-Change Rule Filing in Compliance with Section 119.032 of the Revised Code for Rule 5101:3-3-49.1 of the Administrative Code

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

The above captioned rule has been reviewed in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five-year period. Pursuant to this review, no changes to this rule were filed by ODJFS at this time. This review determined whether a rule should continue without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. The rule was reviewed to ensure that it is clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-49.1 entitled "Nursing facilities (NFs): method for establishing reimbursement for the franchise permit fee reported in account 6091" sets forth the reimbursement method for NFs on the Medicaid program. This rule also sets forth the reimbursement method for NFs new to the medical assistance program that have not been assessed a franchise permit fee.

Should revisions or a re-filing to this rule occur during the hearing process administered by the Joint Committee on Agency Rule Review (JCARR), the revised rule will be published on the Electronic Manuals Internet site at that time. Should no revisions occur, the above referenced rule as published on the Electronic Manuals Internet site will continue in effect with an effective date of September 30, 2001 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site". The Electronic Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet site website is as follows:

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to the Electronic Manuals Internet site through the Internet, the JFS 03400 may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 04-02 Order Form

NFTL 04-01

Nursing Facility Transmittal Letter (NFTL) 04-01

February 5, 2004

TO: Administrators, Nursing Facility

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-49.2, 5101:3-3-49.3, 5101:3-3-49.7, 5101:3-3-49.8, and 5101:3-3-49.9 of the Administrative Code (Effective on or About April 12, 2004)

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-49.2 entitled "Identification of nursing facility (NF) and hospital beds subject to the franchise permit fee (FPF)" sets forth the franchise permit fee for NFs. This rule is being proposed for permanent amendment to eliminate the incorporation by reference issue in paragraphs (D)(2), (E)(2), (G)(2),and (I). This rule is also being proposed for permanent amendment to change "of" to "or" in paragraph (E)(2) and for clarification purposes in paragraphs (H) and (I).

Rule 5101:3-3-49.3 entitled "Calculation, billing, collection and appeal process for the franchise permit fee (FPF)" sets forth the calculation of the franchise permit fee assessment for NFs. This rule is being proposed for permanent amendment to delete paragraph (C)(2)(c), to change the word "provider" to "operator" in paragraphs (C)(1) and (C)(2)(b), and to add language in paragraph (C)(2)(a) to address license beds held for future use or held for sale that were assessed a FPF for the current fiscal year.

Rule 5101:3-3-49.7 entitled "Method of distribution of franchise permit fee (FPF) proceeds" sets forth the identification of programs which are to receive funding from the franchise permit fee assessments and the percent of proceeds to go into each fund. This rule is being proposed for permanent amendment to update the fiscal years in paragraph (A)and paragraph (B)(4) regarding money remaining from the FPF proceeds after payments and transfers are done. This rule is also being proposed for permanent amendment to add language in paragraph (B)(4)(b) to state if cash in excess of amounts needed for required transfers remain in fiscal years 2004 and 2005, that it may be used for the Ohio Access Success Project.

Rule 5101:3-3-49.8 entitled "Enforcement of franchise permit fee program" sets forth the rights of the Ohio Department of Job and Family Services to conduct investigations and to utilize the Attorney General's Office to enforce the franchise permit fee rules and explains the responsibility of the NF for the franchise permit fee when the facility changes providers or closes. This rule is being proposed for permanent amendment to add "for nursing facilities (NFs) and hospitals" to the title of the rule and to add paragraph (C) establishing in the rule the penalty for failing to pay the franchise permit fee when due.

Rule 5101:3-3-49.9 entitled "Procedure for terminating the franchise permit fee (FPF) program for nursing facilities (NFs) and hospitals" sets forth the components of the process to be initiated by both the department and facilities if the United States Health Care Financing Administration determines that the franchise permit fee is an impermissible health care related tax. This rule is being proposed for permanent amendment to correct the name of CMS in the first paragraph and to add language in paragraphs (B), (B)(1), (B)(2), (B)(3), (B)(4), and (B)(5) for clarification purposes.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about April 12, 2004 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from the "Electronic Manuals Internet site". The Electronic Manuals Internet site is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The Electronic Manuals Internet site website is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

At the Electronic Manuals Internet site home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "NF Transmittal"(left column)

4) Select "NFTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a NF provider does not have access to the Electronic Manuals Internet site through the Internet, the JFS 03400 may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 04-01 Order Form

NFTL 03-03

Nursing Facility Transmittal Letter (NFTL) 03-03

November 25, 2003

TO: Administrators, Nursing Facility

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Emergency Amendment of Rule 5101:3-3-57 of the ADMinISTRATIVE Code (Effective on or About September 30, 2003)

Proposed Permanent Amendment of Rule 5101:3-3-57 of the Administrative Code (Effective on or About December 11, 2003)

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

Enclosed for your review are proposed rule changes made as a result of Amended Substitute House Bill 95 of the 125th General Assembly and take effect for services provided on and after July 1, 2003. The provisions of the bill also repealed Section 5111.22 (A)(2) of the Revised Code which requires the department to provide copies of proposed rules.

The following rule was amended on an emergency basis and subsequently proposed for permanent amendment.

Rule 5101:3-3-57 entitled "Nursing facilities (NFs) expenditure limitation" sets forth the methodology for calculating the total per diem rate expenditure limitations for NFs. This rule is being amended on an emergency basis and proposed for permanent amendment to include the per diem rate expenditure limits, as detailed in paragraphs (D) through (G) of this rule, of one hundred fifty-six dollars and sixty-eight cents for fiscal year 2004 and one hundred fifty-nine dollars for fiscal year 2005, plus the difference by which the fiscal year 2004 limit of one hundred fifty-six dollar and sixty-eight cents exceeds the mean total per diem for all nursing facilities for fiscal year 2004.

Should revisions to the proposed permanent rule occur, you will be notified in a subsequent transmittal letter. Should no revisions occur, the attached rules will become effective on or about December 11, 2003 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the Bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated Ohio Revised Code 5111.22 (A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, the NF providers are now instructed to obtain proposed rules from "DynaWeb". DynaWeb is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The DynaWeb website is a follows:

http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid

At the DynaWeb home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

- Select "Ohio Health Plans - Provider" (left column)
- Select "Long Term Care Manual" (right column)
- Select "NF Transmittal"(left column)
- Select "NFTL #" (left column)
- Scroll to the desired rule number highlighted in blue, select

- desired rule number (right column)
- Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a NF provider does not have access to DynaWeb through the Internet, the JFS 03400 may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all of the boxes on the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 03-03 Order Form

NFTL 03-04

Nursing Facility Transmittal Letter (NFTL) 03-04

November 18, 2003

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-40 of the Administrative Code (Effective January 8, 2004)

Changes in ODJFS Hard-Copy (Paper) Rule Distribution

This rule package sets forth the nursing facility (NF) case mix assessment instrument: minimum data set version 2.0 (MDS 2.0). This rule was reviewed pursuant to Section 119.032 of the Ohio Revised Code (ORC), which requires the review of all state agency rules within a five-year period.

5101:3-3-40 entitled "Nursing facility (NF) case mix assessment instrument: minimum data set version 2.0 (MDS 2.0)" sets forth the resident assessment instrument (RAI) specified by the state and approved by the Centers for Medicare and Medicaid Services (CMS). The RAI is the foundation for planning and delivering care to nursing home residents.

Paragraph (A)(3) of the proposed rule specifies the components of comprehensive assessments which include the resident assessment triggers, the resident assessment protocols (RAPs), and the resident assessment protocols summary form and deletes the phrase "RAP Summary". Paragraphs (A)(9) and (A)(13) of the proposed rule contain an acronym change from HCFA (Health Care Financing Administration) to CMS (Centers for Medicare and Medicaid Services). Clarification of definitions of payment quarter, reporting period end date (RPED), and reporting quarter are proposed in paragraphs (A)(15), (A)(21), and (A)(22) respectively. Paragraph (A)(23) of the proposed rule adds the latest publication date and Internet address for the cited section of the Code of Federal Regulations (CFR) and deletes the phrase "resident assessment protocols". Paragraph (A)(25) of the proposed rule deletes the RAPs (Resident Assessment Protocols) acronym. Paragraph (A)(27) of the proposed rule clarifies the definition of Resource Utilization Groups version III (RUG III).

Paragraph (B) of the proposed rule contains an acronym change from HCFA to CMS and also clarifying that assessments are performed pursuant to the proposed rule and eliminates a comma before the phrase "as defined in" and eliminates the phrase "paragraph (C) of". Paragraph (B)(1) of the proposed rule adds the latest publication date for the cited section of the CFR and the Internet website address. A period was deleted in paragraph (B)(1)(b) of the proposed rule. Paragraph (B)(2) of the proposed rule deletes Section U of the MDS 2.0 because it is no longer a requirement. Paragraph (B)(3) of the proposed rule adds the latest publication date for the cited section of the CFR and the Internet website address. Paragraph (B)(4) of the proposed rule adds new language specifying requirements for the modification or inactivation of MDS records using the MDS correction request form. Paragraph (B)(5) of the proposed rule adds new language to explain the optional use of the MDS Medicare PPS (Prospective Payment System) Assessment Form (MPAF) and to add the latest publication date and Internet address for the CMS Revised Long-Term Care Resident Assessment Instrument User's Manual version 2.0.

Paragraph (C)(1) of the proposed rule adds the latest publication date for the cited section of the CFR and the Internet website address, and also contains an acronym change from HCFA to CMS. Paragraph (C)(2) of the proposed rule adds the latest publication date for the cited section of the CFR and the Internet website address. Paragraph (C)(3) of the proposed rule contains a correction to change the rule reference from (E) to (D)(3) of OAC Rule 5101:3-3-42. Paragraph (C)(5)(d) of the proposed rule contains language clarifying that the calculation of quarterly and annual facility case mix scores includes residents who are temporarily absent and for whom a return is anticipated regardless of whether a bed is being held for their return. Paragraph (C)(7)(a) of the proposed rule adds the latest publication dates for the MDS 2.0 manual and the cited section

of the CFR and the corresponding Internet website addresses. Paragraph (C)(8)(b) of the proposed rule adds a quotation mark that was missing.

Paragraphs (D), (D)(1)(a), (D)(1)(c), and (D)(1)(d) of the proposed rule incorporate the following publications by reference including the latest publication date and the Internet website address: CMS Revised Long Term Care Resident Assessment Instrument User's Manual, version 2.0, (December 2002); and the State Operations Manual (SOM March 1998) issued by CMS. As a result of this review, this rule is being proposed for permanent amendment.

Should revisions to the proposed permanent rule occur, you will be notified in a subsequent transmittal letter at that time. Should no revisions occur, the aforementioned rule will become effective January 8, 2004 on a permanent basis.

Changes in ODJFS hard-copy (paper) rule distribution

In conjunction with an agency-wide change in the method for distribution of proposed rules and other hard-copy publications, the bureau of Long Term Care Facilities (BLTCF) will no longer issue hard-copies of proposed rules in Nursing Facility Transmittal Letters (NFTL). Recent changes in legislation have eliminated ORC Section 5111.22(A)(2) which required the issuance of proposed rules to Medicaid NF providers. In lieu of hard-copy rules, NF providers are now instructed to obtain proposed rules from "DynaWeb". DynaWeb is an Internet accessible website developed by ODJFS for the electronic publication of departmental rules and policies. The DynaWeb website is as follows:

http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid

At the DynaWeb home page for Medicaid, follow these steps to access proposed rules contained in each transmittal letter:

1) Select "Ohio Health Plans - Provider" (left column)

2) Select "Long Term Care Manual" (right column)

3) Select "NF Transmittal" (left column)

4) Select "NFTL #" (left column)

5) Scroll to the desired rule number highlighted in blue, select desired rule number (right column)

6) Once the desired rule appears, print or view as desired

NF providers will only receive hard-copies of the transmittal letter and the JFS 03400 form "Ohio Department of Job and Family Services Health Plan Provider Update Request Form". If a NF provider does not have access to DynaWeb through the Internet, the JFS 03400 form may be used to request hard-copies of proposed rules referenced in the NFTL. When requesting hard-copies of proposed rules, complete all the boxes of the JFS 03400 form. The JFS 03400 form may be faxed or mailed to ODJFS as directed on the form at no cost to the NF provider.

NFTL 03-04 Order Form

NFTL 03-01

Nursing Facility Transmittal Letter (NFTL) 03-01

May 7, 2003

TO: Administrators, Nursing Facility

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-02, 5101:3-3-02.3, 5101:3-3-04, 5101:3-3-04.1, 5101:3-3-16, 5101:3-3-16.2, and 5101:3-3-23 of the Administrative Code (Effective on or About July 1, 2003)

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-02 entitled "Provider agreements: nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the payment and adjustment process for notification of an admission, discharge, or death of a resident in a NF or ICF-MR. This rule is being proposed for permanent amendment to specify "as amended through April 15, 2003" for each statutory and regulatory reference set forth in paragraphs (A)(1)(c), (A)(6), (B)(13), and (B)(14). This rule is also being proposed for permanent amendment to replace the phrase "legal philosophy" with the word "law" in paragraph (B)(2).

Rule 5101:3-3-02.3 entitled "Eligible providers and provider types" sets forth components of the Medicaid provider agreement and bed certification requirements. This rule also sets forth the types of certified facilities that may participate in medicaid, facilities where medicaid services can be provided, types of beds certification may be requested for, and distinct parts may be designated at different certified levels. This rule is being proposed for permanent amendment to add the word "and" in the list under paragraph (B).

Rule 5101:3-3-04 entitled "Payment during the Ohio department of job and family services (ODJFS) administrative appeals process for denial or termination of a provider agreement" sets forth when medicaid payments to eligible resident during administrative appeal process. This rule is being proposed for permanent amendment to reorganize the language in paragraph (A) and replace the semi colons with commas in paragraph (B)(2).

Rule 5101:3-3-04.1 entitled "Payment during the survey agency's administrative appeals process" sets forth the payment requirements for nursing facilities and intermediate care facilities for the mentally retarded during the administrative appeals process for termination or non-renewal of Medicaid certification. This rule is being proposed for permanent amendment to change "federal" to United Sates in paragraph (A)(2), replace the semi colons with commas in paragraph (D)(3)(b), and eliminate the double "the" in paragraph (E)(2).

Rule 5101:3-3-16 entitled "Resident rights in nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the rights of residents in a NF or ICF-MR and protects those residents against inappropriate discharge actions. This rule is being proposed for permanent amendment to update the reference to the Revised Code cites in paragraph (E). This rule is also being proposed for permanent amendment in paragraph (C) to specify "as amended September 23, 1992" for CFR reference 483.12, 483.13, and 483.15 and to specify "as amended June 27, 1995" for CFR reference 483.10.

Rule 5101:3-3-16.2 entitled "Advance directives for nursing facilities" sets forth the advance directive requirements for nursing facilities. This rule is being proposed for permanent amendment to add in paragraph (B)(1) the phrase "for the release", (B)(2) the phrase "provide a method for informing", and (B)(6) the word "for" for clarification purposes. This rule is also being proposed for permanent amendment to specify "as amended November 30, 1999" for the CFR reference set forth in paragraph (B)(1).

Rule 5101:3-3-23 entitled "Private rooms for medicaid residents in nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth components of the Medicaid reimbursement requirements for private room accommodations for residents of NFs and ICFs-MR. This rule is being proposed for permanent amendment for grammatical purposes in the introductory paragraph.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about July 1, 2003 on a permanent basis.

NFTL 02-15

Nursing Facility Transmittal Letter (NFTL) 02-15

November 8, 2002

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-42 of the Administrative Code (Effective January 1, 2003)

This rule package sets forth the calculation of quarterly and annual nursing facility (NF) average case mix scores. This rule is being reviewed pursuant to Section 119.032 of the Ohio Revised Code (ORC), which requires the review of all state agency rules within a five-year period.

5101:3-3-42 entitled "Calculation of quarterly and annual nursing facility (NF) average case mix scores" sets forth the process for determining nursing facility average case mix scores on a quarterly and annual basis. As a result of this review, this rule is being proposed for permanent amendment to reflect current ODJFS practice. Accordingly, proposed rule language identifies an assigned case mix score as an assigned penalty score. The proposed rule language contains updated rule references and corrects capitalization. References to the agency will be changed from the Ohio Department of Human Services (ODHS) to the Ohio Department of Job and Family Services (ODJFS) to reflect the agency name change.

Should revisions to the proposed permanent rule occur, copies of the revised rule will be forwarded to you at that time. Should no revisions occur, the aforementioned rule will become effective January 1, 2003 on a permanent basis.

NFTL 02-14

Nursing Facility Transmittal Letter (NFTL) 02-14

October 25, 2002

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Tom Hayes, Director

SUBJECT: Proposed Permanent Adoption and Amendment of Rules 5101:3-3-20.3, 5105:3-3-51.5, and 5101:3-3-51.6 of the Administrative Code (Effective on or About December 19, 2002)

This rule package has been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period and in response to the rescission of Bureau of Long Term Care Facilities Technical Bulletins (01-12-31-98, 02-07-01-99, 03-07-01-99, 04-01-01-00, 05-07-01-00). The content of the technical bulletins is being incorporated into the Ohio Administrative Code, which involves amending existing administrative rules and promulgating one new rule. The purpose of the review is to determine whether or not the applicable rules reflect the technical bulletins' purpose and scope and to ensure that the rules are clear and concise as written and that program requirements are accurate and up-to-date. This review determines whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rules's purpose and scope. The review also provides local agencies more flexibility and eliminates unnecessary paperwork.

5101:3-3-20.3 entitled "Leased staff reimbursement for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology for appropriately reporting expenses related to leased staff. This rule is being proposed for permanent adoption to define "leased staff services" and identify the criteria for determining when costs related to staff leasing are reimbursable as other/contracted costs. Services that qualify as leased nursing costs will not be reported as purchased nursing costs or subject to the purchased nursing limitations. The rule simply clarifies current practice. The department estimates this adoption does not increase or decrease Medicaid expenditures on an annual aggregate basis.

5101:3-3-51.5 entitled "Reimbursement for leased nursing facilities (NFs)" sets forth the methodology for reimbursement for leased nursing facilities (NFs) sets forth the methodology for determining reimbursement for leased nursing facilities. This rule is being proposed for permanent amendment to clarify when ODJFS will recognize a lease between related parties as an initial lease and identifies the methodology used to determine the maximum reimbursable lease expense when an unrelated party lease transaction follows a related party lease transaction. This rule simply clarifies current practice. The department estimates this adoption does not increase or decrease Medicaid expenditures on an annual aggregate basis.

5101:3-3-51.6 entitled "Notice, escrow, and recovery of excess depreciation paid, change in the medicaid provider agreement, closure or voluntary withdrawal from the medical assistance program for nursing facilities (NFs)" sets forth the notice, escrow, recovery of excess depreciation paid, change in the Medicaid provider agreement, or voluntary termination in the Medicaid assistance program for NFs. This rule is being proposed for permanent amendment to state the information that must be provided to ODJFS for a new operator of a NF to include capital improvements made to the NF during the term of a prior lease and paid for by the prior lessee of the NF in the new allowable capital asset cost basis. This rule simply clarifies current practice. The department estimates this adoption does not increase or decrease Medicaid expenditures on an annual aggregate basis.

Should revisions to the proposed permanent rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur the aforementioned rule will become effective on or about December 19, 2002 on a permanent basis.

NFTL 02-13

Nursing Facility Transmittal Letter (NFTL) 02-13

September 5, 2002

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Tom Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-49.3, 5101:3-3-49.7, 5101:3-3-57, and 5101:3-3-58 of the Administrative Code (Effective on or About September 30, 2002)

Proposed Permanent Recission of Rule 5101:3-3-20.1 (Effective on or About September 30, 2002)

Proposed Permanent Adoption of Rule 5101:3-3-20.1 and Appendix A (Effective on or About September 30, 2002)

This rule package is being reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. However, the following changes to the Medicaid long term care facility reimbursement system emerged as a result of Amended Substitute Senate Bill 261 of the 124th General Assembly and will take effect for services provided on and after July 1, 2002. Also, in accordance with Section 5111.22 (A)(2) of the Revised Code, the department may only provide facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for recission.

5101:3-3-20.1 entitled "Chart of Accounts for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the cost report chart of accounts for NFs and ICFs-MR. This rule is being proposed for permanent adoption in accordance with Am. Sub. S. B. 261 to update the description of account number 6091of the chart of accounts entitled, Franchise Permit Fee, to instruct ICF-MR providers to report one hundred percent of the ICF-MR franchise permit fee in this account; NF providers are instructed to report twenty-three and twenty-six-hundredths percent of the NF franchise permit fee, incurred in fiscal years 2003 through 2005, in this account. NF providers should report seventy-six and seventy-four-hundredths percent of the franchise permit fee, incurred in fiscal years 2003 through 2005, in account 9725, entitled "Other-Specify". NFs will report one hundred percent of the franchise permit fee in account 6091 in fiscal year 2006 and forward.

5101:3-3-49.3 entitled "Calculation, billing, collection and appeal process for the franchise permit fee (FPF)" sets forth components of the calculation, billing, collection and appeal process for the franchise permit fee for nursing facilities. This rule is being proposed for permanent amendment in accordance with section 3721.51 of the Revised Code as amended by Am. Sub. S. B. 261 that increases the franchise permit fee to $4.30 for fiscal years 2003 through 2005. The rule is also being proposed for permanent amendment to reorganize the language in paragraph (C) from old paragraphs (D) and (E) and have a new paragraph (E) that contains the language from old paragraph (D)(3).

Rule 5101:3-3-49.7 entitled "Method of distribution of franchise permit fee (FPF) proceeds" sets forth components for the method of distribution of the FPF proceeds collected from nursing facilities. This rule is being proposed for permanent amendment in accordance with section 3721.56 of the Revised Code as amended by Am. Sub. S. B. 261 to change the percentage of the franchise permit fee paid into the stabilization fund to 76.74% for fiscal years 2003 through 2005 and to change the percentage of the franchise permit fee paid into the home and community-based services for the aged fund to 23.26% for fiscal years 2003 through 2005.

5101:3-3-57 entitled "Nursing facilities (NFs) expenditure limitation" sets forth the methodology for calculating the total per diem rate expenditure limitations for NFs for fiscal year 2002 and 2003. This rule is being proposed for permanent amendment in accordance with Section 10 of Am. Sub. S.B. 261 to increase the

mean total per diem rate utilized in the NFs expenditure limitation calculation for fiscal year 2003, from one hundred fifty-two dollars and sixty-six cents to one hundred fifty-three dollars and forty-one cents.

5101:3-3-58 entitled "Nursing Facilities (NFs) Stabilization Fund: Method of Establishing Payment from the Stabilization Fund" sets forth the method of establishing payment from the NF stabilization fund. Section 63.37 of Am. Sub. H. B. 94 amended Section 3721.51 of the Ohio Revised Code by increasing the amount of the nursing home franchise fee from $1.00 per day to $3.30 per day for SFY 2002 and SFY 2003. This rule is proposed for amendment to implement provisions of Am. Sub. S.B. 261which extends the period of the initial increase and increases the franchise fee by an additional $1.00 to a total fee of $4.30 per bed per day for SFY 2003, SFY 2004, and SFY 2005. The department will make payments to each NF in SFY 2003, SFY 2004, and SFY 2005 for each Medicaid day equal to the amount of the increase in franchise fees paid divided by the NF's inpatient days for the calendar year preceding the calendar year in which that fiscal year begins. This adjustment is provided to reflect the additional Medicaid allocable cost to the NF resulting from the increase in the franchise fee. The costs associated with the increase in the franchise fee may not be reported on the cost report as other protected costs. It is estimated that this change will result in approximately $21.3 million of additional reimbursement to nursing facilities in state fiscal year 2003. This rule also delineates the amount of rate add-on allotted to nursing facilities for the enhancement of quality care. Nursing facilities currently receive a rate add-on of $1.50 per Medicaid day to enhance the provision of quality care. Am. Sub. S.B. 261 increases this add-on by $.75 to $2.25 per Medicaid day in state fiscal years 2003, 2004, and 2005 to further enhance quality of care.

The following rule is proposed for permanent rescission.

5101:3-3-20.1 entitled "Chart of Accounts for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) sets forth the cost report chart of accounts for NFs and ICFs-MR. This rule is being proposed for permanent rescission and replaced with rule 5101:3-3-20.1 of the same name and appendix A.

The enclosed rules will become effective on or about September 30, 2002 on a permanent basis.

NFTL 02-12

Nursing Facility Transmittal Letter (NFTL) 02-12

June 27, 2002

TO: Administrators, Nursing Facility

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-39 and 5101:3-3-59 of the Administrative Code (Effective on or About September 1, 2002)

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

The following rules are proposed for permanent amendment.

Rule 5101:3-3-39 entitled "Payment and adjustment process for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the payment and adjustment process for notification of an admission, discharge, or death of a resident in a NF or ICF-MR. This rule is being proposed for permanent amendment to update the department and county name, the name and number of forms, and the address forms that JFS 09400 and JFS 09401 are mailed to for the reimbursement of services in paragraph (C)(2). This rule is also being proposed for permanent amendment to add paragraph (E) to clarify the hospice notification for a NF.

Rule 5101:3-3-59 entitled "Coverage of bed-hold days for medically necessary and other limited absences in nursing facilities (NFs)" sets forth the criteria for payable bed-hold days, the rate of reimbursement for bed-hold days, the number of bed-hold days allowed per calendar year for each resident, and the readmission after depletion of bed-hold days. This rule also sets forth the criteria for reimbursement of bed-hold days, when bed-hold days are not available, and the responsibility of the NF prior to a resident leaving the facility. This rule is being proposed for permanent amendment to change the numbered rule references to the correct numeric format in paragraphs (A)(8) and (G), change the department and county name, and change the format of the rule in paragraphs (C), (D), (G), and (H).

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about September 1, 2002 on a permanent basis.

NFTL 02-10

Nursing Facility Transmittal Letter (NFTL) 02-10

June 14, 2002

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Tom Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-19, 5101:3-3-21, 5101:3-3-22, 5101:3-3-24, 5101:3-3-24.1, 5101:3-3-51, 5101:3-3-51.1, 5101:3-3-51.2, 5101:3-3-51.3 and 5101:3-3-51.5 of the Administrative Code (Effective on or About June 20, 2002)

Proposed Permanent Recission of Rule 5101:3-3-51.8 (Effective on or About June 20, 2002)

This rule package has been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. The following rules are being proposed for permanent amendment to correct grammatical errors, correct inaccurate references, and to update the name of the agency. In accordance with Section 5111.22(A)(2) of the Ohio Revised Code, the department may provide facilities with the rule number and the title of rules proposed for rescission in lieu of an actual copy of the files proposed for rescission. In addition to the above noted general changes, some rules have specific changes as detailed hereinafter:

5101:3-3-19 entitled "Relationship of other covered medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services"sets forth the methodology for determining the relationship of other covered medicaid services in nursing facilities and intermediate care facilities for the mentally retarded in the prospective reimbursement rates. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-21entitled "Audits of nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"sets forth the methodology for determining the criteria utilized when auditing nursing facilities and intermediate care facilities for the mentally retarded. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-22 entitled "Rate recalculations, interest on overpayments, penalties, repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)"sets forth the methodology utilized for determining rate recalculations, interest on overpayments, penalties, repayment of overpayments for nursing facilities and intermediate care facilities for the mentally retarded. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".The paragraph ranking order was corrected from paragraph (C) throughout the subsequent paragraphs of this rule. The penalty specified in paragraph (B)(2) has been changed from two percent to the current average bank prime rate plus four percent of the last two monthly payments.

5101:3-3-24 entitled "Prospective rate reconsideration for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)" sets forth the methodology utilized when determining prospective rate reconsideration for nursing facilities (NFs) and intermediate care facilities for the mentally retarded. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".In paragraph (C)(6)(e)(i) the last sentence, "The greater of reported inpatient days or ninety-five per cent of licensed bed days shall be used to compute the per diem for capital reimbursement." has been changed to "The per diem for capital reimbursement shall be computed as set forth in paragraph (V) of rule 5101:3-3-01 of the Administrative Code" in accordance with 5111.20 as amended by House Bill 94.

In paragraph (E)(5) the first sentence, "Any rate increase granted under paragraph (E)(2) of this rule shall remain in effect until the effective date of the rate calculated under rule 5101:3-3-51 or 5101:3-3-84 of the Administrative Code that includes costs incurred for a full calendar year for the bed addition, or bed replacement, or change in provider agreement or lease." has been changed to "Any rate increase granted under paragraph (E)(2) of this rule for added or replaced beds shall remain in effect until a new rate is calculated, based on a full year of cost for the bed addition or replacement, pursuant to rules 5101:3-3-51 or 5101:3-3-84 of the Administrative Code." Cost reports filed as a result of a change in provider agreement or lease do not need to include a full year of cost to accurately reflect the rate per diem.

Paragraph (C)(1)(d) has been amended to no longer reference findings of level A deficiencies by the Ohio department of health (ODH), bankruptcy, or foreclosure, as possible factors to be considered as extreme circumstances in the case of NFs. This amendment is the result of an amendment to R.C. 5111.29 by House Bill 94.

5101:3-3-24.1 entitled "Rate adjustments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): government mandates" sets forth the methodology utilized when determining prospective rate adjustments for nursing facilities and intermediate care facilities for the mentally retarded with government mandates. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-51 entitled "Method for establishing capital reimbursement for nursing facilities (NFs)"sets forth the methodology utilized when determining the prospective capital reimbursement rate for nursing facilities. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-51.1 entitled "Capital asset and depreciation guidelines - nursing facilities (NFs)"sets forth detail of Capital asset and depreciation guidelines utilized in the prospective capital reimbursement rate for nursing facilities. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-51.2 entitled "Cost of ownership and efficiency incentive for nursing facilities (NFs)" sets forth the methodology utilized when determining the cost of ownership and efficiency incentive for nursing facilities. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

5101:3-3-51.3 entitled "Nonextensive renovations for nursing facilities (NFs)"sets forth the methodology utilized when determining nonextensive renovations for nursing facilities. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the Ohio Department of Job and Family Services".

5101:3-3-51.5 entitled "Reimbursement for leased nursing facilities (NFs)"sets forth the methodology utilized when determining reimbursement for leased nursing facilities. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services".

The following rule is proposed for permanent rescission.

5101:3-3-51.8 entitled "Assets acquired January 1, 1993 to June 30, 1993 for nursing facilities (NFs)" sets forth the methodology utilized when determining allowable assets acquired January 1, 1993 to June 30, 1993 for nursing facilities. This rule is no longer utilized in the prospective reimbursement rate calculations of nursing facilities and is therefore being proposed for permanent rescission.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur the aforementioned rules will become effective on or about June 20, 2002 on a permanent basis.

NFTL 02-11

Nursing Facility Transmittal Letter (NFTL) 02-11

May 15, 2002

TO: Administrators, Nursing Facilities

Directors, County Departments of Jobs and Family Services

FROM: Tom Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-44 and 5101:3-3-50 of the Administrative Code (Effective on or About June 20, 2002)

This rule package has been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. The review also provides local agencies more flexibility and eliminates unnecessary paperwork.

5101:3-3-44 entitled "Method for establishing the direct care cost component of the prospective rate for nursing facilities (NFs)." This rule sets forth the method for establishing the direct care cost component of the prospective rate for nursing facilities (NFs). This rule is being amended to reflect the department name change from "Ohio Department of Human Services" to "Ohio Department of Job and Family Services."

5101:3-3-50 entitled "Method for establishing the indirect care costs component of the prospective rate for nursing facilities (NFs)." This rule sets forth the method for establishing the indirect care cost component of the prospective rate for nursing facilities (NFs). This rule is being amended to reflect the department name change from "Ohio Department of Human Services" to "Ohio Department of Job and Family Services."

Should revisions to the proposed permanent rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur the aforementioned rule will become effective on or about June 20, 2002 on a permanent basis.

NFTL 02-08

Nursing Facility Transmittal Letter (NFTL) 02-08

May 14, 2002

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-41 of the Administrative Code (Effective July 1, 2002)

This rule package sets forth the rule changes proposed to accommodate recalibration of the relative resource weights for NFs based on three year statewide averages of wages in Ohio long term care facilities as reported on the medicaid cost reports for NFs. This calibration used cost report wage data from the most recent three calendar years available ninety days prior to the start of the fiscal year. Accordingly, calendar year cost reports for 1998, 1999, and 2000 were used to calibrate average wage rates for fiscal year 2003. This package is also being reviewed pursuant to Section 119.032 of the Ohio Revised Code (ORC), which requires the review of all state agency rules within a five-year period. The purpose of this review is to determine whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the intent of the review is to ensure that rules are clear and concise as written, program requirements are accurate and up to date, unnecessary paperwork is eliminated, and when possible local agencies are given more flexibility.

5101:3-3-41 entitled "Resource utilization groups, version III (RUG III): the nursing facility case mix payment system" sets forth components of the Medicaid reimbursement methodology for the nursing facility direct care payment system, based on a core set of items that make up the uniform resident assessment instrument. This rule is being amended to change the agency name from the "Ohio Department of Human Services" to the "Ohio Department of Job and Family Services" and to amend the relative weight assigned to each RUG classification. The calculation of the relative weights will integrate the new Ohio wage data from calendar years 1998 through 2000, as reported on the JFS 02524 Medicaid cost report for NFs, into the case mix reimbursement system. The department is required by rule to recalibrate the relative resource weights every three years to incorporate more recent direct care wage data. The recalibration is performed using the most current worker classification minutes from the United States department of health and human services and the average worker classification wages.

Should revisions to the proposed permanent rule occur, copies of the revised rule will be forwarded to you at that time. Should no revisions occur, the aforementioned rule will become effective July 1, 2002 on a permanent basis.

NFTL 02-07

Nursing Facility Transmittal Letter (NFTL) 02-07

May 14, 2002

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-52.1 of the Administrative Code (Effective July 1, 2002)

This rule package sets forth changes to the exception review process for nursing facilities (NFs). The Medicaid long term care payment system provides for the Ohio Department of Job and Family Services (ODJFS) to perform clinical audits, known as exception reviews, of the Minimum Data Set version 2.0 (MDS 2.0) assessment data provided by NFs. This rule is being reviewed pursuant to Section 119.032 of the Ohio Revised Code (ORC), which requires the review of all state agency rules within a five-year period. The purpose of this review is to determine whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the intent of the review is to ensure that rules are clear and concise as written, program requirements are accurate and up to date, unnecessary paperwork is eliminated, and when possible local agencies are given more flexibility.

5101:3-3-52.1 entitled "Exception review process for nursing facilities (NFs)" sets forth changes to the exception review process for nursing facilities (NFs). This rule is being proposed for permanent amendment to establish consistency in the calculation of the initial sample tolerance level and the calculation of the expanded review tolerance level. Proposed language for the calculation of the error rate is based on the sample size rather than the number of records used for rate setting as the entire population may not be tested during exception review. Data collected from historical assessment periods indicated that the error rate calculation for exception reviews was inconsistent and erroneously allowed assessment errors to fall below established tolerance levels. This will result in more accurate payment rates and is consistent with the existing calculation of the initial sample tolerance level. This amendment would also establish minimum thresholds for determining the expanded sample size. Clarifying language has been proposed indicating that exception review findings will only be taken when acceptable tolerance levels are reached or exceeded. References to the agency will be changed from the Ohio Department of Human Services (ODHS) to the Ohio Department of Job and Family Services (ODJFS) to reflect the agency name change.

Should revisions to the proposed permanent rule occur, copies of the revised rule will be forwarded to you at that time. Should no revisions occur, the aforementioned rule will become effective July 1, 2002 on a permanent basis.

NFTL 02-06

Nursing Facility Transmittal Letter (NFTL) 02-06

May 14, 2002

TO: Administrators, Nursing Facility

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rules 5101:3-3-17.3, 5101:3-3-25, 5101:3-3-54.1, and 5101:3-3-54.5 of the Administrative Code (Effective on or About June 30, 2002)

Proposed Permanent Adoption of Rules 5101:3-3-17.3, 5101:3-3-25, 5101:3-3-54.1, and 5101:3-3-54.5 of the Administrative Code (Effective on or About June 30, 2002)

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. In regard to the rules proposed for rescission, Section 5111.22(A)(2) of the Ohio Revised Code requires that the department provide facilities with only the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

The following rules are proposed for permanent rescission.

Rule 5101:3-3-17.3 entitled "Out-of-state placement for recipients with traumatic brain injury (TBI)" sets forth the TBI level of care criteria, the requirements for out-of-state facilities, the prior authorization process, and the reimbursement methodology for out-of-state TBI services. This rule is being proposed for permanent rescission in conjunction with the permanent adoption of rule 5101:3-3-17.3.

Rule 5101:3-3-25 entitled "Payment methodology for the provision of outlier services" sets forth the calculation of the initial contract rate for an outlier facility and specifies the methodology for calculating the prospective rate. This rule is being proposed for permanent rescission in conjunction with the permanent adoption of a new rule by the same number.

Rule 5101:3-3-54.1 entitled "Outlier long-term care services for recipients with sever maladaptive behaviors due to traumatic brain injury (NF-TBI services)" sets forth the TBI level of care criteria, the facility requirements to provide services, and the prior authorization process. This rule is being proposed for permanent rescission in conjunction with the permanent adoption of rule 5101:3-3-54.1.

Rule 5101:3-3-54.5 entitled "Pediatric outlier care in nursing facilities (NF-PED services)" sets forth the criteria for NF-PED level of care, the requirements of the facility to provide services, and the prior authorization process. This rule is being proposed for permanent rescission in conjunction with the permanent adoption of rule 5101:3-3-54.5.

The following rules are proposed for permanent adoption.

Rule 5101:3-3-17.3 entitled "Out-of-state placement for recipients with traumatic brain injury (TBI)" sets forth the TBI level of care criteria, the requirements for out-of-state facilities, the prior authorization process, and the reimbursement methodology for out-of-state TBI services. This rule is being proposed for permanent adoption to refer to the TBI provisions specified under rule 5101:3-3-54.1 in regard to the level of care criteria and the prior authorization process. This rule is also being proposed for permanent adoption to change the reimbursement methodology from a rate based on what the facility receives from other out-of-state medicaid agencies to the lower of the Ohio average rate paid to NF-TBI facilities or the rate the facility receives from its state of residence. Until such time as an out-of-state provider applies for reimbursement under the proposed rule, the rate resulting from this will not be available. Until such time that multiple out-of-state placements happen, the department estimates that this change in reimbursement will be cost neutral.

Rule 5101:3-3-25 entitled "Payment methodology for the provision of outlier services" sets forth the calculation of the initial contract rate for an outlier facility and specifies the methodology for calculating the prospective rate. This rule is being proposed for permanent adoption to clarify the initial rate and subsequent rate a facility is paid as specified in rule 5101:3-3-87.1.

Rule 5101:3-3-54.1 entitled "Outlier long-term care services for recipients with sever maladaptive behaviors due to traumatic brain injury (NF-TBI services)" sets forth the TBI level of care criteria, the facility requirements to provide services, and the prior authorization process. This rule is being proposed for permanent adoption to reorganize the rule language for purposes of clarification. This rule is also being proposed for permanent adoption to clarify the initial rate and subsequent rate a facility is paid as specified in rule 5101:3-3-87.1.

Rule 5101:3-3-54.5 entitled "Pediatric outlier care in nursing facilities (NF-PED services)" sets forth the criteria for NF-PED level of care, the requirements of the facility to provide services, and the prior authorization process. This rule is being proposed for permanent adoption to reorganize the rule language for purposes of clarification. This rule is also being proposed for permanent adoption to clarify the initial rate and subsequent rate a facility is paid as specified in rule 5101:3-3-87.1.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about June 30, 2002 on a permanent basis.

NFTL 02-09

Nursing Facility Transmittal Letter (NFTL) 02-09

April 24, 2002

TO: Administrators, Nursing Facilities

Directors, County Departments of Jobs and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-53 of the Administrative Code (Effective July 1, 2002)

Enclosed for your review are proposed rule changes which resulted from the review of rules pursuant to the rule review provisions of Section 119.032 of the Revised Code. The purpose of the rule-review provisions under Section 119.032 of the Revised Code is to determine whether or not a rule should be amended, rescinded or adopted based upon the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. Also, in accordance with Section 5111.22 (A)(2) of the Ohio Revised Code, the department may only provide facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

5101:3-3-53 entitled "Nursing Facilities Rates for Providers New to The Medical Assistance Program and Providers That Change Provider Agreements" set forth criteria used to set rates for providers who have no current historical costs to base a rate setting. This rule is being proposed for permanent amendment to clarify procedures to establish rates for new facilities and change of provider agreements. Pursuant to this amendment, payment rates will be established based upon the current rate under the previous provider agreement if the costs are based on the year end cost report prior to the current fiscal year, or a three month cost report within the time period of the provider immediately preceding the change. If the costs are not based upon the prior year end cost report or a subsequent three-month cost report, the department will assign the median rate for the appropriate peer group. The current provider's actual case mix score will only be used when the current provider's direct care costs as reported on a three-month cost report are available. Actual case mix scores for the new provider, which results from a change in the provider agreement will be used only when direct care costs for that provider is available. The actual case-mix score and the three-month actual cost report which determine the cost per case mix unit should be derived from the same provider.

Should revisions to any of these rules occur during the hearing process, a copy of the revised rule or rules will be forwarded to you at that time. Should no revisions occur, the aforementioned rules will become effective July 1, 2002 on a permanent basis.

NFTL 02-05

Nursing Facility Transmittal Letter (NFTL) 02-05

April 30, 2002

TO: Administrators, Nursing Facility

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rules 5101:3-3-60 and 5101:3-3-63 of the Administrative Code: (Effective on or About June 27, 2002)

Proposed Permanent Adoption of Rules 5101:3-3-60 and 5101:3-3-63 of the Administrative Code: (Effective on or About June 27, 2002)

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. In regard to the rules proposed for rescission, Section 5111.22(A)(2) of the Ohio Revised Code requires that the department provide facilities with only the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

The following rules are proposed for permanent rescission.

Rule 5101:3-3-60 entitled "Protection of nursing facility resident's funds and management of personal needs allowance accounts" sets forth the personal needs allowance (PNA) account, resident's right to manage PNA account, Deposit of PNA funds, accounting and records requirements, notice of certain PNA balances, release of PNA funds upon discharge of resident, conveyance of funds upon death, assurance of financial security, limitation on charges to personal funds, services included in medicare or medicare payment, items and services that may be charged to resident's PNA, and monitoring of PNA account. This rule is being proposed for permanent rescission in conjunction with the permanent adoption of a new rule by the same number.

Rule 5101:3-3-63 entitled "Resident protection fund (RPF) for nursing facilities (NFs) and collection of fines" sets forth the procedure for collecting fines imposed by the Ohio department of health (ODH) and the Centers for medicare and medicaid services (CMS), uses of the RPF, procedure for obtaining RPF funds, RPF annual report, and requirements of ODJFS. This rule is being proposed for permanent rescission in conjunction with the permanent adoption of a new rule by the same number.

The following rules are proposed for permanent adoption.

Rule 5101:3-3-60 entitled "Protection of nursing facility (NFs) resident's funds and management of personal needs allowance (PNA) accounts" sets forth the personal needs allowance (PNA) account, resident's right to manage PNA account, Deposit of PNA funds, accounting and records requirements, notice of certain PNA balances, release of PNA funds upon discharge of resident, conveyance of funds upon death, assurance of financial security, limitation on charges to personal funds, services included in medicare or medicare payment, items and services that may be charged to resident's PNA, and monitoring of PNA account. This rule is being proposed for permanent adoption to eliminate the non-Administrative Code references contained in the rule, update the department's name and county department's name, clarify the procedure for collecting fines for CMS, and to reorganize the rule language for purposes of clarification.

Rule 5101:3-3-63 entitled "Resident protection fund (RPF) for nursing facilities (NFs) and collection of fines" sets forth the procedure for collecting fines imposed by the Ohio department of health (ODH) and the Centers for medicare and medicaid services (CMS), uses of the RPF, procedure for obtaining RPF funds, RPF annual report, and requirements of ODJFS. This rule is being proposed for permanent adoption to eliminate the non-

Administrative Code references contained in the rule, update the department's name and HCFA's name change, and to reorganize the rule language for purposes of clarification.

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on or about June 27, 2002 on a permanent basis.

NFTL 02-04

Nursing Facility Transmittal Letter (NFTL) 02-04

April 30, 2002

TO: Administrators, Nursing Facilities

Directors, County Department of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rule 5101:3-3-48 of the Administrative Code (Effective July 1, 2002)

Proposed Permanent Adoption of Rule 5101:3-3-48, 5101:3-3-48.1, 5101:3-3-48.2 of the Administrative Code (Effective July 1, 2002)

The rules contained in this package have been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules every five years. The intent of the review is to determine whether a rule should be continued without amendment, should be amended, or should be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures the rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated and when possible, local agencies are given more flexibility. Also, in accordance with Section 5111.22 (A)(2) of the Revised Code, the department may only provide facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

Rule 5101:3-3-48 entitled "Compensation Cost Limits for Administrators, Owners, and Relatives of Owners in Nursing Facilities (NFs)" sets forth the compensation cost limits for administrators, owners, and relatives of owners in NFs. This rule is being proposed for permanent rescission in conjunction with the adoption of a new rule by the same number.

Rule 5101:3-3-48entitled "Compensation Cost Limits and Reasonable Costs for Compensation of Owners, Relatives of Owners, and Administrators in Nursing Facilities (NFs)" sets forth the compensation cost limits and reasonable costs for compensation of owners, relatives of owners, and administrators. This rule is being proposed for permanent adoption to specify the two components which determine the methodology for compensation cost limits and reasonable costs for compensation of administrators, owners, and relatives of owners as set forth in rules 5101:3-3-48.1 and 5101:3-3-48.2.

Rule 5101:3-3-48.1 entitled "Compensation Cost Limits and Reasonable Compensation for Owners and Relatives of Owners in Nursing Facilities (NFs) " sets forth the compensation cost limits and allowable compensation for owners and relatives of owners in NFs. This rule is being proposed for permanent adoption to develop a method to identify "time slices" as reported by providers. This time slice methodology identifies hours worked in the facility and related facilities. Time slices are subsequently used to determine appropriate compensation cost limits and reasonable compensation costs for each owner or relative of an owner.

Rule 5101:3-3-48.2 entitled "Compensation Cost Limits and Reasonable Costs for Compensation of Administrators in Nursing Facilities (NFs)" sets forth the compensation cost limits and reasonable costs for compensation of administrators in NFs. This rule is being proposed for permanent adoption to develop a method to identify "time slices" as reported by providers. This time slice methodology identifies hours worked in the facility and related facilities. Time slices are subsequently used to determine appropriate compensation cost limits and reasonable compensation costs for each administrator.

Should revisions of any of these rules occur during the hearing process, a copy of the revised rule or rules will be forwarded to you at that time. Should no revisions occur, the aforementioned rules will become effective July 1, 2002 on a permanent basis.

For questions regarding the above mentioned rules, please contact the Reimbursement Section, of the Bureau of Long Term Care Facilities at (614) 466-8460.

NFTL 02-03

Nursing Facility Transmittal Letter (NFTL) 02-03

March 29, 2002

TO: Administrators, Nursing Facility

Directors, County Departments of Human Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-02.1, 5101:3-3-02.2, 5101:3-3-02.4, 5101:3-3-16.1 and 5101:3-3-17 of the Administrative Code

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. In regard to the rules proposed for rescission, Section 5111.22(A)(2) of the Ohio Revised Code, requires that the department need only to provide facilities with the rule number and the title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

The following rules are proposed for permanent amendment.

Rule 5101:3-3-02.1 entitled "Length and Type of Provider Agreements" sets forth the types of provider agreements, requirements for extension of provider agreements, and provider agreement effective dates. This rule is being proposed for permanent amendment to update the department name in paragraph (C) and to clarify the effective date of a provider agreement in paragraph (A).

Rule 5101:3-3-02.2 entitled "Termination and Denial of Provider Agreement: Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)"sets forth the circumstances when a provider agreement may be terminated or denied to a ICF-MR. This rule is being proposed for permanent amendment to update the department name in paragraphs (B), (B)(2), (B)(7), and (C), change the numbered rule reference to the correct numeric format in paragraph (B)(10), and to delete definitions in paragraphs (A)(1) thru (A)(3) that are in rule 5101:3-3-01 of the Administrative Code. This rule is also being amended to include the "ODH" acronym in paragraph (B)(9) and provide the rule reference in paragraph (B)(4).

Rule 5101:3-3-02.4 entitled "Services Provided by an Institution Classified as a Nursing Facility (NF), or an Intermediate Care Facility for the Mentally Retarded (ICF-MR)" sets forth the services rendered in participating Medicaid NFs and ICFs-MR and circumstances when a provider agreements are terminated or denied for an ICF-MR. This rule is being proposed for permanent amendment to include "the following" in paragraph (C).

Rule 5101:3-3-16.1 entitled "Resource Assessment Notice" sets forth components the resource assessment notice must contain and an example of a notice. This rule is being proposed for permanent amendment to update the department name throughout the rule and to clarify paragraph (A).

Rule 5101:3-3-17 entitled "Emergency Relocation Plan" sets forth the components of the relocation plan and the time frame to notify the department and other entities. This rule is being proposed for permanent amendment to update the department name in paragraph (B).

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on a permanent basis.

NFTL 02-02

Nursing Facility Transmittal Letter (NFTL) 02-02

March 29, 2002

TO: Administrators, Nursing Facility

Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-46, 5101:3-3-47, 5101:3-3-47.1, 5101:3-3-47.2 and 5101:3-3-47.3 of the Administrative Code

Enclosed for your review are proposed rule changes made in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period. This review determines whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. In regard to the rules proposed for rescission, Section 5111.22(A)(2) of the Ohio Revised Code, requires that the department provide facilities with only the rule number and the title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

The following rules are proposed for permanent amendment.

Rule 5101:3-3-46 entitled "Prospective Rate Reimbursement of Therapy Services in Nursing Facilities (NFs)" sets forth types of therapies, therapy providers, and exceptions to types of therapy and therapy providers. This rule is being proposed for permanent amendment to change the numbered rule reference to the correct numeric format and to include the "NF" acronym in paragraph (B).

Rule 5101:3-3-47 entitled "Nursing facilities (NFs) Therapy Services Provider Eligibility" sets forth the definition of a therapy services provider and individual providers who are eligible to bill for reimbursement. This rule is being proposed for permanent amendment to update the department name and to include the "NF" acronym in paragraph (A). This rule is also being amended to change the numbered rule references to the correct numeric format, to include acronyms, and to add the word "Medicaid" which replaces the phrase "of medical assistance under the medicaid program" in paragraph (B).

Rule 5101:3-3-47.1 entitled "Coverage and Limitations-Nursing Facility (NF) Therapy Services" sets forth the definitions used in the therapy rules and the covered therapy services. This rule is being proposed for permanent amendment to change the numbered rule references to the correct numeric format in paragraph (A), to include the "NF" acronym in paragraph (A)(2), and to delete language in (A)(8)(b) that is the same in rule 5101:3-3-472 of the Administrative Code. This rule is also being amended to use acronyms in paragraphs (B)(1)(a) thru (B)(1)(d) and update the department name in (B)(1)(d).

Rule 5101:3-3-47.2 entitled "Reimbursement for Covered Nursing Facility (NF) Therapy Services" sets forth the process for receiving reimbursement, the amount of allowable reimbursement, and the exceptions to therapy claims. This rule is being proposed for permanent amendment to update the department name, to include acronyms, and to change the numbered rule references to the correct numeric format throughout the rule. This rule is also being amended to clarify the reimbursement for direct cost of therapies provided by NF therapy service providers in paragraph (D).

Rule 5101:3-3-47.3 entitled "Payment Authorization of Covered Therapy Services Denied by Medicare and Required for Facility Certification" sets forth the time frame for a request and what the request must contain. This rule is being proposed for permanent amendment to update the "Health Care Financing Administration (HCFA)" to "Centers for Medicare and Medicaid Services (CMS)" in paragraph (B)(6), correct a spelling error in (D)(4), and to add the word "and" to the list in paragraphs (B)(1) thru (B)(5) and (D)(1) thru (D)(3).

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on a permanent basis.

NFTL 02-01

Nursing Facility Transmittal Letter (NFTL) 02-01

March 27, 2002

TO: Administrators, Nursing Facilities

Directors, County Department of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Proposed Permanent Recission of Rule 5101:3-3-18 of the Administrative Code

Proposed Permanent Adoption of Rule 5101:3-3-18 of the Administrative Code

The rule contained in this package has been reviewed pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules every five years. The intent of the review is to determine whether a rule should be continued without amendment, should be amended, or should be rescinded, taking into consideration the rule's purpose and scope. In addition, the review ensures the rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated and when possible, local agencies are given more flexibility. Also, in accordance with Section 5111.22 (A)(2) of the Revised Code, the department may only provide facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

Rule 5101:3-3-18 entitled "Aggregate Medicaid Rates and Aggregate Medicare Rates Comparison for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the aggregate Medicaid rates and aggregate Medicare rates comparison for NFs and ICFs-MR. This rule is being proposed for permanent rescission in conjunction with the adoption of a new rule by the same number.

Rule 5101:3-3-18 entitled "Inpatient Services: Application of Medicare Upper Payment Limit Calculation (MUPLC) for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the inpatient services application of Medicare Upper Payment Limit Calculation (MUPLC) for NFs and ICFs-MR. This rule is being proposed for permanent adoption to specify the provisions of the application for the Medicare Upper Payment Limit Calculation (MUPLC) as set forth in Section 447.272 (a) and (b) of the Code of Federal Regulations (CFR). These provisions changed the groups of facilities subject to the MUPLC to include state government-owned or operated facilities, non-state government-owned or operated facilities, and privately-owned and operated facilities.

Should revisions to this rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur, the aforementioned rule will become effective on a permanent basis.

For questions regarding the above mentioned rule, please contact the Planning and Research Section, of the Bureau of Long Term Care Facilities at (614) 466-9243.

NFTL 01-2

Nursing Facility Transmittal Letter (NFTL) 01-2

October 17, 2001

TO: Administrators, Nursing Facilities

Directors, County Departments of Jobs and Family Services

FROM: Thomas J. Hayes,. Director

SUBJECT: Proposed Permanent Recission of Rules 5101:3-3-49.2, 5101:3-3-49.3, 5101:3-3-49.4, 5101:3-3-49.5, 5101:3-3-49.6, and 5101:3-3-49.7 of the Administrative Code

Proposed Permanent Adoption of Rules 5101:3-3-49.2, 5101:3-3-49.3, 5101:3-3-49.7, 5101:3-3-57, and 5101:3-3-58 of the Administrative Code

Proposed Permanent Amendment of Rules 5101:3-3-01, 5101:3-3-02, 5101:3-3-20.1, 5101:3-3-45, 5101:3-3-49.1, 5101:3-3-49.8, 5101:3-3-49.9, 5101:3-3-51.4, and 5101:3-3-51.6 of the Administrative Code

Enclosed for your review are proposed rule changes which resulted from the implementation of the provisions of Am. Sub. H. B. 94, Am. Sub. H. B. 299, and the rule-review provisions of Section 119.032 of the Revised Code. Notwithstanding the legislative changes, the purpose of the rule-review provisions under Section 119.032 of the Revised Code is to determine whether or not a rule should be amended, rescinded or adopted based upon the rule's purpose and scope. In addition, the review ensures that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility. In conjunction with the adoption of Am. Sub. H. B. 94, Am. Sub. H. B. 299, and the application of the aforementioned rule review provisions, the Ohio Department of Job and Family Services (ODJFS) is providing a copy of the affected rules for your review. However, in accordance with Section 5111.22 (A)(2) of the Ohio Revised Code, the department may only provide facilities with the rule number and title of rules proposed for rescission in lieu of an actual copy of the rules proposed for rescission.

5101:3-3-01 entitled "Definitions" sets forth the definitions which apply to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) under Chapter 5101:3-3 of the Administrative Code. This rule is being proposed for permanent amendment in accordance with Section 63.36 of Am. Sub. H. B. 94 and Am. Sub. H. B. 299 to change the imputed occupancy percentage for indirect costs set forth in paragraph (V)(1) from eighty-five percent to eighty-two percent effective SFY 2002. This rule is also being proposed for permanent amendment to change the imputed occupancy percentage for capital costs set forth in paragraph (V)(2) from ninety-five percent to eighty-eight percent effective SFY 2002. This rule is also being proposed for permanent amendment to correct grammatical errors, rule number references, and acronym references.

5101:3-3-02 entitled "Provider Agreements: NFs and ICFs-MR" sets forth the provider agreement requirements for Medicaid NFs and ICF-MR. This rule is being proposed for permanent amendment in accordance with Section 119.032 of the Revised Code to add definitions of terminology in paragraph (A), to clarify NF and ICF-MR responsibilities for providing notification of closures or voluntary withdrawal from the Medicaid program in paragraphs (C) and (D), to delete payment time-frame requirements in paragraph (E), and to integrate new statutory requirements concerning the responsibility of the provider to admit or retain persons who are or may become Medicaid eligible in "failure to pay" circumstances in paragraph (J).

5101:3-3-20.1 entitled "Chart of Accounts for Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) sets forth the cost report chart of accounts for NFs and ICFs-MR. This rule is being proposed for permanent amendment in accordance with Section 63.37 of Am. Sub. H. B. 94 and Am. Sub. H. B. 299 to clarify franchise permit fee reimbursement for NFs. Cost report account 6090 has been changed to include the "Stabilization Fund Assessment". Cost report account 6091 has been changed to clarify references to franchise permit fee rules 5101:3-3-49.2 to 5101:3-3-49.9 and 5101:3-3-82.2 to 5101:3-3-82.7 and to specify the cost reporting criteria for NFs and ICFs-MR during SFYs 2002-2003.

5101:3-3-45 entitled "Purchased Nursing Services Reimbursement for Nursing Facilities (NFs) sets forth the purchased nursing reimbursement for NFs. This rule is being proposed for permanent amendment in accordance with Section 5111.262 of the Revised Code as amended by Am. Sub. H. B. 94 to change the purchased nursing allowance. For costs incurred in CY 2000 and thereafter, costs for purchased nursing services shall be allowable direct care costs up to 20% of a nursing facility's costs specified in the cost report for services provided that year by registered nurses, licensed practical nurses and nurse aides who are employees of the facility, plus one half of the amount by which reported costs for purchased nursing services exceed 20%.

5101:3-3-49.1 entitled "Nursing Facilities (NFs): Method for Establishing Reimbursement for the Franchise Permit Fee" sets forth the method for establishing reimbursement for the franchise permit fee for NFs. This rule is being proposed for permanent amendment in accordance with Section 63.37 of Am. Sub. H. B. 94 and Am. Sub. H. B. 299 to change the title to include "reported in account 6091" and to clarify change in NF operators in paragraph (B).

5101:3-3-49.2 entitled "Nursing Facilities (NFs): Franchise Permit Fee" sets forth the franchise permit fee for NFs. This rule is being proposed for permanent rescission in conjunction with the adoption of a new rule by the same number.

5101:3-3-49.2 entitled "Identification of Nursing Facility (NF) and Hospital Beds Subject to the Franchise Permit Fee (FPF)" sets forth the components of the identification of nursing home and hospital beds subject to the FPF, beds not subject to the FPF, provides for exemptions from the FPF and places limits on the number of exemptions to be granted. This rule is being proposed for permanent adoption in accordance with Section 119.032 of the Revised Code to combine into one rule the identification of all beds subject the FPF, beds not subjects to the FPF, exemptions from the FPF, and limits to the number of exemptions that may be granted. The department's name was updated from the Ohio Department of Human Services to the Ohio Department of Job and Family Services.

5101:3-3-49.3 entitled "Calculation of Franchise Permit Fee" sets forth the calculation of the franchise permit fee assessment for NFs. This rule is being proposed for permanent rescission in conjunction with the adoption of a new rule by the same number.

5101:3-3-49.3 entitled "Calculation, Billing, Collection, and Appeals Process for the Franchise Permit Fee (FPF)" sets forth components of the requirements for the calculation of the FPF, the billing to the responsible facilities, the collection of the FPF, and the appeals process to be utilized by the facilities if errors in the franchise permit fee calculation occur. This rule is being proposed for permanent adoption in accordance with Sections 3721.51 and 3721.56 of Am. Sub. H. B. 94 to consolidate the criteria for the calculation, billing, collection, and appeal of the franchise permit fee for specifically defined nursing home and hospital beds.

5101:3-3-49.4 entitled "Method for Exempting Nursing Facilities from the Franchise Permit Fee" sets forth the method for exempting nursing facilities from the franchise permit fee. This rule is being proposed for permanent rescission in conjunction with the adoption of new rule 5101:3-3-49.2.

5101:3-3-49.5 entitled "Identification of Beds Subject to Franchise Permit Fee" sets forth the identification of beds subject to the franchise permit fee assessment. This rule is being proposed for permanent rescission in conjunction with the adoption of new rules 5101:3-3-49.2 and 5101:3-3-49.3.

5101:3-3-49.6 entitled "Appealing the Franchise Permit Fee Assessments" sets forth the process for appealing the franchise permit fee assessment. This rule is being proposed for permanent rescission in conjunction with the adoption of new rules 5101:3-3-49.2 and 5101:3-3-49.3.

5101:3-3-49.7 entitled "Method of Distribution of Funds Deposited in the Home and Community-Based Services for the Aged Fund" sets forth the method of distribution of funds deposited in the Home and Community-Based Services for the Aged Fund. This rule is being proposed for permanent rescission in conjunction with the adoption of a new rule by the same number.

5101:3-3-49.7 entitled "Method of Distribution of Franchise Permit Fee Proceeds"sets forth the identification of programs which are to receive funding from the franchise permit fee assessments, the percent of proceeds to go into each fund and the increase in the FPF assessments for fiscal years 2002 and 2003. This rule is being proposed for permanent adoption in accordance with Section 3721.56 of Am. Sub. H. B. 94 to integrate

the statutory requirements for an increase in the franchise permit fee for FY 2002 and 2003 and to address changes in the disbursement of the funds.

5101:3-3-49.8 entitled "Enforcement of Franchise Permit Fee Program" sets forth the rights of the Ohio Department of Job and Family Services to conduct investigations and to utilize the Attorney General's Office to enforce the franchise permit fee rules and explains the responsibility of the NF for the franchise permit fee when the facility changes providers or closes. This rule is being proposed for permanent amendment in accordance with Section 119.032 of the Revised Code to update the department's name from the Ohio Department of Human Services to the Ohio Department of Job and Family Services and to delete references to rules proposed for permanent rescission.

5101:3-3-49.9 entitled "Procedure for Terminating the Franchise Permit Fee Program for Nursing Facilities (NFs) and Hospitals" sets forth the components of the process to be initiated by both the department and facilities if the United States Health Care Financing Administration determines that the franchise permit fee is an impermissible health care related tax. This rule is being proposed for permanent amendment in accordance with Section 119.032 of the Revised Code to update the department's name from the Ohio Department of Human Services to the Ohio Department of Job and Family Services and to provide consistency in use of the term franchise permit fee.

5101:3-3-51.4 entitled "Nursing Facilities (NFs): Return on Equity" sets forth the return on equity calculation for NFs. This rule is proposed for permanent amendment in accordance with Section 5111.25 of the Revised Code as amended by Am. Sub. H.B. 94 to reduce the maximum amount of return on net equity available to eligible proprietary NFs from $1.00 per day to $.50 per day.

5101:3-3-51.6 entitled "Notice, Escrow, Recovery of Excess Depreciation Paid, Change in the Medicaid Provider Agreement, or Voluntary Termination in the Medical Assistance Program for Nursing Facilities (NFs) sets forth the notice, escrow, recovery of excess depreciation paid, change in the Medicaid provider agreement, or voluntary termination in the Medical assistance program for NFs. This rule is being proposed for permanent amendment in accordance with Sections 5111.25 and 5111.28 of the Revised Code as amended by Am. Sub. H.B. 94 to correct the rule number to include a decimal point, to update the department's name from the Ohio Department of Human Services to the Ohio Department of Job and Family Services throughout the rule, to replace the term "voluntary termination" with the term "closure and voluntary withdrawal" throughout the rule, to add language in paragraph (A) to identify where the definition of "closure and voluntary withdrawal" can be found in the Administrative Code, to add language in paragraph (D) regarding the withholding of monthly vendor payments in escrow if the provider fails to notify ODJFS within the time frames required by this rule, to change the penalty in paragraph (J)(1) if a NF fails to provide notice of a change in provider agreement from the current average bank prime rate plus two percent to the current average bank prime rate plus four percent, and to add language to paragraphs (J)(3) and (J)(4) regarding the release of vendor payments held in escrow.

5101:3-3-57 entitled "Nursing Facilities (NFs) Expenditure Limitation" sets forth the Medicaid nursing facility (NF) expenditure limitation. This rule is proposed for permanent adoption in accordance with Section 63.35 of Am. Sub. H. B. 94 to establish NF expenditure limitations which specify that rates paid to NFs under the medicaid program shall be subject to total per diem rate limitations for SFYs 2002-2003.

5101:3-3-58 entitled "Nursing Facilities (NFs) Stabilization Fund: Method of Establishing Payment from the Stabilization Fund" sets forth the method of establishing payment from the NF stabilization fund. This rule is being proposed for permanent adoption in accordance with Section 63.37 of Am. Sub. H. B. 94 and Am. Sub. H. B. 299 to set forth the method of establishing payment from the NF stabilization fund.

Should revisions to the proposed permanent rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur the aforementioned rule will become effective on a permanent basis.

NFTL 01-1

Nursing Facility Transmittal Letter (NFTL) 01-1

March 19, 2001

TO: Administrators, Nursing Facilities

Directors, County Departments of Jobs and Family Services

FROM: Jo Ann Davidson, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-01 of the Administrative Code

5101:3-3-01 entitled "Definitions" sets forth the definitions which apply to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) under Chapter 5101:3-3 of the Administrative Code. This rule was recently amended as a result of the implementation of the permanent provisions of Sub. H. B. 403 as codified in Sections 5111.25 and 5111.251 of the Revised Code. Pursuant to Sub. H. B. 403, paragraph (BB) of rule 5101:3-3-01 was amended to change the definition of an arms-length transaction for the transfer or lease of a NF or an ICF-MR. This rule is now being amended to allow eligible related-party transactions which occurred prior to the implementation of the provisions of Substitute House Bill 403 to qualify for prospective reimbursement on and after the effective date of this rule if the corresponding state plan amendment is approved by the Health Care Financing Administration.

Should revisions to the proposed permanent rule occur during the hearing process, a copy of the revised rule will be forwarded to you at that time. Should no revisions occur the aforementioned rule will become effective on a permanent basis.

NFTL 00-4

Nursing Facility Transmittal Letter (NFTL) 00-4

December 11, 2000

TO: Administrators, Nursing Facilities

Directors, County Departments of Jobs and Family Services

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-01 and 5101:3-3-201 of the Administrative Code

The following rules are being proposed for permanent amendment to comply with the permanent provisions of Substitute House Bill 403. These rules are also being reviewed in compliance with Section 119.32 of the Ohio Revised Code (ORC), which requires the review of all agency rules every five (5) years. The purpose of this review is to determine whether or not a rule should be amended, rescinded or adopted based upon the rule's purpose and scope. The review also provides local agencies more flexibility and eliminates unnecessary paperwork.

5101:3-3-01 entitled "Definitions" sets forth the definitions which apply to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) under Chapter 5101:3-3 of the Administrative Code. This rule is being proposed for permanent amendment as a result of the implementation of the permanent provisions of Sub. H. B. 403 which amended Sections 5111.25 and 5111.251 of the Revised Code. Pursuant to Sub. H. B. 403, paragraph (BB) is being amended to change the definition of an arms- length transaction for the transfer or lease of a NF or an ICF-MR. Under this rule, transfers of ownership and leases from one party to another that are otherwise between related parties shall be considered arms-length if the transferring provider has no direct or indirect interest in the acquiring provider except as a creditor and does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default, in which case the Department must, in calculating its reimbursement rates for capital costs, treat the facility as if the transfer never occurred. Paragraph (BB) has also been amended to include specific guidelines regarding interest rates for seller financing and the submission of real estate appraisals during the sale or lease of a facility to a related party seeking to qualify for nonrelated party status. Lastly, this rule is being amended to change the agency name from the Ohio Department of Human Services (ODHS) to the Ohio Department of Job and Family Services (ODJFS).

5101:3-3-201 entitled "Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR): Chart of Accounts" sets forth the chart of accounts utilized for cost reporting purposes by NFs and ICFs-MR. This rule is being proposed for permanent amendment as a result of the implementation of the permanent provisions of Sub. H. B. 403 which amended Sections 173.55 and 173.54 of the Revised Code. These provisions require nursing facilities (NFs) to be charged a fee not to exceed four hundred dollars for annual customer satisfaction surveys. The indirect care cost center cost report account 7270 set forth in this rule has been changed to include the fee paid by the NFs for these surveys. This rule is also being amended to change references to the agency name from the Ohio Department of Human Services (ODHS) to the Ohio Department of Job and Family Services (ODJFS).

Should revisions to the proposed permanent rules occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur the aforementioned rules will become effective on a permanent basis.

NFTL 00-3

Nursing Facility Transmittal Letter (NFTL) 00-3

August 14, 2000

TO: Administrators, Nursing Facilities

Directors, County Departments of Job and Family Services

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Proposed Permanent Amendment of Rule 5101:3-3-40 of the Administrative Code

This rule package sets forth the revisions made necessary by the implemention of automated corrections using the new MDS Correction Request Form as published by the Health Care Financing Administration (HCFA). HCFA has also developed a formal attestation statement which certifies the accuracy of all MDS forms (Assessment Forms, Tracking Forms, and the Correction Request Form). The revised MDS2.0 Section S for Ohio is also enclosed. References to the agency will be changed from the Ohio Department of Human Services (ODHS) to the Ohio Department of Job and Family Services (ODJFS) to reflect the recent name change.

In addition, Rule 5101:3-3-40 is being reviewed pursuant to Section 119.032 of the Ohio Revised Code, which requires the review of all state agency rules within a five year period. The purpose of this review is to determine whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the intent of the review is to ensure that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and when possible local agencies are given more flexibility.

5101:3-3-40 entitled "Nursing Facility Case Mix Assessment Instrument: Minimum Data Set Version 2.0 (MDS2.0)" rule sets forth the instrument and procedures by which nursing facilities compile and submit resident assessment data for purposes of determining facility average acuity levels. These case mix levels establish the direct care component of the facility's rate under the payment system which was effective July 1, 1993. This rule is being proposed for amendment on a permanent basis to include information about automated corrections using the new MDS Correction Request Form as published by the Health Care Financing Administration (HCFA). The correction request form is the mechanism used to request correction of error(s) in an MDS assessment record or error(s) in an MDS discharge or reentry tracking form that has been previously accepted into the state MDS database, to identify the inaccurate record, and to attest to the correction request. A correction request can be made to either modify or inactivate a record. MDS2.0 Section S for Ohio has been revised since the Ohio RUG grouper has been updated to utilize the MDS2.0 version, thus eliminating the need to capture previous Section S items for payment purposes. All MDS Assessment Forms, Tracking Forms, and the Correction Request Forms include a new attestation statement which certifies the accuracy of the information collected. The new attestation form also certifies that the collection of information meets Medicare/ Medicaid guidelines.

Should revisions to the proposed permanent rules occur, copies of the revised rules will be forwarded to you at that time. Should no revisions occur, the aforementioned rules will become effective on a permanent basis.

NFTL 00-2

Nursing Facility Transmittal Letter (NFTL) 00-2

August 7, 2000

TO: Administrators, Nursing Facilities

Directors, County Departments of Jobs and Family Services

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Proposed Permanent Amendment of Rules 5101:3-3-01 and 5101:3-3-45 of the Administrative Code

These rules are being proposed for permanent amendment to comply with the temporary provisions of Section Five (5) of Substitute House Bill 403. These rules are also being reviewed in compliance with Section 119.32 of the Ohio Revised Code (ORC), which requires the review of all agency rules every five (5) years. The purpose of this review is to determine whether or not a rule should be amended, rescinded or adopted based upon the rule's purpose and scope. The review also provides local agencies more flexibility and eliminates unnecessary paperwork. In conjunction with these provisions, the Ohio Department of Human Services (ODHS) is requesting your input in the completion of this review.

The following rules are proposed for adoption:

5101:3-3-01 entitled "Definitions" sets forth definitions which apply to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) for purposes of Medicaid reimbursement. This rule is being proposed for permanent amendment to change the imputed occupancy percentage for indirect costs set forth in paragraph (V)(1) from eighty-five percent to seventy-five percent, and to change the imputed occupancy percentage for capital costs set forth in paragraph (V)(2) from ninety-five percent to eighty-five percent. This proposed amendment corresponds with Sections 5 (A) and 5 (B) of Substitute House Bill 403 which become effective July 1, 2000.

Rule 5101:3-3-45 entitled "Purchased nursing services reimbursement for nursing facilities (NFs)" sets forth the purchased nursing services reimbursement calculation for NFs. This rule is being proposed for permanent amendment to change the percentage of allowable employed nursing services costs stated in paragraph (A)(3) from ten percent to seventeen percent. This percentage is used to determine allowable purchased nursing services reimbursement for NFs. This proposed amendment corresponds with Section 5 (C) of Substitute House Bill 403 which becomes effective July 1, 2000.

Should revisions to the proposed permanent rules occur, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur the aforementioned rules will become effective on a permanent basis.

NFTL 00-1

Nursing Facility Transmittal Letter (NFTL) 00-1

May 24, 2000

TO: Administrators, Nursing Facilities

Directors, County Departments of Human Services

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Proposed Permanent RECISSION of Rules 5101:3-3-041, 5101:3-3-16 and 5101:3-3-162 of the Administrative Code

Proposed Permanent Adoption of Rules 5101:3-3-041, 5101:3-3-16 and 5101:3-3-162 of the Administrative Code

Proposed Permanent Amendment of Rules 5101:3-3-023, 5101:3-3-04 and 5101:3-3-23 of the Administrative Code

This rule package is being reviewed pursuant to Substitute House Bill 473, which requires the review of all state agency rules within a five year period. The purpose of this review is to determine whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration the rule's purpose and scope. In addition, the intent of the review is to ensure that rules are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and, when possible, local agencies are given more flexibility.

Rule 5101:3-3-023 entitled "Eligible Providers and Provider Types" sets forth components of the Medicaid provider agreement and bed certification requirements. This rule is being proposed for permanent amendment to delete references to a repealed OAC rule and to update language regarding the withdrawal of certified beds from the medical assistance program to reflect the provisions of section 5111.30 of the ORC.

Rule 5101:3-3-04 entitled "Payment During the Ohio Department of Jobs and Family Services (ODJFS) Administrative Appeals Process for Denial or Termination of a Provider Agreement" sets forth components of Medicaid reimbursement for NFs and ICFs-MR during the administrative appeals process for ODJFS denials or terminations of provider agreements. This rule is being proposed for permanent amendment to correct clerical errors and wording redundancy. The title of this rule has been shortened and the department's new name has been integrated into the rule.

Rule 5101:3-3-041 entitled "Availability of Payment During the State Survey Agency's Administrative Appeals Process for Denial, Termination or Failure to Renew a Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICF-MR) Certification" sets forth the components of the payment requirements for NFs and ICFs-MR during the administrative appeals process for termination of, or the failure to renew facility certification. This rule is being proposed for recission in conjunction with the adoption of a new rule by the same number.

Rule 5101:3-3-041 entitled "Payment During the Survey Agency's Administrative Appeals Process" sets forth the payment requirements for nursing facilities and intermediate care facilities for the mentally retarded during the administrative appeals process for termination or non-renewal of Medicaid certification. This rule is being proposed for permanent adoption to define payment requirements during the ODH administrative appeals process.

Rule 5101:3-3-16 entitled "Residents' Rights in Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth the rights of residents in a NF or ICF-MR and protects those residents against inappropriate discharge actions. This rule is being proposed for recission in conjunction with the adoption of a new rule by the same number.

Rule 5101:3-3-16 entitled "Residents' Rights in Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICF-MR)" sets forth citations of the ORC and CFR which delineate the rights of

residents in nursing facilities and intermediate care facilities for the mentally retarded. This rule is being proposed for permanent adoption to identify citations of the ORC and CFR which delineate residents rights.

Rule 5101:3-3-162 entitled "Advance Directives for Nursing Facilities" sets forth components of nursing facility (NF) requirements for implementing advance directives, and the NF responsibilities for public/community education on advance directives. This rule is being proposed for permanent rescission in conjunction with the proposed permanent adoption of a new rule by the same number.

Rule 5101:3-3-162 entitled "Advance Directives for Nursing Facilities" sets forth the advance directive requirements for nursing facilities. This rule is being proposed for permanent adoption to clarify requirements pursuant to 42 CFR 489.102 which delineates the NFs responsibilities for creating and implementing advance directive policies, procedures and community education efforts.

Rule 5101:3-3-23 entitled "Private Rooms for Medicaid Residents in Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)" sets forth components of the Medicaid reimbursement requirements for private room accommodations for residents of NFs and ICFs-MR. This rule is being proposed for permanent amendment to correct spelling errors.

Should revisions to the proposed permanent rule occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on a permanent basis.

Rule 5101:3-3-871 entitled "ICF-MR Outlier Services for Continual Behavioral Redirection and Medical Monitoring (ICF-MR CBRMM Services)." sets forth the criteria for the identification of a subgroup of persons with an ICF-MR level of care, whose care needs are "outliers" that can neither be adequately reflected by the current RAI, nor adequately measured by the current RAC case mix system; the prerequisites a provider must meet in order to be approved by ODJFS as an eligible provider of these special "outlier" services; and the prior authorization process for individuals seeking Medicaid payment for these outlier services.

Should revisions to the proposed permanent rule occur during the hearing process, a copy of the revised rules will be forwarded to you at that time. Should no revisions occur, the attached rules will become effective on a permanent basis.

Medical Assistance Letters

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.

MAL 516

Medical Assistance Letter No 516 (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

Click here to view MAL 516, Employee Education About False Claims Recovery.

MAL 473

Medical Assistance Letter No 473 (September 2, 2004 - Pharmacy Program Initiatives: Clinical Utilization Edits and Preferred Drug List Implementation), is maintained in the Pharmacy Services e-book.

Click here to view MAL 473, Pharmacy Program Initiatives: Clinical Utilization Edits and Preferred Drug List Implementation in the Pharmacy Services e-book.

MAL 460

Medical Assistance Letter No 460 (December 18, 2003 - Consumer co-payments for prescription medication requiring prior authorization), is maintained in the Pharmacy Services e-book.

Click here to view MAL 460, Consumer co-payments for prescription medication requiring prior authorization in the Pharmacy Services e-book.

MAL 447

Medical Assistance Letter No 447 (March 6, 2003 - Preferred Drug List (PDL) Information), is maintained in the Physician Services Handbook.

Click here to view MAL 447, Preferred Drug List (PDL) Information in the Physician Services Handbook

OAC Chapter 5160-3 Long-Term Care Facilities; Nursing Facilities; Intermediate Care Facilities for Individuals with Intellectual Disabilities

Chapter **5160-3** of the Ohio Administrative Code (OAC) contains administrative rules for Long-Term Care Facilities, primarily nursing facilities. This Chapter also contains certain regulations for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID). See OAC Chapter **5123.** for the ICF-IID rules administered by the Ohio Department of Developmental Disabilities (DODD).

Long Term Care Rules

Definitions

***Formerly* 5101:3-3-01 Definitions**

NFTL 10-03 / ICF-MRTL 10-03

Effective Date: October 1, 2010

***Most Current Prior Effective Date:* December 31, 2006**

Except as otherwise provided in Chapter 5101:3-3 of the Administrative Code:

(A) "Allowable costs" are those costs incurred for certified beds in a facility as determined by the Ohio department of job and family services (ODJFS) to be reasonable, as set forth under paragraph (AA) of this rule, and do not include fines paid under sections 5111.35 to 5111.62, 5111.683, and 5111.99 of the Revised Code. Unless otherwise enumerated in Chapter 5101:3-3 of the Administrative Code, allowable costs are also determined in accordance with the following reference material, as currently issued and updated, in the following priority:

(1) Title 42 Code of Federal Regulations (C.F.R.) Chapter IV (10/1/2005);

(2) The provider reimbursement manual (CMS Publication 15-1, www.cms.hhs.gov/manuals); or

(3) Generally accepted accounting principles in accordance with standards prescribed by the "American Institute of Certified Public Accountants" (AICPA) as in effect on the effective date of this rule. These standards can be obtained at www.aicpa.org.

(B) "Ancillary and support costs" means ~~all reasonable costs incurred by a nursing facility other than direct care costs or capital costs. "Ancillary and support costs" includes, but is not limited to costs of activities, social services, pharmacy consultants, habilitation supervisors, qualified mental retardation professionals, program directors, medical and habilitation records, program supplies, incontinence supplies, food, enterals, dietary supplies and personnel, laundry, housekeeping, security, administration, medical equipment, utilities, liability insurance, bookkeeping, purchasing department, human resources, communications, travel, dues, license fees, subscriptions, home office costs not otherwise allocated, legal services, accounting services, minor equipment, maintenance and repairs, help-wanted advertising, informational advertising, start-up costs, organizational expenses, other interest, property insurance, employee training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims and related costs as specified in rules adopted by the director of job and family services under section 5111.02 of the Revised Code. "Ancillary and support costs" also means the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992~~costs as defined under rule 5101:3-3-42 of the Administrative Code.

(C) "Annual facility average case-mix score" is the score used to calculate the facility's cost per case-mix unit.

(D) "Capital costs" means costs of ownership and, in the case of an intermediate care facility for the mentally retarded, costs of nonextensive renovation.

(1) "Cost of ownership" means the actual expense incurred for all of the following:

(a) Depreciation and interest on any items capitalized including the following:

(i) Buildings;

(ii) Building improvements;

(iii) Equipment;

(iv) Extensive renovation;

(v) Transportation equipment;

(vi) Replacement beds;

(b) Amortization and interest on land improvements and leasehold improvements;

(c) Amortization of financing costs;

(d) Except as provided under paragraph (M) of this rule, lease and rent of land, building, and equipment.

(2) "Costs of nonextensive renovation" means the actual expense incurred for depreciation or amortization and interest on renovations that are not extensive renovations.

(E) "Capital lease" and "operating lease" shall be construed in accordance with generally accepted accounting principles.

(F) "Case mix score" means the measure of the relative direct-care resources needed to provide care and rehabilitation to a resident of a nursing facility (NFs) or intermediate care facility for the mentally retarded (ICFs-MR).

(G) "Cost of construction" means the costs incurred for the construction of beds originally contained in the NF or ICF-MR and the costs incurred for the construction of beds added to the NF or ICF-MR after the construction of the original beds. In the case of NFs or ICFs-MR which extensively renovate, "cost of construction" includes the costs incurred for the extensive renovation.

(H) "Cost per case mix unit" for NFs is determined at least once every ten years for a peer group and shall be used for subsequent years until the department redetermines it. Cost per case mix unit for ICFs-MR is determined annually. The "cost per case mix unit" is calculated by dividing the facility's desk-reviewed, actual, allowable, per diem direct care costs for the applicable calendar year preceding the fiscal year in which the rate will be paid by the facility's annual average case mix score for the applicable calendar year.

(I) "Date of licensure," for a facility originally licensed as a nursing home under Chapter 3721. of the Revised Code, means the date specific beds were originally licensed as nursing home beds under that chapter~~.~~, ~~Regardless~~regardless of whether they were subsequently licensed as residential facility beds. For a facility originally licensed as a residential facility, "date of licensure" means the date specific beds were originally licensed as residential facility beds under that section.

(1) If nursing home beds licensed under Chapter 3721. of the Revised Code or residential facility beds licensed under section 5123.19 of the Revised Code were not required by law to be licensed when they were originally used to provide nursing home or residential facility services, "date of licensure" means the date the beds first were used to provide nursing home or residential facility services, regardless of the date the present provider obtained licensure.

(2) If a facility adds nursing home or residential facility beds or in the case of an ICF-MR with more than eight beds or a NF, it extensively renovates the facility after its original date of licensure, it will have a different date of licensure for the additional beds or for the extensively renovated facility, unless, in the case of the addition of beds, the beds are added in a space that was constructed at the same time as the previously licensed beds but was not licensed under Chapter 3721. or section 5123.19 of the Revised Code at that time. The licensure date for additional beds or facilities which extensively renovate shall be the date the beds are placed into service.

(J) "Desk reviewed" means that costs as reported on a cost report have been subjected to a desk review and preliminarily determined to be allowable costs.

(K) "Direct care costs" means costs as defined under rules 5101:3-3-42 and 5101:3-3-71 of the Administrative Code.

(L) "Fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.

(M) "Indirect care costs" means costs as defined under rule 5101:3-3-71 of the Administrative Code.

(N) "Inpatient days" means all days during which a resident, regardless of payment source, occupies a bed in a NF or ICF-MR that is included in the facility's certified capacity under Title XIX of the "Social Security Act," 49 stat. 620 (1935), 42 U.S.C.A. 301, as amended. Therapeutic or hospital leave days

for which payment is made under section 5111.33 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days.

(O) "Intermediate care facility for the mentally retarded" (ICF-MR) means an intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the medical assistance program by the director of health in accordance with Title XIX of the "Social Security Act."

(P) "Maintenance and repair expenses" means expenditures, except as provided in paragraph (EE) of this rule, that are necessary and proper to maintain an asset in a normally efficient working condition and that do not extend the useful life of the asset two years or more. Maintenance and repairs expense may include, but are not limited to, the cost of ordinary repairs such as painting and wallpapering.

(Q) "Minimum data set ~~- version 2.0~~" (MDS ~~2.0~~) is the resident assessment instrument ~~selected by Ohio and~~ approved by the centers for medicare and medicaid services (CMS) as described in rule 5101:3-3-43.1 of the Administrative Code. The MDS ~~2.0~~ provides the resident assessment data which is used to classify the resident into a resource utilization group in the ~~RUG-III~~RUG case-mix classification system as described in rule 5101:3-3-43.2 of the Administrative Code.

(R) "Nursing facility" (NF) means a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is not an intermediate care facility for the mentally retarded (ICF-MR). "Nursing facility" includes a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is certified as a skilled nursing facility by the director in accordance with Title XIX of the "Social Security Act."

(S) "Other protected costs" means costs as defined under rule 5101:3-3-71 of the Administrative Code.

(T) "Outlier" means residents who have special care needs as defined under rule 5101:3-3-17 of the Administrative Code.

(U) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in a NF or ICF-MR.

(V) "Patient" includes resident or individual.

(W) "Provider" means a person or government entity that operates a NF or ICF-MR under a provider agreement.

(X) "Provider agreement" means a contract between ODJFS and an operator of a NF or ICF-MR for the provision of NF or ICF-MR services under the medical assistance program. The signature of the operator or the operator's authorized agent binds the operator to the terms of the agreement.

(Y) "Purchased nursing services" means services that are provided by registered nurses, licensed practical nurses, or nurse aides who are temporary personnel furnished by a nursing pool on behalf of the facility. These personnel are not considered to be employees of the facility.

(Z) "Quarterly facility average case-mix score" is the facility average case-mix score based on data submitted for one reporting quarter.

(AA) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider.

(BB) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider, as detailed below:

(1) An individual who is a relative of an owner is a related party.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in both provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals

possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.

(3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

(4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all the following conditions are met:

(a) A supplier is a separate bona fide organization;

(b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the provider and there is an open, competitive market for the types of goods or services the supplier furnishes;

(c) The types of goods or services are commonly obtained by other NFs or ICFs-MR from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities;

(d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.

(5) The amount of indirect ownership is determined by multiplying the percentage of ownership interest at each level (e.g., forty per cent interest in corporation "A" which owns fifty per cent of corporation "B" results in a twenty per cent indirect interest in corporation "B").

(6) If a provider transfers an interest or leases an interest in a facility to another provider who is a related party, the capital cost basis shall be adjusted for a sale of a facility to or a lease to a provider that is not a related party if all of the following conditions are met:

(a) For a NF transfer:

(i) The related party is a relative of owner.

(ii) The provider making the transfer retains no interest in the facility except through the exercise of the creditor's rights in the event of default.

(iii) ODJFS determines that the transfer is an arm's length transaction if all the following apply:

(a) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. If the provider making the transfer maintains an interest as a creditor, the interest rate of the creditor shall not exceed the lesser of:

(i) The prime rate, as published by the "Wall Street Journal" on the first business day of the calendar year, plus four per cent; or

(ii) Fifteen per cent.

(b) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the transfer never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) The provider transferring their facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility transferred to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(b) For a NF lease:

(i) The related party is a relative of owner.

(ii) The lessor retains an ownership interest in only real property and any improvements on the real property except when a lessor retains ownership interest through the exercise of a lessor's rights in the event of default.

(iii) ODJFS determines that the lease is an arm's length transaction if all the following apply:

(a) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in this rule, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(b) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the lease never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) A lessor that proposes to lease a facility to a relative of owner shall obtain a certified appraisal(s) for each facility leased. The lessor of the facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility leased to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(v) The provisions set forth in this paragraph do not apply to leases of specific items of equipment.

(c) For an ICF-MR transfer:

(i) The related party is a relative of owner.

(ii) The provider making the transfer retains no interest in the facility except through the exercise of the creditor's rights in the event of default.

(iii) ODJFS determines that the transfer is an arm's length transaction if all the following apply:

(a) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. If the provider making the transfer maintains an interest as a creditor, the interest rate of the creditor shall not exceed the lesser of:

(i) The prime rate, as published by the "Wall Street Journal" on the first business day of the calendar year plus four per cent; or

(ii) Fifteen per cent.

(b) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the transfer never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) The provider transferring their facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility transferred to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(d) For an ICF-MR lease:

(i) The related party is a relative of owner.

(ii) The lessor retains an ownership interest in only real property and any improvements on the real property except when a lessor retains ownership interest through the exercise of a lessor's rights in the event of default.

(iii) ODJFS determines that the lease is an arm's length transaction if all the following apply:

(a) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in this rule, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(b) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the lease never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) A lessor that proposes to lease a facility to a relative of owner shall obtain a certified appraisal(s) for each facility leased. The lessor of the facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility leased to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(v) The provisions set forth in this paragraph do not apply to leases of specific items of equipment.

(e) The provider shall notify ODJFS in writing and shall supply sufficient documentation demonstrating compliance with the provisions of this rule no less than ninety days before the anticipated date of completion of the transfer or lease. In the case of a transaction completed before December 28, 2000 and subject to CMS approval the provider shall

supply sufficient documentation demonstrating compliance with the provisions of this rule within thirty days of the effective date of this rule. If the provider does not supply any of the required information, the provider shall not qualify for a rate adjustment. ODJFS shall issue a written decision determining whether the transfer meets the requirements of this rule within sixty days after receiving complete information as determined by ODJFS.

(f) Subject to approval by CMS of a state plan amendment authorizing such, the provisions of paragraph (BB)(6) of this rule shall apply to any transfer or lease that meets the requirements specified in paragraph (BB)(6) of this rule that occurred prior to December 28, 2000. Any rate adjustments which result from the provisions contained in paragraph (BB)(6) of this rule shall take effect as specified in rule 5101:3-3-24 of the Administrative Code, following a determination by ODJFS that the requirements of paragraph (BB)(6) of this rule are met. A provider seeking a determination from ODJFS that a transaction occurring prior to December 28, 2000, meets the requirements of this rule shall submit the necessary documentation under paragraph (BB)(6)(e) of this rule no later than thirty days after the effective date of this rule.

(CC) "Relative of owner" means an individual who is related to an owner of a NF or ICF-MR by one of the following relationships:

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted parent, child, or sibling;

(4) Stepparent, stepchild, stepbrother, or stepsister;

(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;

(6) Grandparent or grandchild;

(7) Foster parent, foster child, foster brother, or foster sister.

(DD) "Extensive renovation" means a renovation that costs more than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years. To calculate the per-bed cost of a renovation project for purposes of determining whether it is an extensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. Allowable extensive renovations are considered an integral part of cost of ownership as set forth under paragraph (D)of this rule.

(1) For purposes of paragraph (DD) of this rule, the cost of constructing a new bed shall be considered to be forty thousand dollars, adjusted for inflation from January 1, 1993 to the end of the calendar year during which the renovation is completed using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(2) ODJFS may treat a renovation that costs more than eighty-five per cent of the cost of constructing new beds as an extensive renovation if ODJFS determines that the renovation is more prudent than construction of new beds.

(EE) "Nonextensive renovation" means the betterment, improvement, or restoration of ~~a~~an ~~NF or~~ ICF-MR beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. To calculate the per-bed cost of a renovation project for purposes of determining whether it is a nonextensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. A nonextensive renovation may include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A nonextensive renovation may include costs that otherwise would be considered maintenance and repair expenses if they are included as part of the nonextensive renovation project and are an integral part of the structural change that makes up the nonextensive

renovation project. Nonextensive renovation does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity. Allowable nonextensive renovations are not considered cost of ownership as set forth under paragraph (D) of this rule.

(FF) The definitions established in paragraphs (DD) and (EE) of this rule apply to "extensive renovations" and "nonextensive renovations" approved by ODJFS on or after July 1, 1993. Any betterments, improvements, or restorations of NFs or ICFs-MR for which construction is started before July 1, 1993, and that meet the definitions of extensive renovations or nonextensive renovations established by the rules of ODJFS in effect on December 22, 1992, shall be considered extensive renovations or nonextensive renovations. For purposes of renovations approved by ODJFS, "construction is started" means the date in which the actual construction work begins at the facility site.

(GG) "Replacement beds" are beds which are relocated to a new building or portion of a building attached to and/or constructed outside of the original licensed structure of a NF or ICF-MR. Replacement beds may originate from within the licensed structure of a NF or ICF-MR from another NF or ICF-MR. Replacement beds are eligible for the cost of ownership efficiency incentive ceiling which corresponds to the period the beds were replaced.

(HH) ~~"RUG III"~~"RUGs" is the resource utilization groups~~, version III~~ system of classifying ~~nursing facility (NF)~~NF residents into case-mix groups as described in rule 5101:3-3-43.2 of the Administrative Code.

Effective:

R.C. 119.032 review dates: 07/14/2010

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.20

Prior Effective Dates: 7/1/80, 8/1/84, 9/30/93 (Emer), 1/1/94, 11/1/95, 7/1/00, 12/28/00, 5/17/01, 9/30/01, 2/2/06, 12/31/06

5160-3-01.1 Authorization for the Ohio Department of Developmental Disabilities (DODD) to Administer the Medicaid Program for Services Provided by Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)

Formerly **5101:3-3-01.1 Authorization for the Ohio Department of Developmental Disabilities (DODD) to Administer the Medicaid Program for Services Provided by Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)**

ICF-MRTL 12-04

Effective Date: January 10, 2013

(A) The Ohio department of developmental disabilities (DODD), through an interagency agreement with the Ohio department of job and family services (ODJFS), administers the medicaid program for services provided by intermediate care facilities for the mentally retarded (ICFs-MR) on a daily basis in accordance with section **5111.91** of the Revised Code. DODD may develop rules and policies governing the administration of the ICF-MR program, which shall be filed in Chapter **5123:2-7** of the Administrative Code upon review and approval by ODJFS in compliance with 42 C.F.R. 431.10.

(B) In collaboration with DODD, ODJFS shall create and implement oversight measures related to the ICF-MR program in accordance with Chapter **5111.** of the Revised Code. Reviews may consist of, but are not limited to, physical inspections of records and sites where services are provided, and interviews of providers and recipients of ICF-MR services. ICF-MR providers shall provide any records related to the administration and/or provision of ICF-MR services to ODJFS, the center for medicare and medicaid services (CMS), the medicaid fraud control unit, and any of their designees in accordance with the medicaid provider agreement.

(C) ODJFS will monitor payment made under authority of this rule as necessary to ensure that funding is used for authorized purposes in compliance with federal and state laws, regulations, and policies governing the medicaid program. ODJFS and DODD may recover any overpayment identified by requesting voluntary repayment, or through provider payment offsets, or formal adjudicatory or non-adjudicatory recovery proceedings.

(D) Whenever an applicant for or recipient of ICF-MR services is affected by any action proposed or taken by DODD and/or ODJFS, the entity recommending or taking the action will provide medicaid due process in accordance with section **5101.35** of the Revised Code and as specified in Chapters **5101:6-1** to **5101:6-9** of the Administrative Code. Such actions may include, but are not limited to, the approval, denial, or termination of enrollment or a denial of ICF-MR services. If an applicant or enrollee requests a hearing related to an action taken by DODD, the participation of DODD is required during the hearing proceedings to justify the decision under appeal.

Effective: 01/10/2013

R.C. 119.032 review dates: 01/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.226

***Formerly* 5101:3-3-02 Provider Agreements for Nursing Facilities (NFs)**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: July 1, 2010

In addition to provisions in rules **5101:3-3-02.1** and **5101:3-3-02.2** of the Administrative Code, execution and maintenance of a provider agreement between the Ohio department of job and family services (ODJFS) and the operator of a NF ~~or ICF-MR~~ is also contingent upon compliance with requirements set forth in this rule.

(A) Definitions.

(1) "Closure" means the discontinuance of the use of the building or part of the building that houses the facility as a NF ~~or ICF-MR~~, and that results in the relocation of the facility's residents who continue to require NF ~~or ICF-MR~~ services. If the building is converted to a different use and acquires a new type of license, residents who require services offered under the new license type may remain.

(a) A facility's closure occurs regardless of whether there is a replacement of the facility whereby the operator completely or partially replaces the facility's physical plant through the construction of a new physical plant or the transfer of the facility's license from one physical plant location to another.

(b) Facility closure occurs regardless of whether residents of the closing facility elect to be relocated to the operator's replacement facility or to another NF ~~or ICF-MR~~.

(c) A facility closure occurs regardless of action taken by the Ohio department of health (ODH) related to the facility's certification under Title XIX of the Social Security Act, 79 stat. 286 (1965), 42 U.S.C. 1396, that may result in the transfer of part of the facility's survey findings to a replacement facility, or related to retention of a license as a NF under **Chapter 3721.** of the Revised Code ~~or as a residential facility under Chapter 5123. of the Revised Code~~.

(d) The last effective date of the provider agreement of a closed facility will be the date of the relocation of the last resident.

(2) "Continuing care" refers to the living setting that provides the individual with different types of care based on a resident's need over time and may include an apartment or lodging, meals, maintenance services, and when necessary, nursing home care. All services are provided on the premises of the continuing care community. The individual signs a contract that identifies the continuum of services to be covered by the individual's initial entrance fee and subsequent monthly charges. If a continuing care contract provides for a living arrangement that specifically states that all health care services including nursing home services are met in full, medicaid payment cannot be made for those services covered by the contract. If a continuing care contract provides for only a portion of the resident's health care services, that portion shall be deducted from the actual cost of nursing home care and medicaid shall pay the difference up to the medicaid maximum per diem. An individual who entered into a life care or continuing care contract may be eligible for medicaid under the conditions in rule **5101:1-39-02.2** of the Administrative Code.

(3) "Failure to pay" means that an individual has failed, after reasonable and appropriate notice, to pay or to have the medicare or medicaid program pay on the individual's behalf, for the care provided by the NF ~~or ICF-MR~~. An individual shall be considered to have failed to have the individual's care paid for when the individual has a medicaid application in pending status, if both of the following are the case:

(a) The individual's application, or a substantially similar previous application, has been denied by the county department of job and family services (CDJFS); and

(b) If the individual appealed the denial pursuant to division (C) of section **5101.35** of the Revised Code, the director of ODJFS upheld the denial.

(4) "Medicaid eligible" means an individual has been determined eligible by the CDJFS under Chapter **5101:1-39** of the Administrative Code and has been issued an effective date of health care coverage for the time period in question.

(5) "Operator" means the individual, partnership, association, trust, corporation, or other legal entity that operates a NF ~~or ICF-MR~~.

(6) "Voluntary withdrawal" means that the operator of a NF, in compliance with section 1919(c)(2)(F) of the Social Security Act, voluntarily elects to withdraw from participation in the medicaid program but chooses to continue providing services of the type provided by NFs. ~~For ICFs-MR voluntary withdrawal means the operator elects to voluntarily terminate from the medicaid program.~~

(B) A provider of a NF ~~or ICF-MR~~ shall:

(1) Execute the provider agreement in the format provided by ODJFS; and

(2) Apply for and maintain a valid license to operate if required by law; and

(3) Comply with the provider agreement and all applicable federal, state, and local laws and rules; and

(4) Keep records and file reports as required in rule **5101:3-3-20** of the Administrative Code; and

(5) Open all records relating to the costs of its services for inspection and audit by ODJFS and otherwise comply with rule **5101:3-3-20** of the Administrative Code; and

(6) Supply to ODJFS such information as the department requires concerning NF ~~or ICF-MR~~ services to individuals who are medicaid eligible or who have applied to be medicaid recipients; and

(7) Unless the conditions described in paragraph (J) of this rule are applicable, retain as a resident in the NF ~~or ICF-MR~~ any individual who is medicaid eligible, becomes medicaid eligible, or applies for medicaid eligibility. Residents in the NF ~~or ICF-MR~~ who are medicaid eligible, become medicaid eligible, or apply for medicaid eligibility are considered residents in the NF ~~or ICF-MR~~ during any absence for which bed-hold days are reimbursed in accordance with ~~rules~~ rule **5101:3-3-16.4** ~~and 5101:3-3-16.8~~ of the Administrative Code; and

(8) Unless the conditions described in paragraph (J) of this rule are applicable, admit as a resident in the NF ~~or ICF-MR~~, an individual who is medicaid eligible, whose application for medicaid is pending, or who is eligible for both medicare and medicaid, and whose level of care determination is appropriate for the admitting facility. This applies only if less than eighty per cent of the total residents in the NF ~~or ICF-MR~~ are recipients of medicaid.

(a) In order to comply with these provisions, the NF ~~or ICF-MR~~ admission policy shall be designed to admit individuals sequentially based on the following:

(i) The requested admission date; and

(ii) The date and time of receipt of the request; and

(iii) The availability of the level of care or range of services necessary to meet the needs of the applicants; and

(iv) Gender: sharing a room with a resident of the same sex (except married couples who agree to share the same room.).

(b) The NF ~~or ICF-MR~~ shall maintain a written list of all requests for each admission. The list shall include the name of the potential resident; date and time the request was received; the requested admission date; and the reason for denial if not admitted. This list shall be made available upon request to the staff of ODJFS, CDJFS, and ODH.

(c) The following are exceptions to paragraph (B)(8) of this rule:

(i) Bed-hold days are exhausted.

Medicaid eligible residents of NFs who are on hospital stays, visiting with family and friends, or participating in therapeutic programs and have exhausted coverage for bed-hold days under rule **5101:3-3-16.4** of the Administrative Code, must be readmitted to the first available semi-private bed in accordance with the provisions of rule 5101:3-3-16.4 of the Administrative Code; or

(ii) Facility is a county home.

Any county home organized under Chapter **5155.** of the Revised Code may admit individuals exclusively from the county in which the county home is located; or

(iii) Facility has a religious sponsor.

Any religious or denominational NF ~~or ICF-MR~~ that is operated, supervised, or controlled by a religious organization may give preference to persons of the same religion or denomination; or

(iv) NF has continuing care contracts.

A NF may give preference to individuals with whom it has contracted to provide continuing care.

(v) Prolonged "medicaid pending" application status.

A NF ~~or ICF-MR~~ may decline to admit a medicaid applicant if that facility has a resident whose application was pending upon admission and has been pending for more than sixty days, as verified by the CDJFS. The NF ~~or ICF-MR~~ shall submit the necessary documentation in a timely manner as required in rules **5101:3-3-15.1** and **5101:3-3-15.3** of the Administrative Code.

(9) Provide the following necessary information to ODJFS and CDJFS to process records for payment and adjustment:

(a) Submit the **JFS 09401** "Facility/CDJFS Transmittal" (rev. ~~4/2007~~4/2011) to the CDJFS to inform the CDJFS of any information regarding a specific resident for maintenance of current and accurate records at the CDJFS and the facility; and

(b) For dates of service prior to July 1, 2005, submit the **JFS 09400** "Nursing Facility Payment and Adjustment Authorization" (rev. ~~12/2001~~10/2012) directly to ODJFS to initiate, terminate, or adjust medicaid payment for a specific resident as required.

(c) For dates of service on or after July 1, 2005, a NF shall submit claims electronically to ODJFS as required in rule **5101:3-3-39.1** of the Administrative Code.~~:~~

~~(i) An ICF-MR shall submit the JFS 09400 directly to ODJFS to initiate, terminate, or adjust medicaid payment for a specific resident as required.~~

~~(ii) A NF shall submit an 837I transaction as required in rule 5101:3-3-39.1 of the Administrative Code to ODJFS to initiate, terminate, or adjust medicaid payment for a specific resident.~~

(10) Permit access to facility and records for inspection by ODJFS, ODH, CDJFS, representatives of the office of the state long-term care ombudsman, and any other state or local government entity having authority to inspect, to the extent of that entity's authority.

(11) In the case of a change of operator as defined in section **5111.65** of the Revised Code, follow the procedures in paragraphs (B)(11)(a) to (B)(11)(d) of this rule.

(a) The exiting operator or owner and entering operator must provide a written notice to ODJFS, as provided in section **5111.67** of the Revised Code, at least forty-five days prior to the effective date of any actions that constitute a change of operator for the NF ~~or ICF-MR~~, but at least ninety days if residents are to be relocated. An exiting operator that does

not give proper notice is subject to the penalties specified in section **5111.28** of the Revised Code.

(b) The entering operator must submit documentation of any transaction (e.g., sales agreement, contract, or lease) as requested by ODJFS to determine whether a change of operator has occurred as specified in section **5111.67** of the Revised Code.

(c) The entering operator shall submit an application for participation in the medicaid program and a written statement of intent to abide by ODJFS rules, the provisions of the assigned provider agreement, and any existing CMS 2567 "Statement of Deficiencies and Plan of Correction" (rev. 2/1999) submitted by the exiting operator.

(d) An entering operator is subject to the same survey findings as the exiting operator unless the entering operator does not accept assignment of the exiting operator's provider agreement. Refusal to accept assignment results in termination of certification on the last day of the exiting operator's participation in medicaid. An entering operator who refuses assignment may reapply for medicaid participation and must undergo a complete initial certification survey by ODH. There may be gaps in medicaid coverage at the facility.

(12) Ensure the security of all personal funds of residents in accordance with ~~rules~~rule **5101:3-3-16.5** ~~and 5101:3-3-16.9~~ of the Administrative Code.

(13) Comply with Title VI and Title VII of the Civil Rights Act of 1964 and Public Law 101-336 (the Americans with Disabilities Act of 1990), and shall not discriminate against any resident on the basis of race, color, age, sex, creed, national origin, or disability.

(14) Provide notice to ODJFS within thirty days of any bankruptcy or receivership pertaining to the provider. Notice shall be mailed to: "Office of Legal Services, Ohio Department of Job and Family Services, 30 East Broad Street-31st. Floor, Columbus, Ohio 43215-3414" and to: "Office of the Attorney General, 150 East Gay Street, 21st Floor, Columbus, Ohio 43215.".

(C) A provider of a NF shall:.

(1) Provide a statement to the individual explaining the individual's obligation to reimburse the cost of care provided during the medicaid application process if it is not covered by medicaid.

(2) Comply with the requirements in rule **5101:3-3-04.1** of the Administrative Code and repay ODJFS the federal share of payments under the circumstances required by sections **5111.45** and **5111.58** of the Revised Code.

(3) During a closure or voluntary withdrawal from the medicaid program provide ODJFS, the resident or guardian, and the residents' sponsors a written notice at least ninety days prior to the closure or voluntary withdrawal. A NF that does not issue the proper notice is subject to the penalties specified in section **5111.28** of the Revised Code.

(4) Comply with the following requirements when voluntarily withdrawing from the medicaid program:.

(a) Continue to provide NF services to residents of the facility who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to medical assistance as of such day).

(i) A NF operator's voluntary withdrawal from participation in the medicaid program is not an acceptable basis for the transfer or discharge of these residents.

(ii) Nothing in this provision invalidates other legal grounds for NF-initiated discharge of medicaid residents after the effective date of withdrawal.

(b) Provide residents admitted after the effective date of withdrawal with information that the facility is not participating in the medicaid program with respect to those residents.

(c) Provide notice to ODJFS within fourteen days after the last medicaid funded resident has been relocated.

(D) ~~A provider of an ICF-MR shall:~~

~~Provide ODJFS, the resident or guardian, and the residents' sponsors a written notice at least ninety days prior to a closure or voluntary withdrawal from the medicaid program. An ICF-MR that does not issue the proper notice is subject to the penalties specified in section 5111.28 of the Revised Code.~~

~~(E)~~(D) A provider of a NF ~~or ICF-MR~~ shall not:

(1) Charge fees for the application process of a medicaid individual or applicant.

(2) Charge a medicaid individual an admission fee.

(3) Charge a medicaid individual an advance deposit. However, a NF may charge an individual whose medicaid eligibility is pending, typically in the form of a pre-admission deposit or payment for services after admission. A NF that has charged a resident for services between the first month of eligibility established by the state and the date notice of eligibility is received is obligated to refund any payments received for that period less the state's determination of any resident's share of the NF costs for that same period.

(4) Require a third party to accept personal responsibility for paying the facility charges out of his or her own funds. However, the facility may require a representative who has legal access to an individual's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the individual's income or resources if the individual's medicaid application is denied and if the individual's cost of care is not being paid by medicare or another third-party payor. A third-party guarantee is not the same as a third-party payor (i.e., an insurance company), and this provision does not preclude the facility from obtaining information about medicare and medicaid eligibility or the availability of private insurance. The prohibition against third-party guarantees applies to all individuals and prospective individuals in all certified NFs ~~or ICFs-MR~~ regardless of payment source. This provision does not prohibit a third party from voluntarily making payment on behalf of an individual.

~~(F)~~(E) ODJFS shall:

(1) Execute a provider agreement in accordance with the certification provisions set forth by the secretary of health and human services and ODH.

(2) In the case of a change of operator, issue an assigned provider agreement to the entering operator contingent upon the entering operator's compliance with paragraph (B)(11)(c) of this rule.

(3) Whenever ODJFS files a proposed rule, or proposed rule in revised form under division (D) of section **111.15**, or division (B) of section **119.03** of the Revised Code, ODJFS shall notify affected persons by posting on the ODJFS website the full text of rules governing the facility's participation as a medicaid provider. ODJFS may also send an email notice of the rule action to all persons whose name or contact information appears on a distribution list maintained by ODJFS. Persons may voluntarily submit an email address on an ODJFS maintained website in order to receive electronic communications regarding proposed rule actions. ODJFS shall maintain the electronic distribution list; however, the sole responsibility of the validity of any email address maintained on the distribution list is that of the person who submitted the email address.

(4) Make payments in accordance with Chapter **5111.** of the Revised Code and Chapter **5101:3-3** of the Administrative Code to the NF ~~or ICF-MR~~ for services to individuals eligible and approved for payment under the medicaid program.

~~(G)~~(F) ODJFS may terminate, suspend, not enter into, or not renew, the provider agreement upon thirty days written notice to the provider for violations of Chapter **5111.** of the Revised Code; Chapters **5101:3-1** and **5101:3-3** of the Administrative Code; and if applicable, subject to **Chapter 119.** of the Revised Code.

~~(H)~~(G) Any NF ~~or ICF-MR~~ violating provisions defined in paragraphs (B)(7) and (B)(8) of this rule will be subject to a penalty in accordance with provisions of section **5111.99** of the Revised Code.

~~(I)~~(H) The CDJFS shall use the **JFS 09401** to communicate with NFs ~~and ICFs-MR~~ regarding the assessment of payment for specific individuals.

~~(J)~~(I) Exclusions.

The provisions of paragraphs (B)(7) and (B)(8) of this rule do not require an individual to be admitted or retained at the NF ~~or ICF-MR~~ if the individual meets one of the following:

(1) The individual requires a level of care or range of services that the NF ~~or ICF-MR~~ is not certified or otherwise qualified to provide; or

(2) The individual has a medicaid application in pending status and meets the definition of "failure to pay" in this rule.

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R.C. 119.032 review dates: 07/01/2015

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5160-3-02.1 Length and Type of Long Term Care Provider Agreements

Formerly **5101:3-3-02.1 Length and Type of Long Term Care Provider Agreements**

NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: **February 15, 2011**

(A) Definitions

(1) "Reasonable assurance period" means a certain period of time, determined by the centers for medicare and medicaid services (CMS), for which a long term care facility operator whose provider agreement has been involuntarily terminated is required to operate without recurrence of the deficiencies that were the basis for termination. Participation in the medicare and medicaid programs may resume only following that period. If corrections were made before submission of a new request for participation, the period of compliance before the new request is counted as part of the period.

(2) "State survey agency" means the agency that is under contract with the state medicaid agency and that inspects long term care facilities for the purposes of survey and certification. The state survey agency in Ohio is the Ohio department of health (ODH). The state medicaid agency in Ohio is the Ohio department of job and family services (ODJFS).

(B) Effective dates - skilled nursing facilities (SNFs), nursing facilities (NFs), and SNF/NFs.

(1) Initial certification of NFs and SNF/NFs.

(a) Effective dates of NF and SNF/NF provider agreements generally are assigned by the state survey agency on the basis of findings of compliance or substantial compliance with standards of certification.

(b) The effective date shall not be earlier than the date on which compliance is documented via the state survey agency's onsite visits to the institution.

(c) The effective date of a provider agreement of a nursing facility that participates in the medicaid program as a SNF/NF shall be the same as that of the facility's medicare provider agreement.

(2) NFs subsequently approved to operate as SNF/NFs.

(a) Upon approval from CMS of a NF to participate in the medicare program as a SNF/NF, ODJFS shall issue a SNF/NF provider agreement.

(b) The effective date of this provider agreement shall be the same as that of the facility's medicare provider agreement.

(3) Re-entry into the program following involuntary termination.

(a) Following involuntary termination of the medicaid provider agreement for a nursing facility, the provider agreement effective date of a facility re-entering the medicaid program shall be the same effective date as the date CMS issues for the facility's medicare provider agreement.

(b) Re-entry may occur only after the successful completion of a reasonable assurance period as determined by CMS.

(C) Term limits - NFs and SNF/NFs.

(1) The term of a provider agreement shall be based on the period of certification established by the state survey agency.

(2) The actual term of the agreement may be less than, but shall not exceed, the certification period recommended by the state survey agency.

(3) NFs and SNF/NFs.

(a) NFs and SNF/NFs are governed by open-end provider agreements.

(b) Open-end agreements have no specific expiration date.

(c) Continuation of an open-end provider agreement is contingent upon findings of continued compliance or substantial compliance with certification standards as determined by the state survey agency.

Replaces: 5101:3-3-02.1

Effective: 01/10/2013

R.C. 119.032 review dates: 01/01/2018

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5160-3-02.2 Termination, Denial, and Non-Renewal of Long Term Care Provider Agreements

Formerly **5101:3-3-02.2 Termination, Denial, and Non-Renewal of Long Term Care Provider Agreements**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: **February 15, 2011**

(A) Written notice

(1) The Ohio department of job and family services (ODJFS) may terminate, deny, or not renew a provider agreement upon thirty days written notice to the nursing facility (NF) ~~or intermediate care facility for the mentally retarded (ICF-MR).~~

(2) Notices and termination orders must comply with provisions set forth in sections **5111.06** and **5111.51** of the Revised Code.

(B) Reasons for which ODJFS may terminate, deny, or not renew a provider agreement.

(1) According to section **5111.22** of the Revised Code, ODJFS may terminate, deny, or not renew a provider agreement if ODJFS determines such an agreement is not in the best interests of the state or medicaid residents of long term care facilities.

(2) ODJFS may terminate, deny, or not renew a provider agreement on the basis of best interest including, but not limited to, the following reasons:

(a) The provider has not fully and accurately disclosed to ODJFS information as required by the provider agreement or any rule contained in division **5101:3-3** of the Administrative Code;

(b) The provider has failed to abide by or to have the capacity to comply with the terms and conditions of the provider agreement and/or rules and regulations promulgated by ODJFS;

(c) The provider has been found liable by a court for negligent performance of professional duties;

(d) The provider has failed to file cost reports as required according to rule **5101:3-3-20** of the Administrative Code;

(e) The provider has made false statements or has altered records, documents, or charts. Alteration does not include properly documented correction of records;

(f) The provider has failed to cooperate or provide requested records or documentation for purposes of an audit or review of any provider activity by any federal, state, or local agency;

(g) The provider has been found in violation of section 504 of the Rehabilitation Act of 1973, as amended; the Civil Rights Act of 1964, as amended; or Public Law 101-336 (the Americans with Disabilities Act of 1990) in relation to the employment of individuals, the provision of services, or the purchase of goods and services;

(h) The attorney general, auditor of state, or any board, bureau, commission, or department has recommended ODJFS terminate the provider agreement where the reason for the request bears a reasonable relationship to the administration of the medicaid program or the integrity of state and/or federal funds;

(i) The provider has violated the prohibition against billing medicaid residents for covered services or factoring as found in rule **5101:3-1-13.1** or **5101:3-1-23** of the Administrative Code;

(j) The facility has been found by the Ohio department of health (ODH) during a survey of the facility to have an emergency that is the result of a deficiency or cluster of deficiencies, and that constitutes immediate jeopardy;

(k) The provider does not comply with the requirements of section **5111.30** of the Revised Code for the installation of fire extinguishing and fire alarm systems, and with the requirements of section 3721.071 of the Revised Code for the submission of a written fire safety code; and

(l) The provider fails to pay the full amount of a franchise permit fee (FPF) pursuant to ~~sections~~ section **3721.541** ~~and 5112.341~~ of the Revised Code.

(C) Reasons for which ODJFS shall terminate, deny, or not renew a provider agreement.

(1) ODJFS shall terminate, deny, or not renew a provider agreement when any of the situations set forth in division (D) of section **5111.06** of the Revised Code occur including, but not limited to, the following:

(a) The provider has been terminated, suspended, or excluded by the medicare program and/or by the United States centers for medicare and medicaid services (CMS) and that action is binding on participation in the medicaid program or renders federal financial participation unavailable for participation in the medicaid program. Under these conditions, medicaid termination and payment sanction dates shall be the same as medicare termination and payment sanction dates;

(b) The facility has been decertified by the Ohio department of health (ODH) and/or the United States department of health and human services;

(c) The provider, or its owner, officer, authorized agent, associate, manager, or employee has pled guilty to or been convicted of a criminal offense, found liable in a civil action, or voluntarily settled a civil suit brought pursuant to section **109.85** of the Revised Code;

(d) The provider has committed medicaid fraud as defined in rule **5101:3-1-29** of the Administrative Code;

(e) The provider has pled guilty to or been convicted of a criminal activity materially related to either the medicare or medicaid program; or

(f) Any license, permit, or certificate that is required by ODJFS or the terms of the provider agreement has been denied, suspended, revoked, or not renewed.

(g) The provider has failed to ensure a nursing facility's full participation in the medicare program as a skilled nursing facility (SNF) pursuant to section **5111.21** of the Revised Code and rule **5101:3-3-02.4** of the Administrative Code.

(2) If ODH terminates certification of a facility, ODJFS shall terminate the facility's provider agreement pursuant to division (D) of section 5111.06 and division (B) of section 5111.52 of the Revised Code.

(D) Adjudication order

(1) According to section **5111.06** of the Revised Code, ODJFS shall terminate, deny, or not renew an existing provider agreement by issuing an order pursuant to an adjudication conducted in accordance with **Chapter 119.** of the Revised Code, unless such action occurred as the result of events described in paragraph (C) of this rule.

(2) According to division (E) of section **5111.51** of the Revised Code, if ODJFS issues a termination order as the result of events set forth in paragraph (B)(2)(j) of this rule, the termination may take effect prior to or during the pendency of the proceeding under **Chapter 119.** of the Revised Code.

(E) Impact of provider actions on CMS-imposed reasonable assurance periods.

(1) When seeking reentry to the medicaid program, providers are subject to procedures set forth in CMS publication 100-07 entitled "State Operations Manual" ~~at Chapter 2 section 2016F to 2017 (10/01/10) and Chapter 3 section 3005G1 (01/26/07) for ICFs-MR, and~~ at Chapter 7 sections 7321B to 7321D (09/10/10) for SNFs and NFs, to comply with the provisions at 42 CFR 489.57 that govern reinstatement after termination, and require that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur.

(a) ~~After CMS has initiated involuntary termination action for a dually certified SNF/NF, or after ODH has initiated involuntary termination action for a medicaid-certified NF, a provider of a NF who is permitted to voluntarily terminate, voluntarily withdraw, or undergoes a change of operator, or the subsequent operator of the same facility, shall be subject to reasonable assurance requirements set by CMS when seeking reentry to the medicaid program.~~

(b) ~~After CMS has initiated involuntary termination action as a result of a federal look-behind survey of an ICF-MR following a survey by ODH, a provider of an ICF-MR who is permitted to voluntarily terminate, or undergoes a change of operator, or the subsequent operator of the same facility, shall be subject to reasonable assurance requirements set by CMS when seeking reentry to the medicaid program.~~

(2) After CMS has initiated involuntary termination action for a dually certified SNF/NF, or after ODH has initiated involuntary termination action for a medicaid-certified NF, a provider of a NF who is permitted to voluntarily terminate, voluntarily withdraw, or undergoes a change of operator, or the subsequent operator of the same facility, shall be subject to reasonable assurance requirements set by CMS when seeking reentry to the medicaid program.

~~(2)~~(3) CMS or ODH initiates a termination action when it sends a provider the initial notice certifying noncompliance and proposing termination.

~~(3)~~(4) Certification of noncompliance is a citation of noncompliance with a condition, or a nursing facility certification requirement cited at or above a scope level one and a severity level two pursuant to section **5111.35** of the Revised Code.

Effective: 01/10/2013

R.C. 119.032 review dates: 02/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 109.85, 3721.071, 3721.541, 5111.01, 5111.02, 5111.03, 5111.06, 5111.22, 5111.30, 5111.31, 5111.51, 5111.52, 5111.58, 5111.60, 5112.341

Prior Effective Dates: 4/7/77, 12/30/77, 1/1/79, 3/23/79, 8/31/79, 11/1/79, 7/1/80, 7/7/80, 10/1/87, 1/1/95, 5/16/02, 9/29/05, 2/15/11

5160-3-02.3 Institutions Eligible to Participate in Medicaid as Nursing Facilities (NFs)

Formerly **5101:3-3-02.3 Institutions Eligible to Participate in Medicaid as Nursing Facilities (NFs)**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: **February 15, 2011**

(A) Definitions

(1) "Certification" means the process by which the state survey agency certifies its findings to the federal centers for medicare and medicaid services (CMS) or the Ohio department of job and family services (ODJFS) with respect to a facility's compliance with health and safety requirements of divisions (a), (b), (c), and (d) of section 1919 of the federal Social Security Act.

(2) "Certified beds" mean beds that are counted in a provider facility that meets medicaid standards. A count of facility beds may differ depending on whether the count is used for certification, licensure, eligibility for medicare or medicaid payment formulas, ~~eligibility for waivers,~~ or other purposes.

(3) "Distinct part" means a portion of an institution or institutional complex that is certified to provide skilled nursing facility (SNF) and/or nursing facility (NF) services, or intermediate care facility for the mentally retarded (ICF-MR) services. A distinct part shall be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. A distinct part may be a separate building, wing, floor, hallway, or one side of a corridor. A hospital-based SNF or NF is a distinct part by definition. A long term care facility with both SNF and NF distinct parts is one facility, even though the distinct parts are certified separately for medicare and medicaid. "Distinct part", when applied to NFs or SNF/NFs, has the same definition and requirements as in 42 C.F.R. 483.5.

(4) "Dually participating" means simultaneous participation of an institution or institutional complex in both the medicare and medicaid programs.

(5) "Dually participating long term care facility" means an institution that participates as both a SNF under the medicare program, and as a NF under the medicaid program. Such a facility is referred to as a SNF/NF.

(6) "Facility" means the entity subject to certification and approval in order for the provider to be approved for medicaid payment. A facility may be an entire institution such as a free-standing nursing home, or may be a distinct part of an institution such as a hospital or continuing care retirement community.

~~(7) "ICF-MR services" means those services provided to individuals with mental retardation or a related condition requiring active treatment as defined in rule 5101:3-3-07 of the Administrative Code and that are available in facilities certified as intermediate care facilities for individuals with mental retardation or other developmental disabilities by the Ohio department of health (ODH) or by the state survey agency of another state.~~

~~(8)~~(7) "Long term care facility" means a NF, SNF, or dually participating SNF/NF~~, or ICF-MR~~ as defined in division **5101:3-3** of the Administrative Code.

~~(9)~~(8) "Long term care institutional services" means those medicaid funded, institutional medical, health, psycho-social, habilitative, rehabilitative, and/or personal care services that may be provided to eligible individuals in a NF~~,~~ or SNF/NF~~, or ICF-MR.~~

~~(10)~~(9)"NF services" means those services available in institutions, or parts of institutions, that are certified as nursing facilities by ODH or by the state survey agency of another state.

~~(11)~~(10) "Religious non-medical health care institution" (RNHCI) means an institution as defined in the Social Security Act, section 1861 (ss) (1), 79 Stat. 286 ~~(1965)~~, 42 U.S.C. 1395x (ss) (1), ~~as amended~~, such as the "Christian Science RNHCIs" accredited by the "Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc." RNHCIs are subject to conditions of participation in the medicaid program according to 42 C.F.R. 403 subpart G.

~~(12)~~(11) "State survey agency" means the agency designated as the state health standard setting authority, and state health survey agency responsible for certifying and determining compliance of long term care facilities with the requirements for participation in the medicaid program. The state survey agency in Ohio is ODH.

(B) Types of long term care institutional services.

(1) The types of long term care institutional services covered ~~under medicaid are those services provided~~ in compliance with the provisions of division 5101:3 of the Administrative Code ~~and~~ are NF services provided to eligible residents requiring either a skilled level of care as set forth in rule **5101:3-3-05** of the Administrative Code or an intermediate level of care as set forth in rule **5101:3-3-06** of the Administrative Code.~~:~~

(a) ~~NF services provided to eligible residents requiring either a skilled level of care as set forth in rule 5101:3-3-05 of the Administrative Code or an intermediate level of care as set forth in rule 5101:3-3-06 of the Administrative Code; and~~

(b) ~~ICF-MR services provided to eligible residents requiring an ICF-MR level of care as set forth in rule 5101:3-3-07 of the Administrative Code.~~

(2) Institutions not eligible for participation are:

(a) An institution licensed or approved as a tuberculosis hospital;

(b) A prison, juvenile criminal facility, or an institution used to incarcerate individuals involuntarily who have committed a violation of a criminal or civil law; and

(c) An institution for mental disease, as defined in rule **5101:3-3-06.1** of the Administrative Code, for persons under sixty-five years old.

(C) Requirements for participation.

To participate in the Ohio medicaid program and receive payment from ODJFS for long term care institutional services to eligible residents, operators of long term care facilities shall meet all of the following requirements:

(1) Operate an institution that meets the licensure, registration, and other applicable state standards as set forth in this rule; and

(2) Operate an institution certified by ODH or by the state survey agency of another state as being in compliance with applicable federal regulations for medicaid participation as a NF with a minimum of four NF certified beds~~, or as an ICF-MR with a minimum of four ICF-MR certified beds, as set forth in this rule~~; and

(3) Operate an institution for which a current, completed, and signed **JFS 03623** "Ohio Medicaid Provider Agreement for Long Term Care Facilities (NFs and ICF-MRs)" (rev. 7/2007) is on file with ODJFS.

(D) Qualified types of Ohio NFs.

To be eligible for certification as a NF, an institution shall qualify as one of the following:

(1) A nursing home licensed by ODH under section **3721.02** of the Revised Code, or a nursing home licensed by a political subdivision certified under section **3721.09** of the Revised Code. Licensed nursing homes eligible for medicaid certification include:

(a) RHNCIs; and

(b) Veterans' homes operated under Chapter **5907.** of the Revised Code; or

(2) A county home, county nursing home, or district home owned by the county and operated by the county commissioners in accordance with Chapter **5155.** of the Revised Code, or operated by

the board of county hospital trustees in accordance with section **5155.011** of the Revised Code; or

(3) A unit of any hospital registered under section **3701.07** of the Revised Code that contains beds categorized before August 5, 1989, as skilled nursing facility beds per section **3702.522** of the Revised Code; or

(4) A unit of any hospital registered under section **3701.07** of the Revised Code that contains beds categorized as long term care beds as defined in rule **3701-59-01** of the Administrative Code.

(E) Mandatory dual participation.

To participate as a NF, all Ohio facilities shall comply with the provisions in rule **5101:3-3-02.4** of the Administrative Code regarding dual participation in the medicare program as a SNF/NF.

~~(F) Qualified types of Ohio ICFs-MR~~

~~To be eligible for certification as an ICF-MR, an institution shall qualify as one of the following:~~

~~(1) A residential facility licensed by the Ohio department of developmental disabilities (DODD) in accordance with section 5123.19 of the Revised Code and rules adopted pursuant to Chapter 5123. of the Revised Code, with an operator who has received development approval from DODD to operate the residential facility as an ICF-MR under one of the following conditions:~~

~~(a) An operator has requested a new residential facility license from DODD and obtained development approval from DODD pursuant to rule 5123:2-16-01 of the Administrative Code to operate the facility as an ICF-MR, except as provided for in section 5123.193 of the Revised Code; or~~

~~(b) An operator of an existing residential facility who has received development approval from DODD to operate a facility other than an ICF-MR, and has submitted a new request to DODD for development approval that specifies the plan to modify the type or source of funding for the facility, and has received development approval from DODD pursuant to rule 5123:2-16-01 of the Administrative Code to operate the facility as an ICF-MR; or~~

~~(2) As described in section 5123.192 of the Revised Code, a nursing home or portion of a nursing home licensed by ODH that holds beds initially certified as ICF-MR beds before June 30, 1987, that continue to be certified as ICF-MR beds; or~~

~~(3) A county home, county nursing home, or district home operated in compliance with Chapter 5155. of the Revised Code that was certified as an ICF-MR before January 20, 2005.~~

~~(G)~~(F) Certification of NFs and beds subject to certification survey.

(1) Certification.

A facility's certification as a NF by ODH or by the state survey agency of another state governs the types of services the operator of the facility may provide.

(2) Provider agreements.

(a) A provider agreement with the operator of an Ohio NF or SNF/NF shall include any part of the facility that meets standards for certification of compliance with federal and state laws and rules for participation in the medicaid program.

(b) Exceptions to this provision are NFs or SNFs that between July 1, 1987 and July 1, 1993 added beds licensed as nursing home beds under Chapter 3721. of the Revised Code. Such facilities are not required to include those beds in a provider agreement, unless otherwise required by federal law. This exception continues to apply if such facilities subsequently undergo a change of operator.

(3) Beds subject to certification survey.

(a) All beds in a medicaid participating NF or SNF/NF, except those licensed nursing home beds added between July 1, 1987 and July 1, 1993, shall be surveyed to determine

compliance with the applicable certification standards and, if certifiable, included in the provider agreement as NF or SNF/NF beds.

(b) Beds that could quality as NF or SNF/NF beds and were added between July 1, 1987 and July 1, 1993 may be surveyed for compliance at the discretion of the operator. Such facilities are not required to include those beds in a provider agreement, unless otherwise required by federal law.

(c) All other beds that meet NF or SNF/NF standards shall be certified as NF or SNF/NF beds.

(4) The only other basis for allowing nonparticipation of a portion of an Ohio NF or SNF/NF that is not hospital-based is certification of noncompliance by ODH.

~~(H) Certification of ICFs-MR and beds subject to certification survey.~~

~~(1) Certification.~~

~~A facility's certification as an ICF-MR by ODH or by the state survey agency of another state governs the types of services the facility may provide.~~

~~(2) Provider agreements.~~

~~A provider agreement with an Ohio ICF-MR shall include any part of the facility that meets standards for certification of compliance with federal and state laws for participation in the medicaid program.~~

~~(3) Emergency services.~~

~~(a) Waiver of licensed capacity.~~

~~(i) To accommodate persons in emergency need of services, the DODD may issue to the operator of a licensed residential facility a waiver of licensed capacity.~~

~~(ii) A waiver of licensed capacity is time-limited and temporarily permits the operator to exceed the maximum number of licensed beds~~

~~(b) Institutional respite care.~~

~~(i) A waiver of licensed capacity may be made specifically in order to provide institutional respite care as a prior authorized service to persons enrolled on a home and community based services (HCBS) waiver in accordance with division 5101:3 of the Administrative Code.~~

~~(ii) Beds designated for institutional respite care for HCBS enrollees shall not be included in the provider agreement.~~

~~(4) Beds subject to certification survey.~~

~~(a) All beds in a medicaid-participating ICF-MR that are not designated for institutional respite care for persons enrolled on an HCBS waiver shall be surveyed to determine compliance with the applicable certification standards.~~

~~(b) If the beds are certifiable, they shall be included in the provider agreement.~~

~~(c) Beds authorized through a waiver of residential facility licensed capacity in accordance with rule 5123:2-16-01 of the Administrative Code that are used to provide ICF-MR services shall be included in the provider agreement.~~

~~(d) The only other basis for allowing nonparticipation of a portion of an Ohio ICF-MR is certification of noncompliance by ODH.~~

~~(I)~~(G) Requirements for out-of-state providers of long term care institutional services.

(1) To participate in the Ohio medicaid program and receive payment from ODJFS for long term care institutional services to eligible Ohio residents, an operator of a long term care facility located outside Ohio shall meet all of the following requirements in their state of origin:

(a) The operator of the facility shall hold a valid state-required license, registration, or equivalent from the respective state that specifies the level(s) of care the facility is qualified to provide; and

(b) The operator of the facility shall hold a valid and current medicaid provider agreement from the respective state as a NF~~,~~ or SNF/NF~~, or ICF-MR~~ provider type.

(2) Additionally, out-of-state providers shall meet the following Ohio requirements:

(a) The operator of the facility shall have a current, completed and signed **JFS 03623** on file with ODJFS; and

(b) The operator of the facility shall obtain resident-specific and date-specific prior authorization from ODJFS in accordance with rule **5101:3-1-11** of the Administrative Code.

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R.C. 119.032 review dates: 02/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

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5160-3-02.4 Mandatory Dual Participation by Nursing Facilities (NFs) in the Medicare Program

Formerly **5101:3-3-02.4 Mandatory Dual Participation by Nursing Facilities (NFs) in the Medicare Program**

NFTL-10-04

Effective Date: February 15, 2011

Most Current Prior Effective Date: **October 1, 2005**

(A) Definitions.

(1) For purposes of this rule, the terms "certified beds," "distinct part," "dually participating," "facility," and "religious non-medical health care institution" (RNHCI) are defined in rule **5101:3-3-02.3** of the Administrative Code.

(2) For purposes of this rule, the term "reasonable assurance period" is defined in rule **5101:3-3-02.1** of the Administrative Code.

(3) "Fully participating" means participation of an institution in its entirety, either in the medicare or medicaid program, or both. A fully participating skilled nursing facility (SNF) is one in which every bed is certified for participation in medicare. A fully participating nursing facility (NF) is one in which every bed is certified for participation in medicaid. A fully participating SNF/NF is one in which every bed is certified for participation in both medicare and medicaid.

(B) Mandatory SNF participation and exceptions.

(1) Operators of Ohio NFs shall have all medicaid-certified beds as counted in the medicaid provider agreement also certified under medicare as SNF beds, in accordance with the provisions of this rule.

(2) Exceptions to mandatory SNF participation are:

(a) RNHCIs; and

(b) Veteran's homes operated under Chapter 5907. of the Revised Code; and

(c) A NF that has distinct part beds that are not required or permitted to participate in medicaid in accordance with paragraph (G) of rule **5101:3-3-02.3** of the Administrative Code or section ~~3702.52.2~~3702.522 of the Revised Code. These beds are excluded from the requirement to be both dually and fully participating SNF/NF certified beds.

(C) SNF/NFs that are both dually and fully participating are in compliance.

~~Operators of Ohio NFs currently holding a medicaid provider agreement under which all medicaid-certified beds are also medicare-certified are in compliance with the requirement for NFs to be both dually and fully participating SNF/NFs.~~

(1) Operators of Ohio NFs currently holding a medicaid provider agreement under which all medicaid-certified beds are also medicare-certified are in compliance with the requirement for NFs to be both dually and fully participating SNF/NFs.

(2) Pursuant to rule **5101:3-3-02.2** of the Administrative Code, the Ohio department of job and family services (ODJFS) shall terminate or not renew an operator's provider agreement if the provider fails to ensure a nursing facility's full participation in the medicare program as a SNF.

(D) ~~Transition of currently participating NFs and SNF/NFs to fully participating medicaid and medicare facilities.~~

(1) ~~Transition of NFs to both dually and fully participating SNF/NFs.~~

(a) ~~On or prior to January 1, 2007, all NFs except those described in paragraphs (B)(1) to (B)(3) of this rule must become both dually and fully participating medicare and medicaid SNF/NFs. For non-excluded facilities, every medicaid-certified NF bed must also be medicare-certified as a SNF bed in order for the operator of the facility to continue to hold~~

~~a medicaid provider agreement with the Ohio department of job and family services (ODJFS).~~

(b) ~~Operators of facilities with medicaid-certified beds in a NF must request medicare certification as a SNF from the United States department of health and human services, centers for medicare and medicaid services (CMS). The facility shall meet the conditions for medicare participation and be medicare-certified on or before January 1, 2007.~~

(c) ~~After ODJFS is notified by CMS that the request for medicare certification has been approved, a SNF/NF provider agreement shall be issued by ODJFS using the medicare SNF's effective date of certification.~~

(d) ~~ODJFS may terminate a NF provider agreement in accordance with rule 5101:3-3-02.2 of the Administrative Code if the operator has not obtained medicare certification for all medicaid-certified beds with an effective date on or before January 1, 2007.~~

(2) ~~Transition of dually participating SNF/NFs to both dually and fully participating SNF/NFs in both the medicare and medicaid programs.~~

(a) ~~On or prior to January 1, 2007, all SNF/NFs that are operated with distinct part SNF beds, and therefore do not have all their NF beds participating as SNFs (except those NFs described in paragraph (B) of this rule), shall become fully participating medicare and medicaid SNF/NFs. For non-excluded facilities, every medicaid-certified bed in a SNF/NF shall also be medicare-certified as a SNF bed in order for the operator of the facility to continue to hold a medicaid provider agreement with ODJFS.~~

(b) ~~Operators of SNF/NFs that have medicaid-certified beds that are not also medicare-certified shall submit a request to CMS for full participation in the medicare program. The procedure for this change in bed capacity is governed by CMS medicare policy, and the effective date of the change is determined by CMS on a prospective basis. A SNF may not self-designate the effective date of a change in bed capacity.~~

(c) ~~After ODJFS is notified by CMS that the request for a bed change has been approved, a letter shall be issued by ODJFS reflecting the addition of medicare beds to the provider agreement. This letter must be attached to the provider agreement to show the certified bed capacity of the facility.~~

(d) ~~ODJFS may terminate a SNF/NF provider agreement in accordance with rule 5101:3-3-02.2 of the Administrative Code if the operator has not obtained medicare certification for all medicaid-certified beds with an effective date on or before January 1, 2007.~~

~~(E)~~(D) Enrollment of new facilities in the medicaid program.

(1) ~~On or after October 1, 2005, operators~~ Operators of Ohio facilities requesting participation in the medicaid NF program must provide documentation that they have requested full participation in the medicare SNF program.

(2) ~~On or after October 1, 2005, operators~~ Operators of Ohio facilities requesting participation in the medicaid NF program that have been recommended for medicaid certification by the Ohio department of health (ODH) and that have provided documentation that they have requested full participation in the medicare SNF program, may be issued a fully participating NF medicaid provider agreement with an effective date determined in accordance with rule **5101:3-3-02.1** of the Administrative Code.

(3) After ODJFS is notified by the centers for medicare and medicaid services (CMS) that a facility operator's request for medicare certification has been approved, a SNF/NF provider agreement may be issued by ODJFS using the medicare SNF's effective date of certification in accordance with rule 5101:3-3-02.1 of the Administrative Code.

(4) If ODJFS is notified by CMS that a facility operator's request for medicare participation has been denied and all appeals have been exhausted, ODJFS shall terminate the NF's provider agreement in accordance with rule **5101:3-3-02.2** of the Administrative Code.

~~(F)~~(E) Readmission of an Ohio facility to the medicaid program.

(1) ~~On or after October 1, 2005, a~~ A facility operator requesting readmission to the medicaid program must provide documentation of the request for admission or readmission and full participation in the medicare SNF program.

(2) If a facility's participation in the medicaid program ends due to voluntary withdrawal from participation by the operator, and the operator requests readmission to the medicaid NF program, enrollment will be processed in the same manner as for a new facility as set forth in paragraph (D) of this rule.

(3) If a facility's participation in the medicaid program ends due to involuntary termination, cancellation, or non-renewal by ODJFS, and ODH recommends that the facility receive certification, ODJFS may issue a provider agreement that begins on or after the effective date of medicare certification or recertification. If CMS has imposed a reasonable assurance period prior to re-entry to the medicare program, the reasonable assurance period also shall be imposed for medicaid enrollment purposes.

~~(2) Effective April 1, 2006:~~

~~(a) If a facility's participation in the medicaid program ends due to voluntary withdrawal from participation by the operator, and the operator requests readmission to the medicaid NF program, enrollment will be processed in the same manner as for a new facility as set forth in paragraph (E) of this rule.~~

~~(b) If a facility's participation in the medicaid program ended due to involuntary termination, cancellation, or non-renewal by ODJFS, and ODH recommends that the facility receive certification, ODJFS may issue a provider agreement that begins on or after the effective date of medicare certification or recertification. If CMS has imposed a reasonable assurance period prior to re-entry to the medicare program, the reasonable assurance period also shall be imposed for medicaid enrollment purposes.~~

~~(G)~~(F) Facilities undergoing a change of operator.

If a SNF/NF undergoes a change of operator that results in a change of provider agreement, the entering operator must either accept assignment of the exiting operator's provider agreement and survey results, or refuse assignment and undergo a new certification survey. An operator may accept or refuse assignment of the medicare provider agreement and/or the medicaid provider agreement.

(1) If an entering operator of a SNF/NF accepts assignment of both the medicare and medicaid provider agreements of the exiting operator, ODJFS shall issue a SNF/NF provider agreement to the entering operator. The entering operator must continue to operate a dually participating facility that fully participates in both the medicare and medicaid programs.

(2) If an entering operator of a SNF/NF refuses to accept assignment of the exiting operator's medicare provider agreement, but does accept assignment of the exiting operator's medicaid provider agreement, the entering operator must meet requirements for medicare participation in the same manner as for a new facility as set forth in paragraph ~~(E)~~(D) of this rule.

(3) If an entering operator of a SNF/NF refuses to accept assignment of the exiting operator's medicaid provider agreement, ODJFS shall terminate the agreement of the exiting operator. To enter the medicaid program, the entering operator must apply for medicaid participation as a new facility. Upon notice of certification approval from ODH, ODJFS may issue a medicaid provider agreement to the entering operator in the same manner as for new facilities as set forth in paragraph ~~(E)~~(D) of this rule.

Effective:

R.C. 119.032 review dates: 11/19/2010

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 9/29/05

5160-3-02.7 Emergency Management and Resident Relocation Plan for Nursing Facilities (NFs)

Formerly **5101:3-3-02.7 Emergency Management and Resident Relocation Plan for Nursing Facilities (NFs)**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: July 1, 2010

(A) Purpose.

The purpose of this rule is to set forth provisions for the preparation for, response to, and recovery from an emergency at a NF ~~or ICF-MR~~. The provisions of this rule are in addition to the requirements set forth in sections **5111.51**, **5111.53**, and **5111.54** of the Revised Code, and in ~~rules~~rule **3701-17-25** ~~and 5123:2-3-11~~ of the Administrative Code.

(B) Definitions.

"Emergency" means an unexpected situation or sudden occurrence of a serious or urgent nature that creates a substantial likelihood that one or more of a facility's residents may be seriously harmed if allowed to remain in the facility. Events that may constitute an emergency include, but are not limited to, the following:

(1) Tornado, severe wind, severe storm, flood, or other natural disaster; or

(2) Fire; or

(3) Explosion; or

(4) Loss of electrical power; or

(5) Release of hazardous chemicals or other hazardous material; or

(6) Civil disaster; or

(7) A labor strike that suddenly causes the number of staff members in a facility to be below that necessary for resident care.

(C) Written emergency relocation plan.

(1) Each provider shall have a written plan of procedure to be followed in the event of an emergency that requires relocation of residents.

(2) The plan must be clearly communicated and reviewed with all the facility's staff.

(D) Resident relocation components of emergency plan.

The emergency plan shall include all of the following components:

(1) Procedures for securing emergency shelter, including resident identification and tracking; and

(2) Procedures for resident care, including supplies, equipment, and staffing; and

(3) Procedures for contacting physicians, family, guardians, other individuals responsible for residents, and government agencies; and

(4) Procedures for resident transportation, hospitalization, therapy, and other appropriate services, including post-emergency transportation; and

(5) Procedures for records transfer.

(E) Notification

(1) The provider shall notify all of the following:

(a) Residents' families. Each resident's family, guardian, sponsor, next of kin, or other person responsible for the resident; and

(b) County department of job and family services (CDJFS). The CDJFS shall be notified of the following within one working day after the relocation of residents:

(i) Nature of the emergency; and

(ii) Any injuries to residents; and

(iii) New location of residents who have been relocated; and

(iv) Plans for the restoration or rehabilitation of the facility to allow residents to re-occupy the facility; and

(v) An estimated timeframe for the resumption of operations, if applicable; and

(c) Ohio department of job and family services (ODJFS), bureau of long term services and supports (BLTSS) designated emergency coordinator. The BLTSS emergency coordinator shall be notified of the following within one working day after the relocation of residents:

(i) Nature of the emergency; and

(ii) Any significant injuries to residents related to the emergency that result in hospitalization; and

(iii) New location of residents who have been relocated; and

(iv) Plans for the restoration or rehabilitation of the facility to allow residents to re-occupy the facility; and

(v) An estimated timeframe for the resumption of operations, if applicable; and

(d) The ~~appropriate licensing agency i.e., the~~ Ohio department of health (ODH) ~~or the Ohio department of developmental disabilities (DODD)~~ within one working day after the relocation of residents.

(2) The provider shall submit weekly updates to the BLTSS emergency coordinator until the facility is permanently closed, residents are returned, or a partial evacuation has been resolved.

(F) Compliance and reimbursement.

The provider may consult with ODJFS regarding the functions that may be impaired by the temporary relocation of residents, including the following:

(1) Cost reporting; and

(2) Minimum data sets (MDS) reporting as it impacts case mix scores; and

~~(3) Individual assessment forms (IAFs); and~~

~~(4)~~(3) Level of care and pre-admission reviews for transferred residents; and

~~(5)~~(4) Access to residents' personal needs allowance (PNA) accounts; and

~~(6)~~(5) Claims processing.

(G) Termination of NF services.

Pursuant to section 5111.65 of the Revised Code, a NF closure does not occur if all of the facility's residents are relocated due to an emergency evacuation and one or more of the residents return to a medicaid-certified bed in the facility not later than thirty days after the evacuation occurs.

Effective: 01/10/2013

R.C. 119.032 review dates: 07/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.36

Rule Amplifies: 5111.21, 5111.53

Prior Effective Dates: 1/1/80, 1/1/95, 5/16/02, 7/1/06, 7/1/10

5160-3-03.2 Nursing Facilities (NFs): Resident Protection Fund and Collection of Fines

NFTL 15-01

Effective Date: March 22, 2015

(A) Definitions.

(1) "Certification requirements" means the requirements with which a facility must be in compliance in order to be eligible to participate in the medicaid or medicare programs.

(2) "Deficiency" means a facility's failure to meet a participation requirement in the medicaid or medicare program.

(3) "Dually participating facility" means a facility that has a provider agreement in both the medicaid and medicare programs.

(4) "Fines" means civil monetary penalties (CMPs) and other assessments imposed against a NF as a remedy for deficiencies or a cluster of deficiencies that were not substantially corrected before a survey.

(5) "Interest rate" means the rate determined by the tax commissioner on the fifteenth day of October each year by rounding the federal short-term rate to the nearest whole number per cent and adding three per cent. This is the interest rate per annum used in computing the interest that accrues during the following calendar year.

(6) "Noncompliance" means failure to substantially meet all applicable certification requirements.

(B) Procedure for collection of fines imposed by the centers for medicare and medicaid services (CMS) and the Ohio department of health (ODH).

(1) ODH shall provide the Ohio department of medicaid (ODM) with a copy of the letter issued to a medicaid-only facility regarding imposition of a fine for noncompliance with certification requirements. ODM shall attempt to collect the fine.

(2) If CMS has been unable to collect a CMP fine directly and notifies ODM, ODM shall attempt to collect the fine.

(3) ODM shall inform the NF, via certified mail, of the following available payment options:

(a) Lump sum payment.

A lump sum payment, including any interest accrued, from the provider; or

(b) Periodic payments.

Periodic payments, including any interest accrued, in accordance with a schedule approved by ODM for a period not to exceed twelve months; or

(c) Medicaid payment offset.

Following the date on which the fine plus interest becomes due, an appropriate reduction to medicaid payments made to the provider for care rendered to medicaid eligible residents in accordance with a schedule approved by ODM for a period not to exceed twelve months; or

(d) Attorney general's office (AGO).

If the facility is no longer active in the medicaid program, the fine may be referred to the AGO for collection in accordance with section **131.02** of the Revised Code.

(4) Not later than ten days after notification, the NF shall select a payment option and advise ODM in writing.

(5) If the NF fails to adhere to the terms of the payment agreement or fails to select a payment option within ten days, ODM shall immediately implement collection from an actively participating facility by medicaid payment offset(s).

(6) ODM shall retain the fine and any interest collected from the NF in the resident protection fund.

(7) ODM shall notify CMS in writing when the CMP fine has been collected in full.

(C) Uses of the resident protection fund.

(1) Proceeds from all fines, including interest collected, shall be deposited in the state treasury to the credit of the resident protection fund.

(2)) Monies in the resident protection fund shall be used in accordance with **42 CFR 488.433** and **488.442** (October 1, 2014) for activities that protect or improve the quality of care or quality of life for residents of NFs in which deficiencies are found. All activities and plans for utilizing civil monetary penalty funds must be approved in advance by CMS in accordance with 42 CFR 488.433.

(D) ODM shall provide budgetary, accounting, and other related management functions for the resident protection fund. When medicaid payment offset is used as a means of collection, the amount equal to the reduction in medicaid payments shall be deposited to the credit of the resident protection fund.

(E) Procedure for ODM to obtain reimbursement or payment from the resident protection fund.

(1) ODM shall prepare a report setting forth the amount spent or to be spent by ODM on the activities listed in paragraph (C) of this rule.

(2) Upon approval of the report by the medicaid director, ODM shall submit a request to the treasurer of state to transfer funds from the resident protection fund to ODM.

(F) Annual report.

ODM shall provide an annual report to the directors of ODH and the Ohio department of aging (ODA). The report shall include the following information:

(1) A list of all fines deposited in the fund, and the names and addresses of the NFs that paid the fines; and

(2) A list, by type, of all expenditures of the resident protection fund.

(G) The provisions of this rule are applicable only to the extent that monies are available in the resident protection fund.

Replaces: 5160-3-03.2

Effective: 03/22/2015

Five Year Review (FYR) Dates: 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5162.02

Rule Amplifies: 5162.66

Prior Effective Dates: 1/1/95, 7/1/02, 7/1/05, 1/1/09

Payment During the Ohio Department of Medicaid (ODM) Administrative Appeals Process for Denial or Termination of a Provider Agreement

***Formerly* 5101:3-3-04 Payment During the Ohio Department of Job and Family Services (ODJFS) Administrative Appeals Process for Denial or Termination of a Provider Agreement**

NFTL 14-04

Effective Date: October 3, 2014

***Most Current Prior Effective Date:* January 10, 2013**

(A) When ~~ODJFS~~ODM is required to provide an adjudicatory hearing pursuant to **Chapter 119.** of the Revised Code, payment shall continue for medicaid-covered services provided to eligible residents during the appeal of, and the proposed termination or non-renewal of, a nursing facility (NF) provider agreement. Payment shall not be made under this provision for services rendered on or after the effective date of ~~ODJFS~~ODM issuance of a final order of adjudication pursuant to Chapter 119. of the Revised Code, except as provided in paragraph (B) of this rule.

(B) Payment may be provided up to thirty days following the effective date of termination or non-renewal of a NF provider agreement; or after an administrative hearing decision that upholds the ~~ODJFS~~ODM termination or non-renewal action. Payment will be available if both of the following conditions are met:

(1) Residents were admitted to the NF before the effective date of termination or expiration; and

(2) The NF cooperates with the state, local, and federal entities in the effort to transfer residents to other NFs, institutions, or community programs that can meet the residents' needs.

(C) When ~~ODJFS~~ODM acts under instructions from the United States department of health and human services, payment ends on the termination date specified by that agency.

Effective: 10/03/2014

Five Year Review (FYR) Dates: 07/01/2014 and 10/03/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 09/23/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.38, 5165.35

Prior Effective Dates: 3/18/88 (Emer.), 6/16/88, 1/1/95, 7/1/2000, 7/1/03, 7/1/08, 1/10/13

5160-3-04.1 Payment to Nursing Facilities (NFs) During the Survey Agency's Administrative Appeals Process

Formerly **5101:3-3-04.1 Payment to Nursing Facilities (NFs) During the Survey Agency's Administrative Appeals Process**

NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: **July 1, 2008**

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

(1) "State survey agency" means for the purpose of medicaid certification, the Ohio department of health (ODH).

(2) "Effective date of termination" means the date set by the state survey agency or the United States department of health and human services for the termination of certification.

(B) When medicaid certification is either terminated or not renewed, ODJFS must also either terminate or not renew the medicaid provider agreement.

(C) The following requirements apply:

(1) During the appeals process provided by the state survey agency for the proposed termination or non-renewal of certification, payment for covered services provided to eligible residents is available if:

(a) Payment is for those residents admitted prior to the effective date of an order issued under sections **5111.46**, **5111.48**, **5111.51**, and **5111.57** of the Revised Code, placing a ban on admissions to medicaid eligible residents and/or for certain diagnostic groups with specialized care needs; and

(b) The appeal is conducted prior to the effective date of termination or non-renewal.

(2) If the NF appeal process results in an adjudication order that upholds the ODH action or if the administrative hearing is not completed prior to the certification termination/non-renewal date, payment for services provided to eligible residents may be available for an additional thirty days if:

(a) The eligible resident was admitted prior to the termination/non-renewal date and prior to any ban on admissions as described in paragraph (C)(1)(a) of this rule; and

(b) The NF cooperates with the state, local, and federal entities in the effort to transfer residents to other NFs, institutions, or community programs that can meet the residents' needs.

(3) If a NF's appeal of the termination or non-renewal of its certification is upheld, payment for covered services provided to eligible residents is resumed. If the appeal decision is reached after the termination/ non-renewal date, payment is made retroactive to the date of termination.

(4) When the state survey agency certifies that there is jeopardy to residents' health and safety by issuing an order under Chapter **5111.** of the Revised Code, or when it fails to certify that there is no jeopardy, payment will end on the effective date of termination.

(5) When ODJFS acts under instructions from the United States department of health and human services, payment ends on the date specified by that agency.

Replaces: 5101:3-3-04.1

Effective: 01/10/2013

R.C. 119.032 review dates: 01/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.21

Prior Effective Dates: 3/18/88 (Emer.), 6/16/88, 1/1/95, 7/1/00, 7/1/03, 7/1/08

***Formerly* 5101:3-3-05 Level of Care Definitions**

LTCSSTL 12-03

Effective Date: March 19, 2012

Most Current Prior Effective Date: July 1, 2008

(A) This rule contains the definitions used in the process of making a determination of an individual's level of care. The definitions in this rule apply unless a term is otherwise defined in a specific rule.

(B) Definitions.

(1) "Active Treatment" means a continuous treatment program including aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services for individuals with mental retardation and/or other developmental disabilities that are directed toward the following:

(a) The acquisition of the behaviors necessary for the individual to function with as much self determination and independence as possible; and

(b) The prevention or deceleration of regression or loss of current optimal functional status.

(2) "Activity of daily living (ADL)" means a personal or self-care task that enables an individual to meet basic life needs. For purposes of this rule, the term "ADL" includes the following defined activities:

(a) "Bathing" means the ability of an individual to cleanse one's body by showering, tub, or sponge bath, or any other generally accepted method.

(b) "Dressing" means the ability of an individual to complete the activities necessary to dress oneself and includes the following two components:

(i) Putting on and taking off an item of clothing or prosthesis; and

(ii) Fastening and unfastening an item of clothing or prosthesis.

(c) "Eating" means the ability of an individual to feed oneself. Eating includes the processes of getting food into one's mouth, chewing, and swallowing, and/or the ability to use and self-manage a feeding tube.

(d) "Grooming" means the ability of an individual to care for one's appearance and includes the following three components:

(i) Oral hygiene;

(ii) Hair care; and

(iii) Nail care.

(e) "Mobility" means the ability of an individual to use fine and gross motor skills to reposition or move oneself from place to place and includes the following three components:

(i) "Bed mobility" means the ability of an individual to move to or from a lying position, turn from side to side, or otherwise position the body while in bed or alternative sleep furniture;

(ii) "Locomotion" means the ability of an individual to move between locations by ambulation or by other means; and

(iii) "Transfer" means the ability of an individual to move between surfaces, including but not limited to, to and from a bed, chair, wheelchair, or standing position.

(f) "Toileting" means the ability of an individual to complete the activities necessary to eliminate and dispose of bodily waste and includes the following four components:

(i) Using a commode, bedpan, or urinal;

(ii) Changing incontinence supplies or feminine hygiene products;

(iii) Cleansing self; and

(iv) Managing an ostomy or catheter.

(3) "Adverse level of care determination" means a determination that an individual does not meet the criteria for a specific level of care.

(4) "Alternative form" means a form that is used in place of and contains all of the data elements of, the JFS 03697, "Level of Care Assessment" (rev. 4/2003) to request a level of care determination from the Ohio department of job and family services (ODJFS) or its designee.

(5) "Assistance" means the hands-on provision of help in the initiation and/or completion of a task.

(6) "Authorized representative" has the same meaning as in rule **5101:1-37-01** of the Administrative Code.

(7) "CBDD" means a county board of developmental disabilities as established under Chapter 5126. of the Revised Code.

(8) "Current diagnoses" means a written medical determination by the individual's attending physician, whose scope of practice includes diagnosis, listing those diagnosed conditions that currently impact the individual's health and functional abilities.

(9) "Delayed face-to-face visit" means an in-person visit that occurs within a specified period of time after a desk review has been conducted that includes the elements of a long-term care consultation, in accordance with Chapter 173-43 of the Administrative Code, for the purposes of exploring home and community-based services (HCBS) options and making referrals to the individual as appropriate.

(10) "Desk review" means a level of care determination process that is not conducted in person.

(11) "Developmental delay" means that an individual age birth through five has not achieved developmental milestones as expected for the individual's chronological age as measured, documented, and determined by qualified professionals using generally accepted diagnostic instruments or procedures.

(12) "Face-to-face" means an in-person level of care assessment and determination process with the individual for the purposes of exploring nursing facility services or HCBS options and making referrals to the individual as appropriate, that is not conducted by a desk review only.

(13) "Habilitation" in accordance with 42 U.S.C. 1396n(c)(5) as in effect December 27, 2005, means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

(14) "ICF-MR" means an intermediate care facility for persons with mental retardation.

(15) "ICF-MR-based level of care" means the levels of care as described in rules **5101:3-3-07**, **5101:3-3-15.3**, and **5101:3-3-15.5** of the Administrative Code.

(16) "Individual" means a medicaid recipient or person with pending medicaid eligibility.

(17) "Instrumental activity of daily living (IADL)" means the ability of an individual to complete community living skills. For the purposes of this rule, the term "IADL" includes the following defined activities:

(a) "Community access " means the ability of an individual to use available community services and supports to meet one's needs and includes the following three components:

(i) "Accessing transportation" means the ability to get and use transportation.

(ii) "Handling finances" means the ability of an individual to manage one's money and does not include transportation. Handling finances includes all of the following:

(a) Knowing where money is;

(b) Knowing how to get money;

(c) Paying bills; and

(d) Knowing how to get and use benefits and services, including but not limited to:

(i) Health benefits and insurance;

(ii) Social benefits; and

(iii) Home utilities.

(iii) "Telephoning" means the ability to make and answer telephone calls or use technology to connect to community services and supports.

(b) "Environmental management" means the ability of an individual to maintain the living arrangement in a manner that ensures the health and safety of the individual and includes the following three components:

(i) "Heavy chores" means the ability to move heavy furniture and appliances for cleaning, turn mattresses, and wash windows and walls; and

(ii) "House cleaning" means the ability to make beds, clean the bathroom, sweep and mop floors, dust, clean and store dishes, pick up clutter, and take out trash;

(iii) "Yard work and/or maintenance" means the ability to care for the lawn, rake leaves, shovel snow, complete minor home repairs, and paint.

(c) "Meal preparation" means the ability of an individual to prepare or cook food for oneself.

(d) "Personal laundry" means the ability of an individual to wash and dry one's clothing and household items by machine or by hand.

(e) "Shopping" means the ability to obtain or purchase one's necessary items. Necessary items include, but are not limited to, groceries, clothing, and household items. Shopping does not include handling finances or accessing transportation.

(18) "Less than twenty-four hour support" means that an individual requires the presence of another person, or the presence of a remote monitoring device that does not require the individual to initiate a response, during a portion of a twenty-four hour period of time.

(19) "Level of care determination" means an assessment and evaluation by ODJFS or its designee of an individual's physical, mental, social, and emotional status, using the processes described in rules 5101:3-3-15, 5101:3-3-15.3, and 5101:3-3-15.5 of the Administrative Code, to compare the criteria for all of the possible levels of care as described in rules **5101:3-3-06** to **5101:3-3-08** of the Administrative Code, and make a decision about whether an individual meets the criteria for a level of care.

(20) "Level of care validation" means the verification process for ODJFS or its designee to review and enter an individual's current level of care in the electronic records of the individual that are maintained by ODJFS.

(21) "Long-term services and supports" means institutional or community-based medical, health, psycho-social, habilitative, rehabilitative, or personal care services that may be provided to medicaid-eligible individuals.

(22) "Major life area" has the same meaning as in rule 5101:3-3-07 of the Administrative Code.

(23) "Manifested" means a condition is diagnosed and interferes with the individual's ability to develop or maintain functioning in at least one major life area.

(24) "Medication administration" means the ability of an individual to prepare and self-administer all forms of over-the-counter and prescription medication.

(25) "Need" means the inability of an individual to complete a necessary and applicable task independently, safely, and consistently. An individual does not have a need when:

(a) The individual is not willing to complete a task or does not have the choice to complete a task.

(b) The task can be completed with the use of available assistive devices and accommodations.

(26) "Nursing facility (NF)" has the same meaning as in section **5111.20** of the Revised Code. A facility that has submitted an application packet for medicaid certification to ODJFS is considered to be in the process of obtaining its initial medicaid certification by the Ohio department of health and shall be treated as a NF for the purposes of this rule.

(27) "NF-based level of care" means the intermediate and skilled levels of care, as described in rule 5101:3-3-08 of the Administrative Code.

(28) "NF-based level of care program" means a NF, a home and community-based services medicaid waiver that requires a NF-based level of care, or other medicaid program that requires a NF-based level of care.

(29) "PASRR" means the preadmission screening and resident review requirements mandated by section 1919(e)(7) of the Social Security Act and implemented in accordance with rules **5101:3-3-14**, **5101:3-3-15.1**, **5101:3-3-15.2** and **5122-21-03** and **5123:2-14-01** of the Administrative Code.

(30) "Physician" means a person licensed under Chapter 4731. of the Revised Code or licensed in another state as defined by applicable law, to practice medicine and surgery or osteopathic medicine and surgery.

(31) "Psychiatrist" means a physician licensed under Chapter 4731. of the Revised Code or licensed in another state as defined by applicable law, to practice psychiatry.

(32) "Psychologist" means, a person licensed in Ohio as a psychologist or school psychologist, or licensed in another state as a psychologist as defined by applicable law.

(33) The terms "psychologist," "the practice of psychology," "psychological procedures," "school psychologist," "practice of school psychology," "licensed psychologist," "licensed school psychologist," and "certificated school psychologist" have the same meanings as in section 4732.01 of the Revised Code.

(34) "Skilled nursing services" means specific tasks that must, in accordance with Chapter 4723. of the Revised Code, be provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly.

(35) "Skilled rehabilitation services" means specific tasks that must, in accordance with Title 47 of the Revised Code, be provided directly by a licensed or other appropriately certified technical or professional health care personnel.

(36) "Sponsor" means an adult relative, friend, or guardian of an individual who has an interest in or responsibility for the individual's welfare.

(37) "Substantial functional limitation" means the inability of an individual to independently, adequately, safely, and consistently perform age-appropriate tasks as associated with the major life areas and as referenced in paragraph (B)(4) of this rule, without undue effort and within a reasonable period of time. An individual who has access to and is able to perform the tasks independently, adequately, safely, and consistently with the use of adaptive equipment or assistive devices is not considered to have a substantial functional limitation.

(38) "Supervision" means either of the following:

(a) Reminding an individual to perform or complete an activity; or

(b) Observing while an individual performs an activity to ensure the individual's health and safety.

(39) "Twenty-four hour support" means that an individual requires the continuous presence of another person throughout the course of the entire day and night during a twenty-four hour period of time.

(40) "Unstable medical condition" means clinical signs and symptoms are present in an individual and a physician has determined that:

(a) The individual's signs and symptoms are outside of the normal range for that individual;

(b) The individual's signs and symptoms require extensive monitoring and ongoing evaluation of the individual's status and care and there are supporting diagnostic or ancillary testing reports that justify the need for frequent monitoring or adjustment of the treatment regimen;

(c) Changes in the individual's medical condition are uncontrollable or unpredictable and may require immediate interventions; and

(d) A licensed health professional must provide ongoing assessments and evaluations of the individual that will result in adjustments to the treatment regimen as medically necessary. The adjustments to the treatment regimen must happen at least monthly, and the designated licensed health professional must document that the medical interventions are medically necessary.

Replaces: Part of 5101:3-3-05, 5101:3-3-06, 5101:3-3-07, 5101:3-3-08, 5101:3-3-15

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.204, 5111.205

Prior Effective Dates: 4/7/77, 10/14/77, 7/1/80, 11/10/83, 8/1/84, 1/17/92 (Emer.), 4/16/92, 9/24/93 (Emer.), 10/1/93 (Emer.), 12/24/93, 12/31/93, 11/5/01 (Emer.), 1/20/02, 7/1/08

***Formerly* 5101:3-3-06 Criteria for the Protective Level of Care**

LTCSSTL 12-03

Effective Date: March 19, 2012

Most Current Prior Effective Date: July 1, 20083

(A) This rule describes the criteria for an individual to meet the protective level of care.

(B) The criteria for the protective level of care is met when:

(1) The individual's needs for long-term services and supports (LTSS), as defined in rule **5101:3-3-05** of the Administrative Code, are less than the criteria for the intermediate or skilled levels of care, as described in paragraphs (B)(4), (C), and (D)(4) of rule **5101:3-3-08** of the Administrative Code.

(2) The individual's LTSS needs are less than the criteria for the ICF-MR-based level of care, as defined in rule 5101:3-3-05 of the Administrative Code.

(3) The individual has a need for:

(a) Less than twenty-four hour support, as defined in rule 5101:3-3-05 of the Administrative Code, in order to prevent harm due to a cognitive impairment, as diagnosed by a physician or other licensed health professional acting within his or her applicable scope of practice, as defined by law; or

(b) Supervision, as defined in rule 5101:3-3-05 of the Administrative Code, of one activity of daily living (ADL), as defined in rule 5101:3-3-05 of the Administrative Code and as described in paragraph (C) of this rule, or supervision of medication administration, as defined in rule 5101:3-3-05 of the Administrative Code; and

(c) Assistance, as defined in rule 5101:3-3-05 of the Administrative Code, with three instrumental activities of daily living (IADL), as defined in rule 5101:3-3-05 of the Administrative Code and as described in paragraph (D) of this rule.

(C) For the purposes of meeting the criteria described in paragraph (B)(3) of this rule, an individual has a need in an ADL when:

(1) The individual requires supervision of mobility in at least one of the following three components:

(a) Bed mobility;

(b) Locomotion; or

(c) Transfer.

(2) The individual requires supervision of bathing.

(3) The individual requires supervision of grooming in all of the following three components:

(a) Oral hygiene;

(b) Hair care; and

(c) Nail care.

(4) The individual requires supervision of toileting in at least one of the following four components:

(a) Using a commode, bedpan, or urinal;

(b) Changing incontinence supplies or feminine hygiene products;

(c) Cleansing self; or

(d) Managing an ostomy or catheter.

(5) The individual requires supervision of dressing in at least one of the following two components:

(a) Putting on and taking off an item of clothing or prosthesis; or

(b) Fastening and unfastening an item of clothing or prosthesis.

(6) The individual requires supervision of eating.

(D) For the purposes of meeting the criteria described in paragraph (B)(3) of this rule, an individual has a need in an IADL when:

(1) The individual requires assistance with meal preparation.

(2) The individual requires assistance with environmental management in all of the following three components:

(a) Heavy chores;

(b) House cleaning; and

(c) Yard work and/or maintenance.

(3) The individual requires assistance with personal laundry.

(4) The individual requires assistance with community access in at least one of the following three components:

(a) Accessing transportation;

(b) Handling finances; or

(c) Telephoning.

(5) The individual requires assistance with shopping.

Replaces: Part of 5101:3-3-08

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.204

Prior Effective Dates: 9/24/93 (Emer.), 12/24/93, 7/1/08

5160-3-06.1 Institutions for Mental Diseases (IMDs)

Formerly **5101:3-3-06.1 Institutions for Mental Diseases (IMDs)**

NFTL 14-03

Effective Date: October 3, 2014

Most Current Prior Effective Date: **July 1, 2008**

(A) Section 1905 (a) of the Social Security Act provides that federal financial participation (FFP) is not available for any medical assistance for individuals who are in an institution for mental disease (IMD) unless the payments are for inpatient hospital or nursing facility (NF) services for individuals sixty-five years of age or older, or for inpatient psychiatric hospital services for individuals under age twenty one, and in certain circumstances under age twenty-two. The purpose of this rule is to set forth the process by which the Ohio department of ~~job and family services (ODJFS)~~medicaid (ODM) shall identify nursing facilities (NFs) that are at risk of becoming IMDs, the preventive measures to be taken by ~~ODJFS~~ODM when such facilities have been identified, and the course of action to be taken if a NF is identified as an IMD.

(B) Definitions.

(1) "At risk facility". A NF is considered to be an at risk facility if it meets two or more of the IMD evaluation criteria set forth in paragraph (C)(2)(b) of this rule but has not been determined to meet the definition of IMD set forth in paragraph (B)(2) of this rule.

(2) "Institution for mental diseases (IMD)" means a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. A NF is considered to be an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An intermediate care facility for the mentally retarded (ICF-MR) is not an IMD.

(3) "Mental diseases" means diseases listed as mental disorders in the "International Classification of Diseases, Tenth Revision, Clinical Modification," ~~"International Classification of Diseases, Ninth Edition, Modified for Clinical Applications" (ICD-9-CM),~~ or the most recent edition, with the exception of mental retardation, senility, and organic brain syndrome. This publication is available on the internet via the website http://www.cdc.gov/nchs/icd/icd10cm.htm.

(4) "Potentially at risk of becoming an IMD". A NF is considered to be potentially at risk of becoming an IMD if any one of the following applies:

(a) The NF is licensed as a mental nursing home as defined in rule **3701-17-01** of the Administrative Code;

(b) The NF was identified as an at risk facility during a prior IMD review; or

(c) Forty-five per cent or more of the NF's residents have been determined to need specialized services for serious mental illness by the Ohio department of mental health and addiction services ~~(ODMH)~~(ODMHAS) in accordance with rules ~~5101:3-3-15.1, 5101:3-3-15.2~~**5160-3-15.1**, **5160-3-51.2**, and **5122-21-03** of the Administrative Code.

(C) Identification of at risk facilities and IMDs.

(1) ~~ODJFS~~ODM shall identify and maintain a list of NFs that are potentially at risk of becoming IMDs.

(2) IMD reviews shall be conducted for any potentially at risk facility on the list.

(a) IMD reviews shall be scheduled as follows:

(i) ~~ODJFS~~ODM shall schedule and complete an initial on-site IMD review of any NF that is newly identified as meeting the criteria set forth in paragraphs (B)(4)(a)

and/or (B)(4)(c) of this rule. Initial reviews shall be completed within sixty calendar days following the identification of the NF's potentially at risk status;

(ii) ~~ODJFS~~ODM shall conduct annual on-site IMD reviews in each potentially at risk facility for at least two consecutive years after it is identified as potentially at risk of becoming an IMD.

(b) IMD review criteria. The following criteria shall be used to evaluate the overall character of a NF:

(i) Whether the NF is licensed as a psychiatric facility. For purposes of this rule, this includes licensure as a mental nursing home in accordance with rule **3701-17-01** of the Administrative Code;

(ii) Whether the NF is accredited as a psychiatric facility by the "Joint Commission," which accredits and certifies health care organizations and programs in the United States ~~on the Accreditation of Healthcare Organizations" (JCAHO)~~;

(iii) Whether the NF is under the jurisdiction of the ~~(ODMH)~~ODMHAS;

(iv) Whether the NF specializes in providing psychiatric and/or psychological care and treatment, as evidenced by any of the following indicators:

(a) Fifty per cent or more of individuals residing in the NF have medical records indicating that they are receiving psychiatric/psychological care and treatment;

(b) Fifty per cent or more of the NF's staff have specialized psychiatric/psychological training; or

(c) Fifty per cent or more of individuals residing in the NF are receiving psychopharmacological drugs; and

(v) Whether the current need for institutionalization for more than fifty per cent of all the individuals residing in the NF results from mental diseases. In determining whether this criterion is met, the reviewer must consider whether more than fifty per cent of individuals residing in the NF have serious mental illness (as defined in rule ~~5101:3-3-15.1~~**5160-3-15** of the Administrative Code) and have been determined by ~~ODMH~~ODMHAS to need specialized services for serious mental illness in accordance with rule ~~5101:3-3-15.1~~**5160-3-15.1** or ~~5101:3-3-15.2~~**5160-3-15.2**, and rule **5122-21-03** of the Administrative Code.

(c) IMD review results. At the conclusion of each IMD review, ~~ODJFS~~ODM shall make one of the following determinations:

(i) The NF is not at risk of becoming an IMD;

(ii) The NF is an at risk facility as defined in paragraph (B)(1) of this rule; or

(iii) The facility is determined to be an IMD.

(D) ~~ODJFS~~ODM action pursuant to IMD review results. Upon completion of the IMD review, ~~ODJFS~~ODM shall proceed with the follow-up activities corresponding to the determination that was made for the NF:

(1) For NFs determined not to be at risk of becoming an IMD:

(a) Any NF that is determined not to meet the criteria for potential risk shall be notified and removed from the list of facilities that are potentially at risk of becoming an IMD.

(b) Any NF determined to be potentially at risk of becoming an IMD but that does not meet at least two of the IMD review criteria set forth in paragraph (C)(2)(b) of this rule shall be notified of its status as a potentially at risk facility and that it shall continue to be subject to annual IMD reviews, and retained on the list of facilities that are potentially at risk of becoming an IMD.

(2) NFs determined to be at risk of becoming an IMD shall be notified of the determination, offered the opportunity to receive technical assistance to prevent them from becoming IMDs, and shall be monitored closely by ~~ODJFS~~ODM following the at risk determination. Such monitoring may include the performance of additional, unannounced, on-site IMD reviews by ~~ODJFS~~ODM.

(3) For NFs determined to be an IMD:

(a) The NF shall be notified by certified mail of the determination, that eligibility to receive medicaid vendor payment shall be terminated with respect to all individuals residing in that NF who are under age sixty-five, and that it has ten working days from the date the notice was mailed to exercise its appeal rights pursuant to paragraph (B) of rule ~~5101:3-1-57~~**5160-1-57** of the Administrative Code;

(b) If the facility requests a reconsideration pursuant to paragraph (B) of rule ~~5101:3-1-57~~**5160-1-57** of the Administrative Code, eligibility to receive vendor payment will continue until the issuance of a final decision by ~~ODJFS~~ODM.

(c) On the eleventh day following the date the IMD determination notice was mailed to the NF, or upon issuance of a final decision by ~~ODJFS~~ODM, if the IMD determination is upheld on appeal, ~~ODJFS~~ODM shall notify the county department of ~~human~~job and family services (CDJFS) in writing, to initiate the process for termination of the vendor payment and a redetermination of the residents' continued eligibility for medicaid and to provide notice of all applicable appeal rights to all affected residents of that IMD in accordance with Chapters **5101:6-1** to **5101:6-9** of the Administrative Code.

(E) A NF which has been determined to be an IMD may, following a period of not less than six months, submit a written request that ~~ODJFS~~ODM conduct a redetermination survey when changes have been made in its overall character such that the administrator of the facility believes it would no longer qualify as an IMD. ~~ODJFS~~ODM shall respond to such requests by conducting a redetermination survey within sixty days of the receipt of the request.

(1) If the redetermination survey finds that the NF no longer meets the definition of an IMD set forth in paragraph (B)(2) of this rule, ~~ODJFS~~ODM shall:

(a) Follow the procedures set forth in paragraph (D)(1) or (D)(2) of this rule; and

(b) Notify the ~~county department of job and family services (CDJFS)~~CDJFS in writing, of the effective date of the determination that the facility is not an IMD, to initiate vendor payment, regardless of the age of the individual and in accordance with rule ~~5101:3-3-15~~**5160-3-15** of the Administrative Code, on behalf of medicaid eligible individuals seeking medicaid payment of their stay in that NF.

(2) If the redetermination survey finds that the NF continues to be an IMD, the NF shall be notified by certified mail of the determination, the basis for the determination, that it has ten working days from the date the notice was mailed to exercise its appeal rights pursuant to paragraph (B) of rule ~~5101:3-1-57~~**5160-1-57** of the Administrative Code, and that if the NF does not exercise its appeal rights within that time it may not request another reconsideration survey for at least six months from the date of the determination.

Effective: 10/03/2014

Five Year Review (FYR) Dates: 07/17/2014 and 10/03/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 09/23/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.06

Prior Effective Dates: 6/15/88 (Emer.), 8/29/88, 9/1/94, 7/1/08

Intermediate Care for Individuals with Mental Retardation and Developmental Disabilities

***Formerly* 5101:3-3-07** **Intermediate Care for Individuals with Mental Retardation and Developmental Disabilities**

OAC 5160-3-07

***Formerly* 5101:3-3-08 Criteria for Nursing Facility-Based Level of Care**

LTCSSTL 12-03

Effective Date: March 19, 2012

Most Current Prior Effective Date: July 1, 2008

(A) This rule describes the criteria for an individual to meet the nursing facility (NF)-based level of care. The NF-based level of care includes the intermediate and skilled levels of care. An individual is determined to meet the NF-based level of care when the individual meets the criteria as described in paragraphs (B) to (D) of this rule.

(B) The criteria for the intermediate level of care is met when:

(1) The individual's needs for long-term services and supports (LTSS), as defined in rule **5101:3-3-05** of the Administrative Code, exceed the criteria for the protective level of care, as described in paragraph (B)(3) of rule **5101:3-3-06** of the Administrative Code.

(2) The individual's LTSS needs are less than the criteria for the skilled level of care, as described in paragraph (D)(4) of this rule.

(3) The individual's LTSS needs do not meet the criteria for the ICF-MR-based level of care, as defined in rule 5101:3-3-05 of the Administrative Code.

(4) The individual has a need for a minimum of one of the following:

(a) Assistance, as defined in rule 5101:3-3-05 of the Administrative Code, with the completion of a minimum of two activities of daily living (ADL), as defined in rule 5101:3-3-05 of the Administrative Code and as described in paragraph (C) of this rule;

(b) Assistance with the completion of a minimum of one ADL as described in paragraph (C) of this rule, and assistance with medication administration, as defined in rule 5101:3-3-05 of the Administrative Code;

(c) A minimum of one skilled nursing service or skilled rehabilitation service, as defined in rule 5101:3-3-05 of the Administrative Code; or

(d) Twenty-four hour support, as defined in rule 5101:3-3-05 of the Administrative Code, in order to prevent harm due to a cognitive impairment, as diagnosed by a physician or other licensed health professional acting within his or her applicable scope of practice, as defined by law.

(C) For the purposes of meeting the criteria described in paragraph (B)(4) of this rule, an individual has a need in an ADL when:

(1) The individual requires assistance with mobility in at least one of the following three components:

(a) Bed mobility;

(b) Locomotion; or

(c) Transfer.

(2) The individual requires assistance with bathing.

(3) The individual requires assistance with grooming in all of the following three components:

(a) Oral hygiene;

(b) Hair care; and

(c) Nail care.

(4) The individual requires assistance with toileting in at least one of the following four components:

(a) Using a commode, bedpan, or urinal;

(b) Changing incontinence supplies or feminine hygiene products;

(c) Cleansing self; or

(d) Managing an ostomy or catheter.

(5) The individual requires assistance with dressing in at least one of the following two components:

(a) Putting on and taking off an item of clothing or prosthesis; or

(b) Fastening and unfastening an item of clothing or prosthesis.

(6) The individual requires assistance with eating.

(D) The criteria for the skilled level of care is met when:

(1) The individual's LTSS needs exceed the criteria for the protective level of care, as described in paragraph (B)(3) of rule 5101:3-3-06 of the Administrative Code.

(2) The individual's LTSS needs exceed the criteria for the intermediate level of care as described in paragraph (B)(4) of this rule.

(3) The individual's LTSS needs exceed the criteria for the ICF-MR-based level of care.

(4) The individual requires a minimum of one of the following:

(a) One skilled nursing service within the day on no less than seven days per week; or

(b) One skilled rehabilitation service within the day on no less than five days per week.

(5) The individual has an unstable medical condition, as defined in rule 5101:3-3-05 of the Administrative Code.

(E) When an individual meets the criteria for a skilled level of care, as described in paragraph (D) of this rule, the individual may request placement in an intermediate care facility for persons with mental retardation (ICF-MR) that provides services to individuals who have a skilled level of care. When an individual with a skilled level of care requests placement in an ICF-MR, the following requirements apply:

(1) The individual may be determined to meet the criteria for the ICF-MR-based level of care; and

(2) The ICF-MR must provide written certification that the services provided in the facility are appropriate to meet the needs of an individual who meets the criteria for a skilled level of care.

Replaces: Part of 5101:3-3-05, 5101:3-3-06

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.204

Prior Effective Dates: 7/1/80, 11/10/83, 10/1/93 (Emer.), 12/31/93, 7/1/08

***Formerly* 5101:3-3-15 Process and Timeframes for a Level of Care Determination for Nursing Facility-Based Level of Care Programs**

LTCSSTL 12-03

Effective Date: March 19, 2012

***Most Current Prior Effective Date:* July 1, 2008**

(A) This rule describes the processes and timeframes for a level of care determination, as defined in rule **5101:3-3-05** of the Administrative Code, for a nursing facility (NF)-based level of care program, as defined in rule 5101:3-3-05 of the Administrative Code.

(1) The processes described in this rule shall not be used for a determination for an ICF-MR-based level of care, as defined in rule 5101:3-3-05 of the Administrative Code.

(2) A level of care determination may occur face-to-face or by a desk review, as defined in rule 5101:3-3-05 of the Administrative Code, and is one component of medicaid eligibility in order to:

(a) Authorize medicaid payment to a NF; or

(b) Approve medicaid payment of a NF-based home and community-based services (HCBS) waiver or other NF-based level of care program.

(3) An individual who is seeking a NF admission is subject to both a preadmission screening and resident review (PASRR) process, as described in rules **5101:3-3-14**, **5101:3-3-15.1**, **5101:3-3-15.2**, **5122-21-03**, and **5123:2-14-01** of the Administrative Code, and a level of care determination process.

(a) The preadmission screening process must be completed before a level of care determination or a level of care validation can be issued.

(b) In order for the Ohio department of job and family services (ODJFS) to authorize payment to a NF, the individual must have received a non-adverse PASRR determination and subsequent NF-based level of care determination.

(i) ODJFS may authorize payment to the NF effective on the date of the PASRR determination.

(ii) The level of care effective date cannot precede the date that the PASRR requirements were met.

(iii) If a NF receives medicaid payment from ODJFS for an individual who does not have a NF-based level of care, the NF is subject to the claim adjustment for overpayments process described in rule **5101:3-1-19** of the Administrative Code.

(B) Level of care request.

(1) In order for ODJFS or its designee (hereafter referred to as ODJFS) to make a level of care determination, ODJFS must receive a complete level of care request. A level of care request is considered complete when all necessary data elements are included and completed on the **JFS 03697**, "Level of Care Assessment" (rev. 4/2003) or alternative form, as defined in rule 5101:3-3-05 of the Administrative Code, and any necessary supporting documentation is submitted with the JFS 03697 or alternative form, as described in paragraphs (B)(2) to (B)(4) of this rule.

(2) Necessary data elements on the JFS 03697 or alternative form:

(a) Individual's legal name;

(b) Individual's medicaid case number, or a pending medicaid case number;

(c) Date of original admission to the facility, if applicable;

(d) Individual's current address, including county of residence;

(e) Individual's current diagnoses;

(f) Date of onset for each diagnosis, if available;

(g) Individual's medications, treatments, and required medical services;

(h) A description of the individual's activities of daily living and instrumental activities of daily living;

(i) A description of the individual's current mental and behavioral status; and

(j) Type of service setting requested.

(3) Physician certification on the JFS 03697 or alternative form.

(a) A physician certification means a signature from a physician, as defined in rule 5101:3-3-05 of the Administrative Code, and date on the JFS 03697 or alternative form.

(b) A physician certification must be obtained within thirty calendar days of submission of the JFS 03697 or alternative form.

(c) Exceptions to the physician certification:

(i) When an individual resides in the community and ODJFS determines that the individual's health and welfare is at risk and that it is not possible for the submitter of the JFS 03697 or alternative form to obtain a physician signature and date at the time of the submission of the JFS 03697 or alternative form, a verbal physician certification is acceptable.

(ii) ODJFS must obtain a physician certification within thirty days of the verbal physician certification.

(4) Necessary supporting documentation with the JFS 03697 or alternative form when the individual is subject to a preadmission screening process:

(a) A copy of the **JFS 03622**, "Preadmission Screening/Resident Review (PAS/RR) Identification Screen" (rev. 11/2010) and **JFS 07000**, "Hospital Exemption from Preadmission Screening Notification" (rev. 11/2010), as applicable, in accordance with rules 5101:3-3-15.1 and 5101:3-3-15.2 of the Administrative Code; and

(b) Any preadmission screening results and assessment forms.

(C) Process when ODJFS receives a complete level of care request.

(1) When ODJFS determines that a level of care request is complete, ODJFS shall:

(a) Issue a level of care determination.

(b) Inform the individual, and/or the sponsor and the authorized representative, as applicable, about the individual's PASRR results.

(c) Notify the individual, and/or the sponsor and the authorized representative, as applicable, as defined in rule 5101:3-3-05 of the Administrative Code, of the level of care determination.

(d) When there is an adverse level of care determination, inform the individual, the sponsor, and the authorized representative, as applicable, about the individual's hearing rights in accordance with division 5101:6 of the Administrative Code.

(2) In accordance with rules **5101:1-38-01** and **5101:1-39-23** of the Administrative Code, the county department of job and family services (CDJFS) shall determine medicaid eligibility and issue proper notice and hearing rights to the individual.

(D) Process when ODJFS receives an incomplete level of care request.

(1) When ODJFS determines that a level of care request is not complete, ODJFS shall:

(a) Notify the submitter that a level of care determination cannot be issued due to an incomplete JFS 03697 or alternative form.

(b) Specify the necessary information the submitter must provide on or with the JFS 03697 or alternative form.

(c) Notify the submitter that the level of care request will be denied if the submitter does not submit the necessary information to ODJFS within fourteen calendar days.

(i) When the submitter provides a complete level of care request to ODJFS within the fourteen calendar day timeframe, ODJFS shall perform the steps described in paragraph (C) of this rule.

(ii) When the submitter does not provide a complete level of care request to ODJFS within the fourteen calendar day timeframe, ODJFS may deny the level of care request and document the denial in the individual's electronic record maintained by ODJFS.

(2) In accordance with rules 5101:1-38-01 and 5101:1-39-23 of the Administrative Code, the CDJFS shall determine medicaid eligibility and issue proper notice and hearing rights to the individual.

(E) Desk review level of care determination.

(1) A desk review level of care determination is required within one business day from the date of receipt of a complete level of care request when:

(a) ODJFS determines that an individual is seeking admission or re-admission to a NF from an acute care hospital or hospital emergency room.

(b) A CDJFS requests a level of care determination for an individual who is receiving adult protective services, as defined in rule **5101:2-20-01** of the Administrative Code, and the CDJFS submits a JFS 03697 or alternative form at the time of the level of care request.

(2) A desk review level of care determination is required within five calendar days from the date of receipt of a complete level of care request when:

(a) ODJFS determines that an individual who resides in a NF is requesting to change from a non-medicaid payor to medicaid payment for the individual's continued NF stay.

(b) ODJFS determines that an individual who resides in a NF is requesting to change from medicaid managed care to medicaid fee-for-service as payment for the individual's continued NF stay.

(c) ODJFS determines that an individual is transferring from one NF to another NF.

(F) Face-to-face level of care determination.

(1) A face-to-face level of care determination is required within ten calendar days from the date of receipt of a complete level of care request when:

(a) An individual or the authorized representative of an individual requests a face-to-face level of care determination.

(b) ODJFS makes an adverse level of care determination, as defined in rule 5101:3-3-05 of the Administrative Code, during a desk review level of care determination.

(c) ODJFS determines that the information needed to make a level of care determination through a desk review is inconsistent.

(d) An individual resides in the community and ODJFS verifies that the individual does not have a current NF-based level of care.

(e) ODJFS determines that an individual has a pending disenrollment from a NF-based HCBS waiver due to the individual no longer having a NF-based level of care.

(2) A face-to-face level of care determination is required within two business days from the date of a level of care request from a CDJFS for an individual who is receiving adult protective services when the CDJFS does not submit a JFS 03697 or alternative form at the time of the level of care request.

(G) Delayed face-to-face visit.

(1) A delayed face-to-face visit, as defined in rule 5101:3-3-05 of the Administrative Code, is required within ninety calendar days after ODJFS conducts a desk review level of care determination for an individual as described in paragraphs (E)(1)(a), (E)(1)(b), and (E)(2)(a) of this rule.

(2) The following are exceptions to the delayed face-to-face visit:

(a) An individual as described in paragraphs (E)(2)(b) and (E)(2)(c) of this rule.

(b) An individual who declines a delayed face-to-face visit.

(c) An individual who has had a long-term care consultation, in accordance with Chapter 173-43 of the Administrative Code, since the individual's NF admission.

(d) An individual who has had an in-person resident review, in accordance with Chapter 5101:3-3 of the Administrative Code, since the individual's NF admission.

(e) An individual who is receiving care under a medicaid care management system that utilizes a care management, case management, or care coordination model, including but not limited to case management services provided through an HCBS waiver.

(H) Level of care validation.

ODJFS may conduct a level of care validation, as defined in rule 5101:3-3-05 of the Administrative Code, in lieu of a face-to-face level of care determination within one business day from the date of a level of care request for:

(1) An individual who is enrolled on a NF-based HCBS waiver and is seeking admission to a NF.

(2) An individual who is a NF resident and is seeking readmission to the same NF after a hospitalization.

Replaces: 5101:3-3-15

Effective:

R.C. 119.032 review dates:

Certification

Date

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Prior Effective Dates: 4/7/77, 10/14/77, 7/1/80, 8/1/84, 1/17/92 (Emer.), 4/16/92, 10/1/93 (Emer.), 12/31/93, 7/1/08

Preadmission Screening and Resident Review (PASRR) Definitions

LTCSSTL 14-10

Effective Date: November 16, 2014

Most Current Prior Effective Date: **December 1, 2009**

(A) The purpose of this rule is to set forth the definitions for terms contained in rules ~~5101:3-3-15.1, 5101:3-3-15.2~~**5160-3-15.1**, **5160-3-15.2**, **5122-21-03** and **5123:2-14-01** of the Administrative Code.

(B) Definitions:

(1) 'Active treatment' means a continuous treatment program including aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services for individuals with ~~mental retardation and/or other~~ developmental disabilities that are directed toward the following:

(a) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and

(b) The prevention, deceleration, regression or loss of current optimal functional status.

(2) 'Adverse determination' means a determination made in accordance with rules ~~5101:3-3-15.1, 5101:3-3-15.2~~**5160-3-15.1**, **5160-3-15.2**, **5122-21-03** and **5123:2-14-01** of the Administrative Code, that an individual does not require the level of services provided by a nursing facility ~~(NF)~~. A determination that an individual does not require ~~NF~~nursing facility services shall meet both of the following conditions:

(a) A face-to-face assessment of the individual, and a review of the medical records accurately reflecting the individual's current condition, is performed by one of the following professionals within the scope of his/her practice.

(i) Medical doctor or doctor of osteopathic medicine;

(ii) Registered nurse (RN);

(iii) Master of science of nursing;

(iv) Clinical nurse specialist;

(v) Certified Nurse practitioner;

(vi) Licensed social worker, under supervision of a licensed independent social worker (LISW);

(vii) Licensed independent social worker;

(viii) Professional counselor, under supervision of a licensed professional clinical counselor (PCC);

(ix) Professional clinical counselor;

(x) Psychologist;

(xi) Qualified intellectual disability professional; or

(xii) Service and support administrator.

(b) Authorized personnel from the Ohio department of mental health and addiction services ~~(ODMH)~~(OhioMHAS) and/or Ohio department of developmental disabilities (DODD), other than the personnel identified in paragraph (B)(2)(a) of this rule who have conducted the face-to-face assessment, have reviewed the assessment and made the final determination regarding the need for ~~NF~~nursing facility services and specialized services.

(3) 'Categorical determination' means a preadmission screening ~~mental retardation~~ developmental disabilities (PAS-~~MRDD~~DD) or preadmission screening serious mental illness (PAS-SMI) determination which may be made for an individual with ~~MRDD~~a developmental disability (DD)

and/or serious mental illness (SMI) without first completing a full PAS-~~MRDD~~DD and/or PAS-SMI evaluation when the individual's circumstances fall within one of the following two categories:

(a) The individual requires an 'emergency ~~NF~~nursing facility stay', as defined in paragraph (B)(7) of this rule;

(b) The individual is seeking admission to a ~~NF~~nursing facility for a 'respite ~~NF~~nursing facility stay' as defined in paragraph ~~(B)(27)~~(B)(26) of this rule.

~~(4) 'Convalescent' exemption has the same meaning as hospital exemption defined in paragraph (B)(10) of this rule.~~

~~(5)~~(4) 'Current diagnoses' means a written medical determination by the individual's attending physician, whose scope of practice includes diagnosis, listing those diagnosed conditions which currently impact the individual's health and functional abilities. To be considered current, the written documentation of the diagnoses must reflect the diagnoses was assigned by the individuals attending physician within one hundred eighty calendar days of submission for the ~~PAS~~ preadmission screening review certifying that the listed diagnoses are an accurate reflection of the individual's current condition;

(a) 'Primary diagnosis' means the diagnosis identified as the primary diagnosis by the physician, whose scope of practice includes diagnosis. ~~If~~ When two or more diagnoses have such indications, none of them can be considered to be the primary diagnosis for the purposes of this rule.

(b) 'Secondary diagnosis' means any diagnoses other than a primary diagnosis as defined in paragraph ~~(B)(5)(a)~~(B)(4)(a) of this rule.

~~(6)~~(5) 'Dementia.' An individual is considered to have dementia ~~if~~when he or she meets either of the following criteria:

(a) The individual has a primary diagnosis of a dementia, including alzheimer's disease or a related disorder, as described in the 'diagnostic and statistical manual of mental disorders,' ~~fourth~~fifth edition~~, text revision~~ (~~DSM-IV-TR~~DSM-5) (5/2013); or

(b) The individual has a secondary diagnosis of a dementia, including alzheimer's disease or a related disorder, ~~(~~as described in the ~~DSM-IV-TR~~DSM-5~~)~~ (5/2013), and a primary diagnosis which is not a major mental disorder specified in paragraph ~~(B)(32)(a)~~(B)(31)(a) of this rule.

(6) Developmental disability' an individual is considered to have a developmental disability when he or she has:

~~(a)~~ A condition as described in the American association on intellectual and developmental disabilities manual "Intellectual Disability: Definition, Classification, and Systems of Supports (11th Edition)" (October 15, 2009); or

~~(b)~~ A related condition which means a severe, chronic disability meeting all of the following conditions:

~~(i)~~ It is attributable to:

~~(a)~~ Cerebral palsy, epilepsy; or

~~(b)~~ Any other condition other than mental illness, found to be closely related to an intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability, and requires treatment or services;

~~(ii)~~ It is manifested before the person reaches the age of twenty-two; and

~~(iii)~~ It is likely to continue indefinitely; and

~~(iv)~~ It results in substantial functional limitations in three or more of the following areas of major life activity:

~~(a)~~ Self-care;

~~(b)~~ Understanding and use of language;

~~(c)~~ Learning;

~~(d)~~ Mobility;

~~(e)~~ Self-direction;

~~(f)~~ Capacity for independent living; or

~~(g)~~ Economic self-sufficiency (for persons sixteen years and older);

~~(v)~~ Individuals who have a developmental disability as defined in section **5123.01** of the Revised Code are considered to have a related condition.

(7) 'Emergency ~~NF~~nursing facility stay' means the individual is being admitted to a nursing facility pending further assessment for a period not to exceed seven days when the placement in the ~~NF~~nursing facility is necessary to avoid serious risk to the individual of immediate harm or death.

(8) 'Guardian' has the same meaning as in section **2111.01** of the Revised Code.

(9) 'Hospital ~~(convalescent)~~ exemption' means an exemption from preadmission screening ~~(PAS)~~ for a new admission, as defined in paragraphs ~~(B)(17)(a)~~(B)(16)(a) to ~~(B)(17)(d)~~(B)(16)(d) of this rule, to a ~~NF~~nursing facility. The discharging hospital shall request a hospital exemption via the ODM 07000 (rev. 7/2014), "Hospital Exemption from Preadmission Screening Notification" or the electronic system approved by the Ohio department of medicaid (ODM). Effective April 1, 2015, the discharging hospital shall request a hospital exemption via only the electronic system approved by ODM. Exceptions to electronic submission must be approved by ODM or its designee. ~~that meets the following criteria:~~

~~(a) The individual is to be admitted or enrolled directly from an Ohio hospital after receiving acute inpatient care at that hospital or is an Ohio resident being admitted or enrolled directly from an out-of-state hospital after receiving acute inpatient care at the hospital; and~~

~~(b) The individual requires the level of services provided by a NF for the condition which was treated in the hospital; and~~

~~(c) The individual's attending physician has provided written certification, signed and dated no later than the date of discharge from the hospital, stating that the individual is likely to require the level of services provided by a NF for less than thirty days.~~

(10) '~~ICF/MR~~ICF/IID' means intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities. An ~~ICF/MR~~ICD/IID is a long-term care facility certified to provide ~~ICF/MR~~ICF/IID services, as defined in 42 C.F.R. 440.150, ~~dated~~ as in effect on ~~October 1, 2008~~ February 1, 2014 to individuals with ~~mental retardation~~a developmental disability or related conditions requiring active treatment.

(11) 'Indications of ~~mental retardation and/or other~~ developmental disabilities ~~(MRDD)~~'. An individual shall be considered to have indications of ~~mental retardation and/or other~~ developmental disabilities ~~if~~when the individual meets the criteria specified in paragraph ~~(B)(16)~~(B)(6) of this rule or the individual receives services from a county board of developmental disabilities (CBDD).

(12) 'Indications of serious mental illness (SMI).' An individual shall be considered to have indications of serious mental illness ~~if~~when the individual meets at least two of the three criteria specified in paragraph ~~(B)(32)~~(B)(31) of this rule or, due to a mental impairment, receives supplemental security income authorized under Title XVI of the Social Security Act, as amended, as in effect

on February 1, 2014 or social security disability insurance authorized under Title II of the Social Security Act, as in effect on February 1, 2014.

(13) 'Individual' for the purposes of this rule, means a person regardless of payment source, who is seeking admission, readmission or transfer to a ~~NF~~nursing facility, or who resides in a ~~NF~~nursing facility or facility in the process of becoming certified as a ~~NF~~nursing facility.

(14) 'Long-term resident' means an individual who has continuously resided in a ~~NF~~nursing facility or a consecutive series of ~~NF's~~ nursing facilities and/or medicare skilled nursing facilities for at least thirty months prior to the first resident review ~~(RR)~~ determination in which the individual was found not to require the level of services provided by a ~~NF~~nursing facility, but to require specialized services as defined in paragraphs ~~(B)(34)~~(B)(33) and ~~(B)(35)~~(B)(34) of this rule. The thirty months may include temporary absences for hospitalization, therapeutic leave, or visits with family or friends as defined in rule ~~5101:3-3-16.4~~ **5160-3-16.4** of the Administrative Code.

(15) 'Medicaid managed care plan' means a managed care plan (MCP) as defined in rule ~~5101:3-26-01~~ **5160-26-01** of the Administrative Code.

(16) ~~'Mental retardation and/or other developmental disabilities (MRDD).' An individual is considered to have mental retardation and/or a developmental disability if he or she has:~~

~~(a) A level of retardation described in the american association on mental retardation's manual 'mental retardation: definition, classifications and systems of support' (2002); or~~

~~(b) A related condition which means a severe, chronic disability meeting all of the following conditions:~~

~~(i) It is attributable to:~~

~~(a) Cerebral palsy, epilepsy; or~~

~~(b) Any other condition other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services;~~

~~(ii) It is manifested before the person reaches the age of twenty-two; and~~

~~(iii) It is likely to continue indefinitely; and~~

~~(iv) It results in substantial functional limitations in three or more of the following areas of major life activity:~~

~~(a) Self-care;~~

~~(b) Understanding and use of language;~~

~~(c) Learning;~~

~~(d) Mobility;~~

~~(e) Self-direction;~~

~~(f) Capacity for independent living; or~~

~~(g) Economic self-sufficiency (for persons sixteen years and older);~~

~~(v) Individuals who have a developmental disability as defined in section 5123.01 of the Revised Code are considered to have a related condition.~~

~~(17)~~(16) 'New admission' means:

(a) The admission, to an Ohio medicaid certified ~~NF~~nursing facility, of an individual who was not a resident of any Ohio medicaid certified ~~NF~~nursing facility immediately preceding the current ~~NF~~nursing facility admission nor immediately preceding a hospital stay from which the individual is to be admitted directly to a ~~NF~~nursing facility (this includes individuals with no previous ~~NF~~nursing facility admissions; individuals admitted from other

states, regardless of type of prior residence; and individuals with prior Ohio ~~NF~~nursing facility admissions who had been discharged from an Ohio ~~NF~~nursing facility and did not have either an intervening hospital or other ~~NF~~nursing facility stay immediately preceding the current ~~NF~~nursing facility admission); and/or

(b) The admission, with or without an intervening hospital stay, to an Ohio medicaid certified ~~NF~~nursing facility, of an individual discharged, returning to the same ~~NF~~nursing facility or transferred from an Ohio medicaid certified ~~NF~~nursing facility subsequent to an adverse ~~PAS~~preadmission screening or ~~RR~~ resident review determination or following an overruled appeal of an adverse ~~PAS~~preadmission screening or ~~RR~~ resident reviewdetermination immediately preceding the current ~~NF~~nursing facility admission; and/or

(c) For PASRR purposes only and effective on the date the facility submits its application packet for medicaid certification to ~~ODJFS,~~ODM, individuals seeking admission to, or are currently residing in, a facility that is in the process of obtaining its initial medicaid certification by Ohio department of health (ODH) and that facility and its residents were not subject to PASRR requirements preceding the submission of this application for medicaid certification. This does not include facilities that have already received medicaid ~~NF~~nursing facility certification and are undergoing a change of operator; and/or

(d) With the exception of those circumstances specified in paragraphs ~~(B)(17)(a)~~(B)(16)(a) to ~~(B)(17)(c)~~(B)(16)(c) of this rule, ~~NF~~nursing facility transfers and readmissions as defined in paragraphs ~~(B)(19)~~(B)(18) and ~~(B)(25)~~(B)(24) of this rule are not considered to be new admissions for the purposes of this rule.

~~(18)~~(17) 'Nursing facility' has the same meaning as in section **5111.20** of the Revised Code. A long term care facility that has submitted an application packet for medicaid certification to ~~ODJFS~~ODM is considered to be in the process of obtaining its initial medicaid certification by the ODH and shall be treated as a ~~NF~~nursing facility for the purposes of this rule.

~~(19)~~(18) '~~NF~~Nursing facility transfer.' A ~~NF~~nursing facility transfer occurs when an individual's place of residence is changed from any Ohio medicaid certified ~~NF~~nursing facility to another Ohio medicaid certified ~~NF~~nursing facility, with or without an intervening hospital stay.

~~(20)~~(19) 'Preadmission screening identification (PAS/ID).' 'PAS/ID', also known as a level one screen, means the process by which ~~ODJFS~~ODM, or its designee, screens individuals who are seeking new admissions to identify those who have indications of ~~mental retardation and/or other~~ developmental disabilities ~~(MR/DD)~~ or serious mental illness (SMI) as defined in paragraphs (B)(11) and (B)(12) of this rule; and who, therefore, must be further evaluated by ~~ODMH~~OhioMHAS and/or DODD. The PAS/ID is completed via the ODM 03622 "Preadmission Screening/Resident Review (PAS/RR) Identification Screen" (rev. 7/2014) or submitted via the electronic system approved by ODM.

~~(21)~~(20) 'Physician' means a doctor of medicine or osteopathy who is licensed to practice medicine.

~~(22)~~(21) 'Preadmission screening for ~~mental retardation/~~developmental disabilities (PAS-~~MRDD~~DD), also known as a level two screen, means the process by which DODD determines:

(a) Whether, due to the individual's physical and mental condition, an individual who has ~~MRDD~~a developmental disability requires the level of services provided by a ~~NF~~nursing facility or another type of setting; and

(b) ~~If~~ When the level of services provided by a ~~NF~~nursing facility is needed, whether the individual requires specialized services for ~~MRDD~~a developmental disability.

~~(23)~~(22) 'Preadmission screening for serious mental illness ~~(PAS/SMI)~~(PAS-SMI), also known as a level two screen, means the process by which ~~ODMH~~OhioMHAS determines:

(a) Whether, due to the individual's physical and mental condition, an individual who has SMI requires the level of services provided by a ~~NF~~nursing facility or another type of setting; and

(b) Whether the individual requires specialized services for serious mental illness.

~~(24)~~(23) Preadmission screening ~~(PAS)~~ means the pre-admission portion of the PASRR requirements mandated by section 1919(e)(7) of the Social Security Act, as in effect on February 1, 2014, which must be implemented in accordance with rules ~~5101:3-3-15.1~~5160-3-15.1, 5122-21-03 and **5123:2-14-01** of the Administrative Code.

~~(25)~~(24) 'Readmission' means the individual is readmitted to the same ~~NF~~nursing facility, following a stay in the hospital to which he or she was sent for the purpose of receiving care, except as specified in paragraphs ~~(B)(17)(a)~~(B)(16)(a) to ~~(B)(17)(d)~~(B)(16)(d) of this rule.

~~(26)~~(25) 'Resident review ~~(RR)~~' means the resident review portion of the PASRR requirements mandated by section 1919(e)(7) of the Social Security Act, as in effect on February 1, 2014, which must be implemented in accordance with rules ~~5101:3-3-15.2~~5160-3-15.2, 5122-21-03 and 5123:2-14-01 of the Administrative Code.

~~(27)~~(26) 'Respite ~~NF~~nursing facility stay' means the admission of an individual to a ~~NF~~nursing facility for a maximum of fourteen days in order to provide respite to in-home caregivers to whom the individual is expected to return following the brief respite stay.

~~(28)~~(27) '~~RR~~ Resident review identification (RR/ID)' is the process set forth in rules ~~5101:3-3-15.2~~5160-3-15.2, 5122-21-03, and 5123:2-14-01 of the Administrative Code by which individuals who are subject to ~~RR~~ resident review shall be identified.

~~(29)~~(28) 'Resident review for ~~mental retardation/~~developmental disabilities (RR-~~MRDD~~DD)' means the process, set forth in rule 5123:2-14-01 of the Administrative Code, by which the DODD determines whether, due to the individual's physical and mental condition, an individual who is subject to ~~RR~~resident review, and who has ~~mental retardation/~~a developmental ~~disabilities~~disability ~~(MRDD)~~ requires the level of services provided by a ~~NF~~nursing facility or another type of setting; and, whether the individual requires specialized services for ~~MRDD~~a developmental disability.

~~(30)~~(29) 'Resident review for serious mental illness (RR-SMI)' means the process, set forth in rule 5122-21-03 of the Administrative Code, by which the ~~ODMH~~OhioMHAS determines whether, due to the individual's physical and mental condition, an individual who is subject to ~~RR~~resident review, and who has serious mental illness (SMI) requires the level of services provided by a ~~NF~~nursing facility or another type of setting; or whether that individual requires specialized services for serious mental illness.

~~(31)~~(30) 'Ruled out' means that the individual has been determined not to be subject to further review by DODD or ~~ODMH~~OhioMHAS. An individual may be ruled out for further PASRR review at any point in the PASRR process. ~~If~~ When DODD or ~~ODMH~~OhioMHAS finds at any time during the evaluation that the individual being evaluated:

(a) Does not have ~~MRDD~~a developmental disability or SMI; or

(b) Has a primary diagnosis of dementia (including alzheimer's disease or a related disorder); or

(c) ~~has~~ Has a non-primary diagnosis of dementia without a primary diagnosis that is serious mental illness, and does not have a diagnosis of ~~MRDD~~a developmental disability or a related condition.

~~(32)~~(31) 'Serious mental illness (SMI)' includes the following criteria regarding diagnosis, level of impairment and recent treatment.

(a) Diagnosis. The individual does not have dementia (as defined in paragraph ~~(B)(6)~~(B)(5) of this rule), but has a major mental disorder diagnosable under the ~~'Diagnostic and statistical manual of mental disorders,' fourth edition, text revision~~ (~~DSM-IV-TR~~DSM-5)

(5/2013); and this mental disorder is one of the following: a schizophrenic, mood, delusional (paranoid), panic or other severe anxiety disorder, somatoform disorder, personality disorder, other psychotic disorder, or another mental disorder other than ~~mental retardation~~developmental disability that may lead to a chronic disability diagnosable under the ~~DSM-IV-TR~~DSM-5 (5/2013).

(b) Level of impairment. Within the past six months, due to the mental disorder, the individual has experienced functional limitations on a continuing or intermittent basis in major life activities that would be appropriate for the individual's developmental stage.

(c) Recent treatment. The treatment history indicates that the individual has experienced at least one of the following:

(i) Psychiatric treatment more intensive than counseling and/or psychotherapy performed on an outpatient basis more than once within the past two years; or

(ii) Within the last two years, due to the mental disorder, experienced an episode of significant disruption to the usual living arrangement, for which supportive services were required, or which resulted in intervention by housing or law enforcement officials.

~~(33)~~(32) 'Significant change of condition' ~~including~~ means any major decline or improvement in the individual's physical or mental condition, ~~has the same meaning used in administering the routine resident assessment requirements specified~~ as described in 42 C.F.R. 483.20, as in effect on February 1, 2014, ~~and that~~ or when at least one of the following criteria is met:

(a) There is a change in the individual's current diagnosis(es), mental health treatment, functional capacity, or behavior such that, as a result of the change, the individual who did not previously have indications of SMI, or who did not previously have indications of ~~MRDD~~a developmental disability, now has such indications (this includes any individual who may have had indications of one or the other but now has indications of both SMI and ~~MRDD~~DD), or who was previously determined by ~~ODMH~~OhioMHAS not to have SMI but who now meets all three of the defining criteria for SMI (set forth in paragraphs ~~(B)(3)(a)(i)~~(B)(2)(a)(i) to ~~(B)(3)(a)(iii)~~(B)(2)(a)(iii) of rule ~~5101:3-3-15.1~~ 5160-3-15.1 of the Administrative Code); or

(b) The change is such that it may impact the mental health treatment or placement options of an individual previously identified as having SMI and/or may result in a change in the specialized services needs of an individual previously identified as having ~~MRDD~~a developmental disability.

~~(34)~~(33) 'Specialized services for serious mental illness' means those services which are distinct from those available in ~~NFs~~ nursing facilities and results in the continuous and aggressive implementation of an individualized plan of care approved by the medical director of ~~ODMH~~OhioMHAS or designee that:

(a) Is developed and supervised by an interdisciplinary team which includes a physician, trained mental health professionals and, as appropriate, other professionals;

(b) Prescribes specific therapies and treatment activities for an individual experiencing an acute episode of SMI which necessitates supervision by trained mental health personnel in an inpatient setting licensed and/or operated by ~~ODMH~~OhioMHAS; and

(c) Is time limited and directed toward diagnosing and reducing the individual's behavioral symptoms that necessitated intensive and aggressive intervention, improving the individual's level of independent functioning, and achieving a functioning level that permitting reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

~~(35)~~(34) 'Specialized services for ~~mental retardation and/or other~~ developmental disabilities' means the services specified by the PAS-~~MRDD~~DD or RR-~~M/DD~~DD determination and provided or arranged for by the CBDD resulting in continuous active treatment to address needs in each

of the life areas in which functional limitations are identified by the CBDD. Specialized services shall be made available at the intensity and frequency necessary to meet the needs of the individual.

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Five Year Review (FYR) Dates: 08/13/2014 and 11/16/2019

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5160-3-15.1 Preadmission Screening Requirements for Individuals Seeking Admission to Nursing Facilities

Formerly **5101:3-3-15.1 Preadmission Screening (PAS) Requirements for Individuals Seeking Admission to Nursing Facilities (NFs)**

LTCSSTL 14-10

Effective Date: November 16, 2014

Most Current Prior Effective Date: **December 1, 2009**

(A) The purpose of this rule is to set forth the preadmission screening (PAS) requirements in order to comply with section 1919(e)(7) of the Social Security Act, as in effect on January 1, 2014, which prohibits nursing facilities from admitting or enrolling individuals with serious mental illness (SMI), as defined in rule **5160-3-15** of the Administrative Code, or mental retardation and/or other developmental disabilities (MRDD), hereafter referred to as developmental disabilities (DD), as defined in rule 5160-3-15 of the Administrative Code, unless a thorough evaluation indicates that such placement is appropriate and adequate services will be provided. A preadmission screening identification (PAS/ID), as defined in rule 5160-3-15 of the Administrative Code is required:

(1) Prior to any new admission, as defined in rule 5160-3-15 of the Administrative Code, to a nursing facility and prior to any categorical determination, as defined in rule 5160-3-15 of the Administrative Code, unless the nursing facility admission meets the criteria for a hospital exemption as described in paragraph (G) of this rule.

(2) When an individual is directly admitted to a nursing facility from a hospital that is any of the following:

(a) A hospital that the Ohio department of mental health and addiction services (OhioMHAS) maintains, operates, manages, and governs under section **5119.14** of the Revised Code for the care and treatment of mentally ill persons;

(b) A free-standing hospital, or unit of a hospital, licensed by OhioMHAS under section **5119.33** of the Revised Code; or

(c) An out-of-state psychiatric hospital or psychiatric unit within an out-of-state hospital.

(B) Preadmission screening identification (PAS/ID) requirements:

(1) The PAS/ID submitter shall complete and submit to the Ohio department of medicaid (ODM) designee, the PASSPORT administrative agency, the ODM 03622 "Preadmission Screening/Resident Review (PAS/RR) Identification Screen" (rev. 7/2014) or submit the PAS/ID via the electronic system approved by ODM. The submitter shall include any necessary supporting documentation with the ODM 03622 or within the electronic system in order to validate the answers on the ODM 03622.

(a) For an individual seeking medicaid payment, the ODM approved level of care assessment shall also be completed and submitted to ODM or its designee in accordance with rule 5160-3-14 of the Administrative Code, unless the individual is enrolled in a medicaid managed care plan (MCP) as defined in rule **5160-26-01** of the Administrative Code.

(b) For a non-Ohio resident who will be relocating to Ohio who has SMI and/or DD or whose ODM 03622 indicates SMI and/or DD, the submitter shall submit the ODM approved level of care assessment with the ODM 03622, along with the other state's level two evaluation(s) of the individual and any additional documentation to address the required evaluation elements specified in rules 5122-21-03 and 5123:2-14-01 of the Administrative Code. Submission of the required forms and information does not constitute completion of the PAS/ID process.

(c) For a new admission as defined in rule 5160-3-15 of the Administrative Code, when the individual already resides in the facility at the time the PAS/ID is initiated, the submitter

must notify ODM or its designee of the medicaid status of the facility at the time of the PAS/ID submission.

(d) A PAS/ID may be initiated by the individual seeking the new admission, or by another entity on behalf of the individual, or by any state agency or its designee responsible for preadmission screening. The nursing facility is ultimately responsible for ensuring that the PAS/ID is completed and the determination is on file.

(2) ODM or its designee shall review the ODM 03622 or the electronic system to determine whether the individual has a developmental disability and/or indications of SMI.

(a) An individual shall be determined to have indications of SMI when the individual:

(i) Meets at least two of the three criteria specified in rule 5160-3-15 of the Administrative Code; or

(ii) Due to a mental impairment, receives supplemental security income (SSI) authorized under Title XVI of the Social Security Act, as amended; or

(iii) Due to a mental impairment, receives social security disability insurance (SSDI) authorized under Title II of the Social Security Act, as amended.

(b) An individual shall be determined to have indications of DD when the individual's condition meets the defining criteria set forth in rule 5160-3-15 of the Administrative Code.

(3) PAS/ID results shall determine whether an individual is subject to further review.

(a) Individuals determined to have no indications of SMI and/or DD are not subject to further preadmission screening review. Such individuals are considered to have met the preadmission screening requirements effective on the date an accurate and complete record was submitted to ODM or its designee, even when the records were received at a later date.

(b) Individuals determined to have indications of SMI shall be subject to further review by OhioMHAS, in accordance with rule **5122-21-03** of the Administrative Code. Such individuals shall not be considered to have completed the preadmission screening process until OhioMHAS has issued the PAS/SMI determination.

(c) Individuals determined to have indications of DD shall be subject to further review by the Ohio department of developmental disabilities (DODD) in accordance with rule **5123:2-14-01** of the Administrative Code. Such individuals shall not be considered to have completed the preadmission screening process until DODD has issued the PAS/DD determination.

(d) Individuals determined to have indications of both SMI and DD shall be subject to further review by both OhioMHAS and DODD in accordance with rules 5122-21-03 and 5123:2-14-01 of the Administrative Code. Such individuals shall not be considered to have completed the preadmission screening process until OhioMHAS has issued the PAS/SMI determination and DODD has issued the PAS/DD determination.

(e) Any individual twenty-two years of age or older, who has previously been determined by DODD to be ruled out, as defined in rule 5160-3-15 of the Administrative Code, from preadmission screening is not subject to further review.

(4) When an individual has been determined to have indications of SMI and/or DD, ODM or its designee shall forward the ODM 03622 and all supporting documentation to:

(a) OhioMHAS and/or DODD for categorical and out of state requests. In addition, for those individuals relocating from outside of Ohio, ODM or its designee shall also send the other state's evaluation documentation to OhioMHAS and/or DODD.

(b) The county board of DD (CBDD) and/or the OhioMHAS local evaluator, for all other requests.

(5) ODM or its designee, OhioMHAS and/or DODD are the only entities that have the authority to render preadmission screening determinations. The individual must not move into an Ohio nursing facility until the preadmission screening determination has been made.

(6) The receiving nursing facilities are responsible for ensuring that all individuals subject to PAS/ID receive a review and determination by ODM or its designee and, if applicable, a PAS/SMI review and determination by OhioMHAS and/or a PAS/DD review and determination by DODD prior to entering the nursing facility.

(7) Nursing facilities which, whether intentionally or otherwise, accept any new admission, readmission, or nursing facility transfer in violation of this rule are in violation of their medicaid provider agreements. This is true regardless of the payment source for the individual's nursing facility stay.

(C) PAS/SMI and PAS/DD determination requirements:

(1) There shall be no new admission of any individual with SMI or DD, regardless of payment source, unless the individual has either been determined, in accordance with rules 5122-21-03 and/or 5123:2-14-01 of the Administrative Code, to need the level of services provided by a nursing facility, or has qualified for admission under the hospital exemption provision set forth in paragraph (G) of this rule.

(2) PAS/SMI and/or PAS/DD must be completed prior to any new admission of an individual determined by OhioMHAS and/or DODD to have SMI and/or DD.

(a) For an individual identified as a new admission, as defined in rule 5160-3-15 of the Administrative Code, and regardless of payment source, the PAS/SMI and/or the PAS/DD determination requirements must be met before the individual is admitted to any nursing facility or facility in the process of obtaining its initial medicaid certification and nursing facility provider agreement. Individuals determined not to need nursing facility services shall not be admitted or enrolled and medicaid payment will not be available for nursing facility services.

(b) For an individual identified as a new admission, as defined in rule 5160-3-15 of the Administrative Code who are current residents of the facility, the PAS/SMI and/or the PAS/DD requirements must be met prior to the effective date of the nursing facility provider agreement between ODM and the newly certified nursing facility and/or prior to the availability of medicaid payment for the medicaid eligible individual.

(3) OhioMHAS and DODD are prohibited from utilizing criteria relating to the need for nursing facility care or specialized services that are inconsistent with C.F.R. 483.108 and the ODM approved state plan for medicaid. The approved state plan for medicaid includes level of care criteria, contained in Chapter 5160-3 of the Administrative Code. Therefore, OhioMHAS and DODD must use criteria consistent with Chapter 5160-3 of the Administrative Code in making their determinations regarding whether individuals with SMI and/or DD need the level of services provided by a nursing facility.

(D) PAS/ID, PAS/SMI, and PAS/DD requests for additional information:

(1) ODM or its designee, OhioMHAS and/or DODD may request any additional information required in order to make an preadmission screening determination.

(2) When ODM or its designee, OhioMHAS and/or DODD require additional information in order to make the preadmission screening determination they shall provide written notice to the nursing facility, the individual, the hospital, the referring entity, and the individual's representative, if applicable. This notice shall specify the missing forms, data elements and other documentation needed to make the required determinations.

(3) In the event the individual and/or other entity does not provide the necessary information within fourteen calendar days, ODM or its designee, OhioMHAS and/or DODD shall provide written notice to the individual, the individual's guardian or authorized representative, if applicable, and the nursing facility that the admission is prohibited due to failure to provide information

necessary for the completion of the preadmission screening process and that the individual may appeal the determination in accordance with the provisions of division 5101:6 of the Administrative Code. The individual, regardless of payment source, must not be admitted to the nursing facility.

(4) When the individual was seeking medicaid coverage of the proposed nursing facility stay, the county department of job and family services (CDJFS) must also be notified that the individual is not eligible for the admission due to failure to cooperate in the establishment of eligibility.

(5) When the individual or other entity submits the requested information within the timeframes specified in the notice, ODM or its designee, or DODD and/or OhioMHAS shall continue with the preadmission screening process.

(E) PAS/ID, PAS/SMI, and PAS/DD notification:

(1) In accordance with all requirements specified in rule **5101:6-2-32** of the Administrative Code, ODM, or its designee, shall report the outcome of the PAS/ID to the individual, their guardian, or authorized representative (if applicable) and to the entity which initiated the review, and the applicable state department(s) who receive the ODM 03622 and ODM approved level of care assessment (if applicable).

(2) The admitting nursing facility shall maintain the results of the PAS/ID in the individual's resident record at the facility.

(3) In accordance with all requirements specified in rule 5101:6-2-32 of the Administrative Code, DODD and/or OhioMHAS must provide written notice of the PAS-DD and/or PAS-SMI determination to the individual, their legal guardian of person or authorized representative (if applicable), the individual's physician and the facility. When the individual has applied for medicaid payment of the nursing facility stay, ODM and if applicable, the CDJFS and/or the medicaid managed care plan (MCP), must also be notified. When an adverse determination is issued, the facility must then provide the individual, regardless of payment source, with notice of the intent to discharge in accordance with section 3721.16 of the Revised Code.

(4) The admitting nursing facility shall retain the written notification of the PAS/SMI and/or PAS/DD determinations received from OhioMHAS and/or DODD in the individual's resident record at the facility.

(F) An individual shall be required to undergo a new PAS/ID in accordance with the provisions of this rule when:

(1) The individual received PAS/ID, PAS/SMI and/or PAS/DD that nursing facility services are needed and has not been admitted to a nursing facility within one hundred eighty days for the most recent preadmission screening determination that does not meet the definition of a categorical determination, as defined in rule 5160-3-15 of the Administrative Code;

(2) The individual received PAS/SMI and/or PAS/DD that nursing facility services are needed and has not been admitted to a nursing facility within the time period specified by OhioMHAS or DODD for a preadmission screening that meets the definition of a categorical determination, as defined in rule 5160-3-15 of the Administrative Code.

(G) Criteria for a hospital exemption, as defined in rule 5160-3-15 of the Administrative Code.

(1) The following individuals are eligible for a hospital exemption:

(a) The individual will be admitted to a nursing facility directly from an Ohio hospital or a unit of a hospital that is not operated by or licensed by OhioMHAS under section 5119.14 or section 5119.33 of the Revised Code, after receiving acute inpatient care at that hospital; or

(b) The individual is an Ohio resident who will be admitted to a nursing facility directly from an out-of-state hospital that is not an out-of-state psychiatric hospital or psychiatric unit within an out-of-state hospital, after receiving acute inpatient care at that hospital.

(2) Individuals, as described in paragraph (G)(1) of this rule are eligible for a hospital exemption when:

(a) The individual requires the level of services provided by a nursing facility for the condition for which he or she was treated in the hospital; and

(b) The individual's attending physician provides written certification that is signed and dated no later than the date of discharge from the hospital, that the individual is likely to require the level of services provided by a nursing facility for less than thirty days.

(H) Process for a hospital exemption, as defined in rule 5160-3-15 of the Administrative Code.

(1) The discharging hospital shall request a hospital exemption via the ODM 07000 (rev. 7/2014), "Hospital Exemption from Preadmission Screening Notification" or via the electronic system approved by ODM. Effective April 1, 2015, the discharging hospital shall request a hospital exemption via only the electronic system approved by ODM. Exceptions to electronic submission must be approved by ODM or its designee. The ODM 07000 shall be signed and dated by the attending physician no later than the date of discharge from the hospital.

(2) The discharging hospital shall send the completed ODM 07000 to the admitting nursing facility and appropriate PAA.

(3) When the nursing facility accepts the placement of the individual, the nursing facility acknowledges that the individual meets the criteria described in paragraphs (G)(1) and (G)(2) of this rule.

(4) The admitting nursing facility shall maintain the hospital exemption documentation in the resident's record at the nursing facility.

(5) The nursing facility shall initiate the resident review process, as specified in rule **5160-3-15.2** of the Administrative Code, prior to the individual's thirtieth day in the nursing facility.

(6) When an individual admitted to a nursing facility under the hospital exemption is admitted to a hospital or transfers to another nursing facility during the first thirty days of the individual's nursing facility stay, the days in the hospital or previous nursing facility count towards the individual's thirty-day hospital exemption time period. A new hospital exemption shall not be granted during the existing exemption time period.

(7) When an individual requires a continued nursing facility stay beyond thirty days, a resident review shall be initiated by the nursing facility in accordance with rule 5160-3-15.2 of the Administrative Code.

(8) When an adverse determination of either a PAS/SMI, PAS/DD, RR/SMI or RR/DD has been issued by OhioMHAS or DODD within the last sixty calendar days prior to the new nursing facility admission, the individual is not eligible for a hospital exemption. A PAS/ID shall be initiated in accordance with paragraph (B)(1) of this rule.

(I) Medicaid payment is not available for nursing facility stays to individuals who are otherwise medicaid-eligible until the date on which the preadmission screening requirements have been met.

(J) Adverse preadmission screening determinations may be appealed in accordance with division 5101:6 of the Administrative Code.

(K) ODM has authority to assure compliance with the provisions of this rule. Nursing facilities, local administrators, hospitals and all state agencies and their designees shall comply, with accuracy and timeliness, to all requests for records and compliance plans issued by ODM or its designees.

Replaces: 5160-3-15.1

Effective: 11/16/2014

Five Year Review (FYR) Dates: 11/16/2019

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5160-3-15.2 Resident Review Requirements for Individuals Residing in Nursing Facilities

LTCSSTL 15-03

Effective Date: March 1, 2015

Most Current Prior Effective Date: **December 1, 2009**

(A) The purpose of this rule is to set forth ~~the~~ resident review (RR) requirements ~~which must be met~~ in ~~order to comply~~compliance with section 1919~~-~~(e)(7) of the Social Security Act, as in effect on January 1, 2014, ~~amended~~ which prohibits nursing facilities from retaining individuals with serious mental illness (SMI) ~~(~~as defined in ~~paragraph (B)(32) of~~ rule ~~5101:3-3-14~~**5160-3-15** of the Administrative Code~~)~~ or mental retardation and/or other developmental disabilities (MRDD) hereafter referred to as developmental disabilities (DD) ~~(~~as defined in ~~paragraph (B)(16) of~~ rule ~~5101:3-3-14~~5160-3-15 of the Administrative Code~~)~~ unless a thorough evaluation indicates that such placement is appropriate and adequate services are provided.

(B) Resident review identification (RR/ID) is required for ~~all individuals~~an individual who meets any of the following criteria:

(1) The individual was admitted under the exemption from the preadmission screening identification (PAS/ID) provision set forth in ~~paragraph (C) of~~ rule ~~5101:3-3-15.1~~**5160-3-15.1** of the Administrative Code, and has since been found to require more than thirty days of services at the ~~NF~~ nursing facility~~level~~; or

(2) The individual's admission is a ~~NF~~ nursing facility transfer~~,~~ as defined in ~~paragraph (B)(19) of~~ rule ~~5101:3-3-14~~5160-3-15 of the Administrative Code, or a ~~NF~~nursing facility readmission as defined in ~~paragraph (B)(25) of~~ rule ~~5101:3-3-14~~5160-3-15 of the Administrative Code and there are no preadmission screening and resident review (PASRR) records available from the previous ~~NF~~nursing facility placement~~.~~; or

(3) The individual had been in a ~~different NF~~nursing facility and was admitted directly into a different nursing facility following an intervening hospital stay for psychiatric treatment, or was readmitted to the same ~~NF~~ nursing facility directly following a hospital stay for psychiatric treatment, and since the last PASRR determination, has experienced a significant change in condition as defined in ~~paragraph (B)(33) of~~ rule ~~5101:3-3-14~~5160-3-15 of the Administrative Code; or

(4) The individual has experienced a significant change in condition as defined in ~~paragraph (B)(33) of~~ rule ~~5101:3-3-14~~5160-3-15 of the Administrative Code; or

(5) The individual received a categorical preadmission screening serious mental illness (PAS/SMI) ~~PAS-SMI~~ or ~~PAS-MRDD~~preadmission screening developmental disability (PAS/DD) determination as defined in ~~paragraph (B)(3) of~~ rule ~~5101:3-3-14~~5160-3-15 of the Administrative Code, and has since been found to require a stay in a ~~NF~~nursing facility that will exceed the specified time limit for that category; or

(6) The individual received ~~an RR~~a resident review determination for a specified period of time as established by the Ohio department of developmental disabilities (DODD) and/or Ohio department of mental health and addiction services (~~ODMH~~OhioMHAS) and has since been found to require a stay in a ~~NF~~nursing facility exceeding the specified period of time.

(C) Resident review identification (RR/ID) requirements:

(1) The ~~NF~~nursing facility shall initiate a resident review by completing and submitting the Ohio department of medicaid (ODM) 03622 "Preadmission Screening/Resident Review (PAS/RR) Identification Screen" (rev. 8/2014) or by completing and submitting the RR/ID via the electronic system approved by ODM. The submitter shall include supporting documentation with the **ODM 03622** or within the electronic system in order to validate the answers on the ODM 03622.~~:~~

(a) For those individuals specified in paragraph (B)(1) of this rule, as soon as (and no later than the twenty-ninth day from the date of admission) the ~~NF~~ nursing facility has reason

to believe the individual may need to remain in a ~~NF~~nursing facility for thirty days or more.

(b) For those individuals specified in paragraph (B)(2) of this rule, as soon as the ~~NF~~nursing facility finds that no PASRR records are available from the previous ~~NF~~nursing facility placement.

(c) For those individuals specified in paragraphs (B)(3) and (B)(4) of this rule, as soon as the ~~NF~~nursing facility has reason to believe a significant change may have occurred. The completed RR/ID request for an individual with indications of ~~MRDD~~DD or SMI must be submitted to DODD and/or ~~ODMH~~OhioMHAS within seventy-two hours following identification of the significant change.

(d) For those individuals specified in paragraph (B)(5) of this rule, as soon as the ~~NF~~nursing facility has reason to believe the individual may need to remain in a ~~NF~~nursing facility beyond the expiration date of the categorical determination but no later than the date of the expiration of the categorical determination. If the individual has indications of ~~MRDD~~ DD and/or SMI, the completed RR/ID request must be submitted to DODD and/or ~~ODMH~~OhioMHAS no later than the expiration date of the categorical determination.

(e) For those individuals specified in paragraph (B)(6) of this rule, at least thirty days prior to the expiration of the determination.

~~(2) The NF shall initiate the RR/ID via the completion of a PASRR Identification Screen form (JFS 03622) (rev. 11/09) and is responsible for ensuring that necessary documentation for all individuals subject to RR/ID is submitted timely.~~

~~(3)~~(2) The ~~NF~~ nursing facility shall review the completed ~~JFS~~ODM 03622 ~~form~~or RR/ID completed via the ODM-approved electronic system to ensure it is completed accurately and to determine whether the individual has indications of SMI and/or ~~MRDD~~DD ~~(~~as defined in ~~paragraphs (B)(3)(a) and (B)(3)(b) of~~ rule ~~5101:3-3-15.1~~5160-3-15 of the Administrative Code~~)~~.

(a) Individuals determined to have indications of SMI shall be subject to further resident review (RR/SMI) by the ~~ODMH~~OhioMHAS in accordance with rule **5122-21-03** of the Administrative Code.

(b) Individuals determined to have indications of ~~MRDD~~DD shall be subject to further resident review (RR/DD) by the DODD in accordance with rule **5123:2-14-01** of the Administrative Code.

(c) Individuals determined to have indications of both SMI and ~~MRDD~~DD shall be subject to further resident review by both ~~ODMH~~OhioMHAS and DODD in accordance with this rule and rules 5122-21-03 and 5123:2-14-01 of the Administrative Code.

(d) Individuals determined to have no indications of SMI and/or ~~MRDD~~DD are not subject to further ~~RR~~ resident review.

~~(4)~~(3) Routing of a completed ~~JFS~~ ODM 03622 and supporting documentation:

(a) For individuals determined to have no indications of either ~~MRDD~~DD or SMI, the ~~NF~~ nursing facility shall ~~place and~~ maintain the ~~JFS~~ODM 03622 and all supporting evidence in the resident's record at the facility. When using the ODM approved electronic system to complete the RR/ID, all related documentation must be printed and maintained in the resident's record at the facility.

(b) For individuals determined to have indications of ~~either or both~~ SMI and/or ~~MRDD~~DD, the ~~NF~~nursing facility shall timely submit to ~~ODMH~~OhioMHAS and/or DODD, as appropriate, the ~~JFS~~ODM 03622 ~~form~~, supporting documentation ~~supporting the JFS 03622~~, ~~as well as~~ and documentation of the individual's current condition ~~and~~ including evidence of the individual's need for services ~~at the~~in a ~~NF level~~nursing facility. The nursing facility may submit this documentation using the electronic system approved by ODM. If medicaid is

the payer, ~~such~~ documentation must also include the ODM-approved level of care assessment. ~~JFS 03697, 'level of care assessment' form (rev. 4/03).~~

(c) For individuals determined to have indications of ~~MRDD~~DD and/or SMI, the ~~NF~~nursing facility is responsible for the accurate and timely submission of the RR/ID request to DODD and/or ~~ODMH~~OhioMHAS in accordance with the provisions of this rule.

~~(5)~~(4) If the individual is subject to RR/SMI and/or RR/~~-MRDD~~DD and there is no record of the determinations in the medical record and/or no indication that they are in progress, the ~~NF~~ nursing facility shall notify ~~ODMH~~OhioMHAS and/or DODD.

~~(6)~~(5) If an individual who is subject to RR/ID has indications of ~~MRDD~~DD and/or SMI and is discharged from the ~~NF~~nursing facility after submission of the RR/ID request but prior to the determination, and/or prior to the due date for the request, the ~~NF~~nursing facility will notify DODD and/or ~~ODMH~~OhioMHAS.

~~(7)~~(6) If an individual is to be transferred to another Ohio ~~NF~~nursing facility after submission of the RR/ID request but prior to receipt of the RR/ID, RR/~~MRDD~~DD and/or RR/SMI determinations:

(a) The sending ~~NF~~nursing facility must notify DODD and/or ~~ODMH~~OhioMHAS of the transfer. Such notice must be written and must be provided to DODD and/or ~~ODMH~~ OhioMHAS not later than the day the individual is transferred. The sending ~~NF~~nursing facility must provide sufficient contact information to enable the completion of the RR process.

(b) At or prior to the time the individual is transferred, the sending ~~NF~~nursing facility must also provide the receiving ~~NF~~nursing facility with copies of all PASRR related documents pertaining to the individual and written notice of the individual's current status with regard to PASRR. If known, the notice must include contact information for the RR evaluator assigned by ~~ODMH~~OhioMHAS and/or DODD.

(c) The receiving ~~NF~~nursing facility must not accept the individual as a ~~NF~~nursing facility transfer unless it receives this information at or prior to the time the individual is admitted to the receiving ~~NF~~nursing facility.

(d) If the transferring individual is medicaid eligible at the time of the transfer, the sending ~~NF~~nursing facility must also provide written notice of the transfer and the current PASRR status of the individual to ~~ODJFS~~ODM or its designee. Such notice must be provided no later than the date on which the individual is transferred.

~~(8)~~(7) ~~NFs~~A nursing facility that, intentionally or otherwise, accepts any readmission or ~~NF~~nursing facility transfer, or retains as a resident any individual in violation of this rule ~~are~~is in violation of ~~their~~its medicaid provider ~~agreements~~agreement. This is true regardless of the payment source for the individual's ~~NF~~nursing facility stay.

~~(9)~~(8) If it is determined that the ~~NF~~nursing facility failed to initiate the RR/ID in accordance with this rule, an RR/ID may be initiated by the individual or by any state agency or their designee responsible for PASRR or by another entity on behalf of the individual. The ~~NF~~ nursing facility is ultimately responsible to ensure that the RR/ID is completed and the determination is on file.

~~(10)~~(9)Individuals who have indications of SMI or ~~MRDD~~DD shall not be considered to have completed the ~~RR~~resident review process until ~~ODMH~~OhioMHAS and/or DODD have issued the RR/SMI and/or RR/~~MRDD~~DD determinations.

~~(11)~~(10) The ~~NF~~nursing facility shall maintain the ODM 03622, all supporting documentation and results of the RR/ID in the ~~individual's~~ resident's record at the facility. When using the ODM-approved electronic system to complete the RR/ID, this documentation must be printed and maintained in the resident's record at the facility.

(D) RR/SMI and RR/~~MRDD~~DD determination requirements:

(1) No individual with SMI or ~~MRDD~~DD shall be retained as a resident in a ~~NF,~~nursing facility, regardless of payment source, unless it has been determined~~,~~ in accordance with rules 5122-21-03 and 5123:2-14-01 of the Administrative Code, that:

(a) The individual needs the level of services provided by a ~~NF~~nursing facility; or

(b) The individual had resided in a ~~NF~~nursing facility for at least thirty months at the time of the first ~~RR~~resident review determination that established that the individual does not require the level of services provided by a ~~NF~~nursing facility and requires specialized services only; and the individual has chosen to remain in a ~~NF~~nursing facility following receipt of information pertaining to service alternatives to nursing facility placement.

(2) ~~ODMH~~OhioMHAS and/or DODD may approve a determination that the level of services provided by a ~~NF~~nursing facility are needed to best meet the individual's needs long term and for an unspecified period of time.

(3) ~~ODMH~~OhioMHAS and/or DODD may approve a determination that the level of services provided by a ~~NF~~nursing facility are needed to best meet the individual's needs short term and for a specified period of time ~~in order to meet the individual's needs~~.

(a) ~~ODMH~~OhioMHAS and/or DODD may approve such a determination for no more than one hundred eighty days.

(b) ~~ODMH~~OhioMHAS and/or DODD shall not issue an extension to the initial determination without ~~ODJFS~~ODM approval. Extensions shall not exceed ninety days.

(c) In conjunction with local entities, the ~~NF~~nursing facility shall initiate and continue discharge planning activities throughout the period of time specified on the determination notice.

(d) In order to receive consideration for an extension to the initial determination, the ~~NF~~nursing facility shall initiate an RR/ID at ~~last~~least thirty days prior to the expiration of the determination. A request for an extension shall include documentation of discharge planning activities. The written record of discharge planning activities shall include the alternative settings and services explored and the steps taken to ensure that a safe and orderly discharge occurs.

(4) RR/SMI is required for all individuals who were determined by ~~ODMH~~ OhioMHAS during the RR/ID, in accordance with this rule and rule 5122-21-03 of the Administrative Code, to have SMI.

(5) RR~~-MR~~/DD is required for all individuals who were determined by DODD during the RR/ID in accordance with this rule and rule 5123:2-14-01 of the Administrative Code, to have ~~MRDD~~DD.

(6) Individuals with both SMI and ~~MRDD~~DD are subject to both RR/SMI and RR~~-~~/~~MRDD~~DD.

(7) ~~ODMH~~OhioMHAS and/or DODD are prohibited from utilizing criteria relating to the need for ~~NF~~nursing facility care or specialized services that are inconsistent with the statute and the ~~ODJFS~~ODM approved state plan for medicaid. The approved state plan for medicaid includes level of care criteria, contained in Chapter ~~5101:3-3~~5160-3 of the Administrative Code. Therefore, ~~ODMH~~OhioMHAS and DODD must use criteria consistent with Chapter ~~5101:3-3~~5160-3 of the Administrative Code in making their determinations regarding whether individuals with SMI and/or ~~MRDD~~DD need the level of services provided by a ~~NF~~nursing facility.

(8) Any individual twenty-two years of age or older, who has previously been determined by DODD to be ruled out from PAS as defined in ~~paragraph (B)(31) of~~ rule ~~5101:3-3-14~~5160-3-15 of the Administrative Code ~~are~~ is not subject to further review.

(9) An RR determination is not a level of care determination. Individuals seeking medicaid payment for the ~~NF~~nursing facility stay shall meet the level of care requirements in accordance with ~~division~~chapter ~~5101:3~~5160-3 of the Administrative Code.

(E) RR/ID, RR/SMI, and RR/~~MRDD~~DD requests for additional information:

(1) ~~ODMH~~OhioMHAS and/or DODD may request ~~any~~ additional information ~~required in order~~ necessary to make ~~an~~ a ~~RR~~resident review determination.

(2) If ~~ODMH~~OhioMHAS and/or DODD requires additional information ~~in order~~ to make the ~~RR~~resident review determination ~~they~~the agency shall provide written notice to the ~~NF~~nursing facility, the individual, and the individual's representative, if applicable. This notice shall specify the missing forms, data elements and/or other documentation ~~that are~~ needed to make the required determinations.

(3) In the event the individual and/or other entity does not provide the necessary information within fourteen calendar days, the agency that requested the information shall provide written notice to the individual, the individual's representative, if applicable, and the ~~NF~~nursing facility that a continued stay ~~at~~in the ~~NF~~nursing facility is prohibited due to failure to provide information necessary for the completion of the ~~RR~~resident review process and ~~that~~ the individual may appeal the determination in accordance with the provisions of division 5101:6 of the Administrative Code.

(F) RR/ID, RR/SMI, and RR/~~MRDD~~DD notification:

(1) In accordance with all requirements specified in rule **5101:6-2-32** of the Administrative Code, ~~ODMH~~OhioMHAS and/or DODD shall provide written notification of all RR/SMI and/or RR~~-MRDD~~DD determinations made.

(a) Such written notice shall be provided to:

(i) The evaluated individual and his or her legal representative;

(ii) The ~~NF~~nursing facility in which the individual is a resident; ~~and~~

(iii) The individual's attending physician~~.~~;

(iv) ~~In the case of an adverse determination and an approval which is issued for a specified period of time ODJFS~~ODM, ~~and~~ the individual's medicaid managed care plan as defined in rule ~~5101:3-3-14~~ 5160-26-01 of the Administrative Code and the CDJFS, ~~when~~as applicable, when an adverse determination or an approval for a specified period of time is issued .

(b) Such written notice shall include all of the following components:

(i) The determination as to whether and when applicable, ~~for how long~~ the estimated length of time the individual requires the level of services provided by a ~~NF~~nursing facility;

(ii) The determination as to whether the individual requires specialized services for SMI and/or ~~MRDD~~DD;

(iii) The placement and/or service options that are available to the individual consistent with those determinations; and

(iv) The individual's right to appeal the determination(s).

(2) Upon receipt of the written notice of an adverse determination, the ~~NF~~nursing facility shall provide the individual with notice of the intent to discharge. When an expiration date is specified in the written notice, the ~~NF~~nursing facility shall provide the individual with notice of the intent to discharge at least thirty days prior to the expiration date. All individuals, regardless of payment source, who are subject to RR/SMI and/or RR/~~MRDD~~DD and who do not meet the retention criteria set forth in paragraph (D)(1) of this rule must be discharged from the ~~NF~~nursing facility and relocated to an appropriate setting in accordance with section **3721.16** of the Revised Code. The ~~NF~~nursing facility shall maintain a written record of discharge planning activities which shall include the alternative settings and services explored and the steps taken to ensure that a safe and orderly discharge occurs.

(3) The ~~NF~~nursing facility shall retain the written notification of the RR/SMI and/or ~~RR-MRDD~~RR/DD determinations received from ~~ODMH~~OhioMHAS and/or DODD in the ~~individual's~~ resident's record at the facility.

(G) Medicaid payment for services

(1) Medicaid payment is not available for the provision of specialized services for SMI and/or ~~MRDD~~DD.

(2) Medicaid payment is available for the provision of ~~NF~~nursing facility services to medicaid-eligible individuals subject to RR/SMI and/or RR~~-MRDD~~/DD only when the individual has met the criteria for retention set forth in paragraph (D)(1) of this rule.

(3) For medicaid eligible individuals, medicaid payment is available through the time period specified in the notice or during the period an appeal is in progress.

(4) When a RR/ID is not initiated by the ~~NF~~nursing facility within the timeframes specified in paragraph (C~~-~~)(1) of this rule, but is performed at a later date, medicaid payment is not available for services furnished to the eligible individual from the date the RR/ID was due through the earlier of:

(a) If the individual had indications of ~~MRDD~~DD or SMI, the seventh calendar day following the receipt of the ~~JFS~~ ODM 03622 or RR/ID submitted via the ODM approved electronic system ~~form~~ by ~~ODMH~~OhioMHAS or DODD; or

(b) If the individual had no indications of ~~MRDD~~DD or SMI, the date the RR/ID determination was made;

(H) Adverse resident review determinations may be appealed in accordance with division 5101:6 of the Administrative Code.

(I) ~~ODJFS~~ODM has authority to ~~assure~~ensure compliance with the provisions of this rule. ~~NF's~~Nursing facilities, local administrators, hospitals and all state agencies and their designees shall comply, with accuracy and timeliness, to all requests for records and compliance plans issued by ~~ODJFS~~ODM or its designees.

Effective: 03/01/2015

Five Year Review (FYR) Dates: 11/19/2014 and 03/01/2020

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Prior Effective Dates: 5/1/93, 1/1/98, 12/1/09

5160-3-15.3 Level of Care Review Process for Intermediate Care Facilities for the Mentally Retarded

Formerly **5101:3-3-15.3 Level of Care Review Process for Intermediate Care Facilities for the Mentally Retarded**

Effective Date: April 16, 1992

(A) "Level of care review", as used in this rule, is an assessment of an individual's physical, mental, habilitative and social/emotional needs to determine whether the individual requires intermediate care facility services for the mentally retarded. Level of care (LOC) review is conducted pursuant to paragraph 1902(a)(30)(A) of the Social Security Act and are those activities necessary to safeguard against unnecessary utilization. "Intermediate care facility services for the mentally retarded" are those services available in facilities certified as intermediate care facilities for the mentally retarded (ICF-MR) by the Ohio department of health.

The evaluation of an individual's LOC needs determines the appropriately certified facility type for which medicaid vendor payment can be made. Except as provided in paragraph (D) of this rule, vendor payment can be initiated to an ICF-MR only when the applicant is determined to need an ICF-MR LOC according to the criteria specified in rule 5101:3-3-07 of the Administrative Code.

(B) Definitions:

(1) "CDHS" means county department of human services.

(2) "ICF-MR" means intermediate care facility for the mentally retarded. An "ICF-MR" is a long term care facility certified to provide services to individuals with mental retardation or a related condition who require active treatment as defined at 42 CFR 483.440. In order to be eligible for vendor payment in an ICF-MR, a medicaid recipient must be assessed and determined by ODHS to be in need of an ICF-MR level of care as outlined in rule 5101: 3-3-07 of the Administrative Code.

(3) "Individual" means a medicaid recipient or person with pending medicaid eligibility who is making application to a nursing facility (NF) or ICF-MR; or who resides in a NF or an ICF-MR; or is applying for home and community-based services (HCBS) waiver enrollment.

(4) "Physician" means a doctor of medicine or osteopathy who is licensed to practice medicine in the state of Ohio.

(5) "Psychologist" means a degreed psychologist who has been licensed by the Ohio board of psychology to practice psychology in the state of Ohio.

(C) Level of care review is required for individuals in the following situations:

(1) Hospitalized individuals who are not currently ICF-MR residents who are applying for ICF-MR placement.

(2) Hospitalized individuals who are current ICF-MR residents who are seeking admission to a different ICF-MR.

(3) Individuals seeking readmission to the ICF-MR after exhausting available paid hospital leave days (see rule 5101:3-3-03 of the Administrative Code requirements regarding available leave days).

(4) Individuals who are current ICF-MR residents who are seeking admission to a different ICF-MR.

(5) Individuals who are not currently ICF-MR residents who are seeking admission to an ICF-MR from community living arrangements.

(6) Individuals who were on paid leave days are not in a hospital setting and who have exhausted their paid leave days, who are seeking readmission to an ICF-MR.

(7) Current ICF-MR residents who are requesting medicaid reimbursement of their ICF-MR stay.

(8) Individuals applying for HCBS waiver services.

(D) Under the circumstances in paragraphs (D)(1), (D)(2) and (D)(3) of this rule, vendor payment shall be continued or reinstated when a change in institutional setting is sought.

(1) Current ICF-MR residents receiving medicaid vendor payment who wish to transfer to another ICF-MR must submit a completed ODHS 3697 form, not later than the day of transfer to the new ICF-MR, as specified in paragraphs (E)(1) and (E)(2) of this rule to initiate reimbursement in the new ICF-MR effective from the date of admission.

(a) Under this circumstance, vendor payment to the new ICF-MR will be authorized back to the date of the individual's admission to the facility. ODHS shall notify the appropriate CDHS to begin vendor payment. If ODHS determines that the individual is no longer in need of an ICF-MR LOC, ODHS will notify the recipient and the ICF-MR as to the adverse ODHS determination and ODHS's intent to terminate vendor payment. The notice shall set forth the recipient's hearing rights and the time frames within which they must be exercised. ODHS may instruct the appropriate CDHS, as its designee to issue this notice.

(b) If a hearing request is received in response to the notice specified in paragraph (D)(1)(a) of this rule within time frames specified in rule 5101:1-35-04 of the Administrative Code that require the continuation of benefits, authorization for payment will be continued pending the issuance of a state hearing decision.

(c) If the individual does not submit a hearing request within the time frame specified in paragraph (D)(1)(b) of this rule, vendor payment will automatically terminate on the date specified in the notice advising the recipient of ODHS' intent to terminate vendor payment.

(2) Hospitalized individuals who are current ICF-MR residents and are seeking admission to a different ICF-MR, must meet the requirements in paragraphs (D)(1)(a), (D)(1)(b) and (D)(1)(c) of this rule in order to have vendor payment authorized from the date of admission. These requirements must be met regardless of whether they have exhausted paid leave days.

(3) Hospitalized individuals who are seeking readmission to the same ICF-MR after exhaustion of paid leave days may be readmitted to that ICF-MR regardless of the results of the LOC determination if, not later than the date of readmission, the recipient submits a completed ODHS 3697 form to initiate reimbursement effective from the date of readmission. If the LOC determination does not match the certification of the facility as specified in paragraph (A) of this rule, the following procedures will apply:

(a) Vendor payment to the ICF-MR will be authorized back to the date of the individual's admission to the facility. ODHS shall notify the appropriate CDHS to begin vendor payment. If ODHS determines that the individual is no longer in need of an ICF-MR LOC, ODHS will notify the recipient and the ICF-MR as to the adverse ODHS determination and ODHS' intent to terminate vendor payment. The notice shall set forth the recipient's hearing rights and the time frames within which they must be exercised. ODHS may instruct the appropriate CDHS as its designee to issue this notice.

(b) If a hearing request is received in response to the notice specified in paragraph (D)(3)(a) of this rule within the time frames specified in rule 5101:1-35-04 of the Administrative Code that require the continuation of benefits, authorization for payment will be continued pending the issuance of a state hearing decision.

(c) If the individual does not submit a hearing request within the time frame specified in paragraph (D)(3)(b) of this rule, vendor payment will automatically terminate on the date specified in the notice advising the recipient of ODHS' intent to terminate vendor payment.

(E) In order to obtain a LOC determination, an ODHS 3697, or an alternative form specified by ODHS, which has been appropriately completed, accurately reflects the individual's current mental and physical condition, and is certified by a physician must be submitted for review by ODHS.

(1) The ODHS 3697, or another ODHS-authorized alternative form must include the following components and/or attachments:

(a) Individual's name; medicaid number; date of original admission to the facility, if applicable; current address; name and address of residence if current residence is a licensed or certified residential setting or hospital; and county where the individual's medicaid case is active.

(b) A comprehensive medical, social and psychological evaluation of the individual. The psychological evaluation must be made before admission, but not more than three months before admission. Each evaluation must include:

(i) Diagnosis, including medical, psychiatric and developmental diagnoses, including dates of onset, if the date of onset is significant in determining whether the individual has a developmental disability;

(ii) Summary of medical, social and developmental findings;

(iii) Medical and social family history;

(iv) Mental and physical functional capacity;

(v) Prognoses;

(vi) Kinds of services needed including medical treatments, medications, and other professional medical services;

(vii) Evaluation of the resources available in the home, family and community;

(viii) A physician's certification of the individual's need for ICF-MR care made at the time of admission, or if the individual applies for medicaid while a resident of an ICF-MR, prior to the initiation of vendor payment.

(2) The ODHS 3697 must be complete when it is submitted to ODHS in order for a LOC determination to be made. Any entity (a CDHS, hospital or ICF-MR) who submits a LOC request must ensure that all required components are included before submission.

(a) Following receipt by ODHS of the ODHS 3697, ODHS shall make a determination of whether the ODHS 3697 is sufficiently complete for its personnel to perform the LOC review. If the ODHS 3697 is not complete, ODHS shall notify, in writing, the recipient, the contact person indicated on the ODHS 3697, and the ICF-MR or any other entity responsible for the submission of the ODHS 3697, that additional documentation is necessary in order to complete the LOC review. This notice shall specify the additional documentation that is needed and shall indicate that the individual or another entity has twenty days from the date ODHS mails the notice to submit additional documentation or the ODHS 3697 will be denied for incompleteness with no LOC authorized. In the event an individual or other entity is not able to complete an ODHS 3697 in the time specified, ODHS shall, upon good cause, grant one extension of no more than five days when an extension is requested by the recipient or other entity.

(b) If the ODHS 3697 is complete upon receipt by ODHS, or, if within the periods specified in paragraph (E)(2)(a) of this rule, the recipient submits the required documentation, ODHS shall issue a LOC determination within sixty days of the original receipt of the ODHS 3697 by ODHS. A LOC determination will be issued pursuant to the criteria specified in rules 5101:3-3-05, 5101:3-3-06 and 5101:3-3-07 of the Administrative Code.

(3) A request for an ICF-MR LOC will not be denied by ODHS for the reason that the individual does not need ICF-MR services until a qualified professional whose qualifications include being a registered nurse or a qualified mental retardation professional (as specified at 42 CFR 483.430) conducts a face-to-face assessment of the individual, reviews the medical records that accurately reflect the individual's condition for the time period for which payment is being requested; makes a reasonable effort to contact the individual's physician; and investigates and documents alternative community resources including resources available in the home and

family which may be available to meet the needs of the individual. Authorized personnel other than the person who conducted the face-to-face assessment will review the face-to-face assessment and make the final LOC decision.

(F) The LOC review process:

(1) ODHS reviews the application material submitted for the individual and completes the payment authorization (ODHS 3670) and sends it, along with the ODHS 3697, to the CDHS designated on the ODHS 3697. The CDHS shall send a copy of the ODHS 3697 and ODHS 3670 to the ICF-MR.

(2) Authorization of payment to an ICF-MR shall correspond with the effective date of the LOC determination specified on the ODHS 3670. This date shall be:

(a) The date of admission to the ICF-MR if it is within thirty days of the physician's signature; or

(b) A date other than that specified in paragraph (F)(2)(a) of this rule. This alternative date may be authorized only upon receipt of a letter which contains a credible explanation for the delay from the originator of the LOC request. If the request is to backdate the LOC more than thirty days from the physician's signature, the physician must verify the continuing accuracy of the information and need for inpatient care by either adding a statement to that effect on the ODHS 3697 or by attaching a separate letter of explanation.

Replaces part of rule 5101:3-3-15

Effective Date: 4-16-92

Certification:

Date Review

Date

Prior Effective Dates: 4-7-77; 10-14-77; 7-1-80; 8-1-84; 1-17-92 (Emer.)

Rule promulgated under: RC 119.

Rule authorized by: RC 5111.02

Rule amplifies: RC 5111.01, 5111.02

5160-3-15.5 ICF-MR Level of Care Determination Process for Home and Based Medicaid Waivers Administered by the Ohio Department of Mental Retardation and Developmental Disabilities

Formerly **5101:3-3-15.5 ICF-MR Level of Care Determination Process for Home and Based Medicaid Waivers Administered by the Ohio Department of Mental Retardation and Developmental Disabilities**

5160-3-15.5

5160-3-16.1 Nursing Facilities (NFs): Resource Assessment Notice

NFTL 15-01

Effective Date: March 22, 2015

Most Current Prior Effective Date: **January 10, 2013**

(A) General.

The ~~JFS~~**ODM 04080** "Medicaid Resource Assessment Notice" (~~rev. 10/2005~~7/2014) shall conform to all conditions set forth in rule ~~5101:1-39-35~~5160:1-3-35 of the Administrative Code.

(B) Notification.

(1) All NF operators shall furnish written notice at the time of admission to all individuals with a spouse living in the community of the individual's right to have a resource assessment performed by the county department of job and family services (CDJFS). This includes individuals who, at the time of admission, are eligible for the medicare program, or who are covered by a private third party payer.

(2) The NF operator shall do all of the following:

(a) Give a copy of the resource assessment notice to the resident's family member, legal guardian, or authorized agent; and

(b) Send a copy of the signed resource assessment notice to the CDJFS within five working days; and

(c) Post an unsigned copy of the resource assessment notice in a prominent, publicly accessible place within the facility.

(C) Record retention.

A NF operator shall keep a signed copy of the resource assessment notice in a resident's record as long as he or she is a resident of the facility. This copy shall be made available upon request to the staff of the Ohio department of ~~job and family services (ODJFS)~~medicaid (ODM), the CDJFS, and the Ohio department of health (ODH).

Effective: 03/22/2015

Five Year Review (FYR) Dates: 12/08/2014 and 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5162.02

Rule Amplifies: 5162.03

Prior Effective Dates: 1/1/90 (Emer.), 3/22/90, 1/1/95, 1/2/96 (Emer.), 3/14/96, 5/16/02, 9/29/05, 4/1/08, 1/10/13

5160-3-16.3 Nursing Facilities (NFs): Private Rooms

Formerly **5101:3-3-16.3 Private Rooms in Nursing Facilities (NFs)**

NFTL 14-04

Effective Date: October 3, 2014

Most Current Prior Effective Date: January 1, 2008

(A) Medical necessity.

(1) A nursing facility (NF) operator shall provide private room accommodations for a medicaid eligible resident if the resident requires a private room due to medical necessity.

(2) Medicaid payment shall be considered payment in full, and no supplemental payment may be requested or accepted from a resident or a resident's representative.

(B) Semiprivate or ward accommodations unavailable.

(1) Medicaid shall not pay more for a private room than the current medicaid per diem rate the facility is receiving if semiprivate or ward accommodations are not available.

(2) Medicaid payment shall be considered payment in full, and no supplemental payment may be requested or accepted from a resident or a resident's representative.

(C) Supplemental payment.

If semiprivate or ward accommodations are available and are offered to a resident but the resident or the resident's representative makes a written request for a private room, the private room shall be considered a non-covered service for which the facility may seek supplemental payment from the resident or the resident's representative. Such supplemental payment shall conform to all of the following:

(1) The supplemental payment amount shall represent no more than the difference between the charge to private pay residents for a semiprivate room and the charge to private pay residents for a private room; and

(2) The charge for the private room shall not include charges for services covered by medicaid, whether or not medicaid payment meets a NF operator's cost for the per diem service; and

(3) A NF operator shall detail both monthly and annual supplemental charges, if applicable, on a resident's statement of charges so that the additional cost of a private room is evident to the resident and the resident's family; and

(4) The written request for a private room shall be kept in the resident's file; and

(5) The amount of any supplemental payment shall not be considered an offset in determining patient liability for cost of care. All income that would otherwise be considered available to apply to the cost of care ~~at the medicaid rate~~ shall continue to be considered available.

Effective: 10/03/2014

Five Year Review (FYR) Dates: 07/01/2014 and 10/03/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 09/23/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 3721.16

Prior Effective Dates: 9/2/82, 1/1/95, 7/1/00, 7/1/03, 4/1/08

5160-3-16.4 Coverage of Bed-Hold Days for Medically Necessary and Other Limited Absences from Nursing Facilities (NFs)

Formerly **5101:3-3-16.4 Coverage of Bed-Hold Days for Medically Necessary and Other Limited Absences from Nursing Facilities (NFs)**

NFTL 13-01

Effective Date: May 9, 2013

Most Current Prior Effective Date: **March 19, 2012**

(A) Definitions.

(1) "Home and community-based services" (HCBS) means services furnished under the provisions of rule **5101:3-1-06** of the Administrative Code, which enable individuals to live in a community setting rather than in an institutional setting such as a NF, an intermediate care facility for the mentally retarded (ICF-MR), or a hospital.

(2) "Hospitalization" means transfer and admission of a NF resident to a medical institution as defined in paragraph (A)(4) of this rule.

(3) "Institution for mental disease" (IMD) means a hospital, NF, or other institution of more than sixteen beds that is engaged primarily in the diagnosis, treatment, and care of persons with mental diseases, and that provides medical attention, nursing care, and related services. An institution is determined to be an IMD when its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

(4) "Medical institution" means an institution other than a NF that meets all of the following criteria:

(a) Is organized to provide medical care, including nursing and convalescent care; and

(b) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health care needs of patients on a continuing basis in accordance with accepted standards; and

(c) Is authorized under state law to provide medical care; and

(d) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. Professional medical and nursing services shall include all of the following:

(i) Adequate and continual medical care and supervision by a physician; and

(ii) Registered nurse or licensed practical nurse supervision and services sufficient to meet nursing care needs; and

(iii) Nurses' aid services sufficient to meet nursing care needs; and

(iv) A physician's guidance on the professional aspects of operating the institution.

(5) "NF admission" means the act that allows an individual who was not considered a resident of any Ohio medicaid certified NF during the time immediately preceding their current NF residence to officially enter a facility to receive NF services. This may include former NF residents who have exhausted their bed-hold days while in the community and/or hospital. A NF admission may be a new admission or a return admission after an official discharge. A NF admission is distinguished from the readmission of a resident on bed-hold status.

(6) "NF bed-hold day," also referred to as "NF leave day," means a day for which a bed is reserved for a NF resident ~~through medicaid payment~~ while the resident is temporarily absent from the NF for hospitalization, therapeutic leave days, or visitation with friends or relatives. Payment for NF bed-hold days may be made only if the resident has the intent and ability to return to the same NF. A resident on NF bed-hold day status is not considered discharged from the NF ~~since the facility is reimbursed to hold the bed while the resident is on temporary leave~~.

(7) "NF discharge" means the full release of a NF resident from the facility, allowing the resident who leaves the facility to no longer be counted in the NF's census. Reasons for NF discharge include but are not limited to the resident's transfer to another facility, exhaustion of NF bed-hold days from any pay source, decision to reside in a community-based setting, or death.

(8) "NF occupied day" means one of the following:

(a) A day of admission; or

(b) A day during which a medicaid eligible resident's stay in a NF is eight hours or more, and for which the facility receives the full per resident per day payment directly from medicaid in accordance with Chapter **5101:3-3** of the Administrative Code.

(9) "NF readmission" means the status of a resident who is readmitted to the same NF following a stay in a hospital to which the resident was sent to receive care, or the status of a resident who returns after a therapeutic program or visit with friends or relatives. A NF resident can only be readmitted to a facility if that individual was not officially discharged from the facility during that NF stay.

(10) "NF therapeutic leave day" means a day that a resident is temporarily absent from a NF with intent and ability to return, and is in a residential setting other than a long-term care facility, hospital, or other entity eligible to receive federal, state, or county funds to maintain a resident, for the purpose of receiving a regimen or program of formal therapeutic services.

(11) "NF transfer" means the events that occur when a person's place of residence changes from one Ohio medicaid certified NF to another, with or without an intervening hospital stay. However, when the person has an intervening IMD admission, or when the person is discharged from a NF during a hospital stay due to exhaustion of available NF bed-hold days and is admitted to a different NF immediately following that hospital stay, the change of residence is not considered a NF transfer.

(12) "Skilled nursing facility" (SNF) means a NF certified to participate in the medicare program.

(B) Prohibition of preadmission NF bed-hold payment.

(1) ~~ODJFS~~The office of medical assistance (OMA) shall not make payment to reserve a bed for a medicaid eligible prospective NF resident.

(2) A NF provider shall not accept preadmission bed-hold payments from a medicaid eligible prospective NF resident or from any other source on the prospective resident's behalf as a precondition for NF admission.

(C) Determination of NF bed-hold day or NF occupied day.

To determine whether a specific day during a resident's stay is payable as a NF bed-hold day or a NF occupied day, the following criteria shall be used:

(1) The day of NF admission counts as one occupied day; and

(2) The day of NF discharge is not counted as either a bed-hold or an occupied day; and

(3) When NF admission and NF discharge occur on the same day, the day is considered a day of admission and counts as one occupied day, even if the day is less than eight hours; and

(4) A part of a day in a NF that is eight hours or more counts as one occupied day for reimbursement purposes. A day begins at twelve a.m. and ends at eleven fifty-nine p.m.

(D) Limits and reimbursement for NF bed-hold days.

(1) For medicaid eligible residents in a certified NF, except those described in paragraph (K) of this rule, ~~the Ohio department of job and family services (ODJFS)~~ OMA shall pay the NF provider to reserve a bed only for as long as the resident intends to return to the facility, but for not more than thirty days in any calendar year, and only if the requirements of paragraph (D)(3) of this rule are met.

(2) According to section **5111.331** of the Revised Code, reimbursement for NF bed-hold days shall be paid as follows:

(a) Fifty per cent of the NF provider's per diem rate if the facility had an occupancy rate in the preceding calendar year exceeding ninety-five per cent; or

(b) Eighteen per cent of the NF provider's per diem rate if the facility had an occupancy rate in the preceding calendar year of ninety-five per cent or less.

~~(a) During calendar year 2011, fifty per cent of the NF provider's per diem rate.~~

~~(b) During calendar year 2012 and each calendar year thereafter:~~

~~(i) Fifty per cent of the NF provider's per diem rate if the facility had an occupancy rate in the preceding calendar year exceeding ninety-five per cent; or~~

~~(ii) Eighteen per cent of the NF provider's per diem rate if the facility had an occupancy rate in the preceding calendar year of ninety-five per cent or less.~~

(3) Reimbursement for NF bed-hold days according to paragraph (D)(2) of this rule shall be considered payment in full, and the NF provider shall not seek supplemental payment from the resident.

(4) Reimbursement for NF bed-hold days shall be made for the following reasons:

(a) Hospitalization.

NF bed-hold days used for hospitalization of NF residents, including NF residents on HCBS waivers, shall be authorized only until:

(i) The day the resident's anticipated level of care (LOC) at the time of NF discharge from the hospital changes to a LOC that the NF provider is not certified to provide; or

(ii) The day the resident is discharged from the hospital, including discharge resulting in transfer to another hospital-based or free-standing NF or SNF; or

(iii) The day the resident decides to go to another NF upon discharge from the hospital and notifies the first NF provider; or

(iv) The day the hospitalized resident dies.

(b) NF therapeutic leave days.

(i) Any plan to use therapeutic leave days must be approved in advance by the resident's primary physician and documented in the resident's medical record. The documentation shall be available for viewing by the ~~CDJFS~~county department of job and family services (CDJFS) and ~~ODJFS~~ OMA staff~~; and~~.

(ii) A NF provider shall make arrangements for the resident to receive required care and services while on approved therapeutic leave, but medicaid shall not pay for care and services that are included in medicaid's continued payments, including but not limited to home health care, personal care services, durable medical equipment (DME), and private duty nursing.

(iii) NF therapeutic leave days are not reimbursable for NF residents who are on an HCBS waiver and do not count towards the annual leave day limit specified in this rule.

(c) Visits with friends or relatives.

(i) Any plan for a limited absence to visit with friends or relatives must be approved in advance by the resident's primary physician and documented in the resident's medical record. The documentation shall be available for viewing by the CDJFS and ~~ODJFS~~OMA staff.

(ii) The number of days per visit is flexible within the maximum NF bed-hold days, allowing for differences in the resident's physical condition, the type of visit, and travel time.

(iii) The NF provider shall make arrangements for the resident to receive required care and services while on approved visits, but medicaid shall not pay for care and services that are included in medicaid's continued payments, including but not limited to home health care, personal care services, DME, and private duty nursing.

(iv) Leave days for visits with friends or relatives are not reimbursable for NF residents who are on an HCBS waiver and do not count towards the annual leave day limit specified in this rule.

(5) The number and frequency of NF bed-hold days used shall be considered in evaluating the continuing need of a resident for NF care.

(E) Submission of ~~requests for payment~~claims for NF bed-hold days.

A NF provider shall submit claims for NF bed-hold days electronically to OMA in accordance with rule **5101:3-3-39.1** of the Administrative Code.

(1) ~~A NF provider shall submit requests electronically for payment for NF bed-hold days in compliance with electronic data interchange (EDI) standards established under the Health Insurance Portability and Accountability Act (HIPPA) of 1996 using the ANSI 837 health care claim institutional (837I) transaction as required in rule 5101:3-3-39.1 of the Administrative Code. Ohio medicaid ANSI 837I claim specifications for NFs are provided in the ODJFS 837I companion guide, which is available on the internet at http://hipaa.oh.gov/odjfs/.~~

(2) ~~Electronic requests for payment shall use the national uniform billing data element specifications as developed by the national uniform billing committee (NUBC) in compliance with principles established under HIPPA. National uniform billing data element specifications are available on the internet at http://www.nubc.org/.~~

(F) NF admission after depletion of NF bed-hold days.

(1) A resident who leaves a facility and has already exhausted their bed-hold days is considered in a NF discharge status.

(2) A NF provider shall establish and follow a written policy under which a medicaid resident who has expended their annual allotment of thirty NF bed-hold days, and therefore is no longer entitled to a reserved bed under the medicaid bed-hold limit, and is considered to be discharged, shall be admitted to the first available medicaid certified bed in a semiprivate room.

(a) The first available bed means the first unoccupied bed not being held by a resident (regardless of the source of payment) who has elected to make payment to hold that bed.

(b) Unless involuntary discharge hearing and notice requirements were issued as set forth in section 3721.16 of the Revised Code for the previous admission span, a resident shall be admitted to the first available medicaid certified bed in a semiprivate room even if the resident has an outstanding balance owed to the NF provider from the previous admission. The admitted NF resident may be discharged if the NF provider can demonstrate that nonpayment of charges exists, and if hearing and notice requirements have been issued as set forth in section **3721.16** of the Revised Code.

(3) A medicaid eligible NF resident whose absence from the facility exceeds the bed-hold limit or for whom no bed-hold coverage is available may choose to do one of the following:

(a) Return to the NF upon the availability of the first semiprivate bed in the facility; or

(b) Ensure the timely availability of a specific bed upon return to the facility by making bed-hold payments for any days of absence in excess of the medicaid limit or for which no bed-hold coverage is available. Such payment is separate and distinct from the

prohibition of any third party payment guarantee as set forth in rule **5101:3-3-02** of the Administrative Code.

(4) A medicaid eligible resident's NF bed-hold day rights extend only to situations in which the resident leaves the NF for hospitalization, therapeutic leave days, or visits with friends or relatives, and has the intent and ability to return to the same NF.

(a) If a resident who has depleted medicaid covered NF bed-hold days is transferred from a NF to a hospital and then undergoes a NF transfer to a second NF because the second NF provider offers services the first NF provider does not, the first NF provider has no obligation to admit the resident.

(b) If a resident who has depleted medicaid NF bed-hold days is admitted from a NF to a hospital and then is transferred to a hospital-based NF or SNF, the type of NF or SNF to which the resident is transferred does not change the requirements stated in paragraph (F)) of this rule. Therefore, a resident transfer to a hospital-based NF or SNF shall be considered the same as a transfer to any other NF or SNF, and the first NF provider has no obligation to admit the resident.

(5) NF admission following the depletion of bed-hold days during a prior stay and subsequent NF discharge requires that a resident has a NF LOC and is eligible for medicaid NF services.

(G) Information and notice prior to leave.

(1) Prior to a resident's use of NF bed-hold days, a NF provider shall furnish the resident and their family member or legal representative written information about the facility's bed-hold policies, which shall be consistent with paragraph (F) of this rule.

(2) At the time a resident is scheduled for a temporary leave of absence, a NF provider shall furnish the resident and their family member or legal representative a written notice that specifies all of the following:

(a) The maximum duration of medicaid covered NF bed-hold days as described in this rule; and

(b) The duration of bed-hold status during which the resident is permitted to return to the NF; and

(c) Whether medicaid payment will be made to hold a bed and if so, for how many days; and

(d) The resident's option to make payments to hold a bed beyond the medicaid bed-hold day limit, and the amount of such payments.

(H) Emergency hospitalization.

(1) In the case of emergency hospitalization, a NF provider shall furnish the resident and a family member or legal representative a written notice as described in paragraph (G) of this rule within twenty-four hours of the hospitalization.

(2) This requirement is met if the resident's copy of the notice is sent to the hospital with other documents that accompany the resident.

(I) Maximum number of NF bed-hold days.

(1) Medicaid payment for covered NF bed-hold days is considered reimbursement for reserving a bed for a resident who intends to return to the same NF and is able to do so.

(2) The number of NF inpatient days as defined in rule **5101:3-3-01** of the Administrative Code for the calendar year shall not exceed one hundred per cent of available bed days.

(J) Residents eligible for payment of NF bed-hold days.

(1) Medicaid payment for NF bed-hold days is available under the provisions specified in this rule if a resident meets all of the following criteria:

(a) Is eligible for medicaid services and has met the patient liability and financial eligibility requirements as stated in rule **5101:1-39-24** of the Administrative Code; and

(b) Requires a NF LOC or is using medicare part A SNF benefits as described in paragraph (J)(2) of this rule; and

(c) Is not a participant of special medicaid programs or assigned special status as outlined in paragraph (K) of this rule.

(2) Dual eligible for both medicare and medicaid.

~~If a resident meets all of the criteria in paragraph (J)(1) of this rule and is both medicare part A and medicaid eligible, medicaid payment shall be made for NF bed-hold days up to the maximum number of days specified in this rule. Medicaid will, therefore, pay NF bed-hold days during the acute care hospitalization of a medicaid eligible resident who had been receiving medicare part A SNF benefits in the NF immediately prior to and/or following the period of hospitalization.~~

(a) If a resident meets all of the criteria in paragraph (J)(1) of this rule and is both medicare part A and medicaid eligible, medicaid payment shall be made for NF bed-hold days up to the bed-hold day limit specified in this rule. Medicaid will, therefore, pay NF bed-hold days during the acute care hospitalization of a medicaid eligible resident who had been receiving medicare part A SNF benefits in the NF immediately prior to and/or following the period of hospitalization.

(b) A level of care evaluation is not necessary in the following circumstances:

(i) A medicaid eligible resident receives medicare part A SNF benefits in the NF; or

(ii) A claim for a NF occupied day is submitted on the day the medicare part A covered resident is transferred to the hospital.

(3) Medicaid pending.

If a resident meets all of the criteria in paragraph (J)(1) of this rule, and is pending approval of a medicaid application and requires NF bed-hold days, medicaid payment shall be made retroactive to the date the resident became medicaid eligible and approved for NF medicaid payment, through the date the resident returns from a leave or until the maximum number of NF bed-hold days are exhausted.

(4) Medicaid eligible.

If a resident meets all of the criteria in paragraph (J)(1) of this rule, and is approved for NF medicaid payment, medicaid payment shall be made for NF bed-hold days up to the maximum number of days as specified in this rule.

(5) Qualified medicare beneficiary (QMB) eligible.

If a resident meets all of the criteria in paragraph (J)(1) of this rule and is also QMB eligible, medicaid payment shall be made for NF bed-hold days up to the maximum number of days according to rule **5101:1-39-01.1** of the Administrative Code.

(6) HCBS waiver.

If a resident using the NF for a short-term stay is enrolled in an HCBS waiver program and is not using short-term respite care as a waiver service, medicaid payment shall be made for NF bed-hold days for hospitalization up to the bed-hold day limit specified in this rule. Payment for NF bed-hold days shall not be made for NF residents who are on an HCBS waiver for purposes other than hospitalization.

(K) Exclusions.

NF bed-hold days are not available to medicaid eligible NF residents in the following situations:

(1) Hospice.

A person enrolled in a medicare or medicaid hospice program is not entitled to medicaid covered NF bed-hold days. It is the hospice provider's responsibility to contract with and pay the NF provider. Hospice program provisions and criteria are stated in Chapter **5101:3-56** of the Administrative Code; or

(2) IMD.

A resident over age twenty-one and under age sixty-five who becomes a patient of an IMD loses medicaid eligibility and is not entitled to NF bed-hold days. A NF provider shall not receive reimbursement for NF bed-hold days during the period the person is hospitalized in an IMD. The CDJFS staff shall issue the appropriate notice of medicaid ineligibility as stated in rule **5101:6-2-05** of the Administrative Code; or

(3) HCBS waiver.

NF bed-hold days do not apply to a person enrolled in a HCBS waiver program who is using the NF for short-term respite care as a waiver service. ~~Under the HCBS waiver program, a person may not have concurrent active status as both a HCBS enrollee and as a NF resident approved for NF medicaid payment.~~ Eligibility criteria for the HCBS waiver program are contained in Chapters **5101:3-12**, **5101:3-31**, **5101:3-32**, **5101:3-33**, **5101:3-40**, **5101:3-41**, ~~and~~ **5101:3-42**, **5101:3-45**, **5101:3-46**, 5101:3-47, and **5101:3-50** of the Administrative Code; or

(4) Program of all-inclusive care for the elderly (PACE) or other capitated managed care programs.

NF bed-hold days are not available to a medicaid eligible NF resident who is enrolled in a capitated payment program that subcontracts with a NF and for whom the NF provider does not receive payment directly from medicaid; or

(5) Restricted medicaid coverage.

A person who is medicaid eligible but is in a period of restricted medicaid coverage because of an improper transfer of resources is not eligible for NF bed-hold days until the period of restricted coverage has been met. The criteria for the determination of restricted medicaid coverage are specified in rule **5101:1-39-07** of the Administrative Code; or

(6) Facility closure and resident relocation.

NF bed-hold days are not available to residents who have relocated due to the facility's anticipated closure, voluntary withdrawal from participation in the medicaid program, or other termination of the facility's medicaid provider agreement. No span of NF bed-hold days shall be approved that ends on a facility's date of closure or termination from participation in the medicaid program.

(L) Compliance.

(1) Without limiting such other remedies provided by law for noncompliance with these rules, ~~ODJFS~~OMA may do one of the following:

(a) Terminate the NF provider agreement; or

(b) Require the provider to submit and implement a corrective action plan on a schedule specified by ~~ODJFS~~OMA.

(2) A NF provider shall cooperate with any investigation and shall provide copies of any records requested by ~~ODJFS~~OMA.

Effective: 05/09/2013

R.C. 119.032 review dates: 03/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 04/29/2013

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5160-3-16.5 Nursing Facilities (NFs): Personal Needs Allowance (PNA) Accounts and other Resident Funds

NFTL 15-01

Effective Date: March 22, 2015

Most Current Prior Effective Date: **September 15, 2007**

A NF resident's rights concerning his or her personal financial affairs shall be in accordance with **42 CFR 483.10** ~~(rev. October 1, 2006)~~(June 27, 2013).

(A) Definitions.

(1) "Personal needs allowance" (PNA) has the same meaning as found in rule ~~5101:1-39-24~~**5160:1-3-24** of the Administrative Code.

(2) "PNA account" means an account or petty cash fund that holds the money of a NF resident and is managed for the resident by the NF provider.

(3) "Letters of administration," also known as letters testamentary, means court papers allowing a person to take charge of the property of a deceased person in order to distribute it.

(4) "Surety bond" means an agreement between the principal (i.e., the NF provider), the surety (i.e., the insurance company), and the obligee (i.e., the resident and/or the Ohio department of ~~job and family services (ODJFS)~~medicaid (ODM) acting on behalf of the resident), wherein the principal and the surety agree to compensate the obligee for any loss of the obligee's funds that the principal holds, safeguards, manages, and accounts for.

The purpose of a surety bond is to guarantee that a NF provider will pay a resident, or ~~ODJFS~~ODM on behalf of a resident, for losses occurring from any failure by the facility to hold, safeguard, manage, and account for the resident's funds, including losses incurred as a result of acts of error or negligence, incompetence, or dishonesty. The principal assumes the responsibility to compensate the obligee for the amount of the loss up to the entire amount of the surety bond.

(B) PNA.

(1) A medicaid resident who receives care in a NF certified to participate in the medicaid program is eligible to retain a PNA account in the amount set forth in rule ~~5101:1-39-24~~**5160:1-3-24** of the Administrative Code for the purchase of items and services of his or her choice.

(2) The PNA account is the exclusive property of the resident, who may use the funds in the account as he or she chooses to meet personal needs.

(3) Unless a medicaid resident receives additional irregular contributions from another source, all of his or her personal expenses shall be met through the PNA account.

(C) Management of personal funds.

(1) A NF resident has the right to manage his or her personal financial affairs.

(2) A NF provider shall not require a resident to deposit ~~their~~ his or her PNA funds with the provider. However, if a resident requests assistance from the NF staff in managing his or her PNA account, the request shall be in writing.

(3) Upon written authorization from a resident, a NF shall hold, safeguard, manage, and account for a resident's PNA funds deposited with the provider.

(4) A NF provider shall explain verbally and in writing to the resident or the resident's representative that PNA funds are for the resident to use as he or she chooses. If a representative is the payee for the resident's PNA account, the representative shall be responsible for ensuring that the money is used to meet the personal needs of the resident.

(D) Deposit of PNA account funds and interest earned.

(1) Funds of fifty dollars or less.

If a resident's PNA account funds are fifty dollars or less, a NF provider may deposit the funds in an interest-bearing account, a non-interest bearing account, or a petty cash fund.

(2) Funds in excess of fifty dollars.

If a resident's PNA account funds are in excess of fifty dollars, the NF provider shall deposit the funds in an interest-bearing account (or accounts) that is separate from any of the NF provider's operating accounts within five banking days from the date the balance exceeds fifty dollars.

(3) A NF provider shall credit any interest earned on a resident's PNA funds to the resident's PNA account balance. If pooled accounts are used, the provider shall prorate interest per resident on the basis of actual earnings or end-of-quarter balance.

(4) A NF provider shall not charge a resident a fee for managing the resident's PNA account. Banks, however, may charge the resident a fee for handling the account.

(E) Accounting and records.

(1) A NF provider shall establish and maintain a system that ensures full, complete, and separate accounting of each resident's PNA account funds.

(2) A NF provider shall not commingle a resident's accounts or funds with the provider's accounts or funds, or with the accounts or funds of any individual other than another NF resident.

(3) A NF provider shall provide a resident with access to petty cash (less than fifty dollars) on an ongoing basis and shall arrange for the resident to access larger funds (fifty dollars or more). A NF provider shall give residents a receipt for every transaction, and the NF provider shall retain a copy.

(4) A NF provider shall obtain a resident's signature upon the resident's receipt of PNA funds. If the resident is unable to sign his or her name, he or she shall acknowledge receipt of the money by marking an "X." Two persons shall verify through signature that they have witnessed the resident's action.

(5) A NF provider shall maintain an individual ledger account of revenue and expenses for each PNA account managed by the facility. The ledger account shall meet all the following criteria:

(a) Specify all funds received by or deposited with the NF provider. For PNA account funds deposited in banks, monies shall be credited to the resident's bank account within three business days; and

(b) Specify the dates and reasons for all expenditures; and

(c) Specify at all times the balance due the resident, including interest earned as last reported by the bank to the provider; and

(d) Be available to the resident or the resident's representative for review.

(6) Upon request, a NF provider shall provide receipts to a resident or the resident's representative for purchases made with the resident's PNA funds.

(7) Within thirty days after the end of the quarter, a NF provider shall provide a written quarterly statement to each resident or resident's representative of all financial transactions made by the provider on the resident's behalf.

(F) Notification of certain balances or transactions that may affect medicaid eligibility.

(1) Notice to resident.

(a) A NF provider shall give written notification to each resident who receives medicaid benefits, and whose funds are managed by the NF provider, when the amount in the resident's PNA account reaches two hundred dollars less than the resource limit in accordance with rules ~~5101:1-39-05~~5160:1-3-05 and ~~5101:1-39-01.1~~5160:1-3-01.1 of the Administrative Code.

(b) The notice shall inform the resident that ~~they~~ he or she may lose medicaid eligibility if the amount in ~~their~~ his or her PNA account, in addition to the value of ~~their~~ the other nonexempt resources, reaches ~~their~~ the resource limit amount.

(c) A copy of the notice to the resident shall be retained in the resident's file.

(2) Notice to the county department of job and family services (CDJFS).

(a) A NF provider shall report to the CDJFS any PNA account balance in excess of the resource limit. The CDJFS shall apply the excess amount to the routine cost of NF care according to rule ~~5101:1-38-20~~5160:1-2-20 of the Administrative Code.

(3) If a resident is considering using PNA funds to purchase life insurance, grave space, a burial account, or other item that may be considered a countable resource, the NF provider shall refer the resident or the resident's representative to the CDJFS for an explanation of the effect the purchase may have on the resident's medicaid eligibility.

(G) Release of funds upon discharge.

(1) Upon discharge of a resident, a NF provider shall release all the resident's funds, up to and including the maximum resource limit amount.

(2) Other than for items and services that the resident has requested and that may be charged to the resident's PNA account in accordance with this rule, a NF provider shall not withhold PNA account funds to pay any outstanding balance a resident owes the provider at the time of discharge.

(H) Conveyance of funds upon death.

(1) First thirty days.

A NF provider shall not retain the money in a resident's PNA account beyond thirty days following the resident's death if letters testamentary or letters of administration are issued, or an application for release from administration is filed under section **2113.03** of the Revised Code concerning the resident's estate within that thirty-day period. In these circumstances, the provider shall transfer the funds in the resident's PNA account and a final accounting of those funds to the administrator, executor, commissioner, or person who filed the application for release from administration. If these conditions for release are not met, the provider shall follow paragraph (H)(2) or (H)(3) of this rule.

(2) First sixty days.

If, within sixty days after a resident's death, letters testamentary or letters of administration are issued, or an application for release from administration is filed under section **2113.03** of the Revised Code concerning the resident's estate, the provider shall transfer the resident's PNA account funds and a final accounting of those funds to the administrator, executor, commissioner, or person who filed the application for release from administration.

(3) After sixty days.

(a) If, within sixty days after a resident's death, letters testamentary or letters of administration concerning the resident's estate are not issued, or an application for release from administration is not filed under section **2113.03** of the Revised Code concerning the resident's estate, and if the resident was a recipient of medicaid benefits, the provider shall transfer all the resident's PNA account funds to ~~ODJFS~~ODM no earlier than sixty and no later than ninety days after the death of the resident, with the exception listed in paragraph (H)(3)(c) of this rule.

(b) PNA account funds transferred to ~~ODJFS~~ODM shall be paid by check or money order made payable to "Attorney General of Ohio" and shall be accompanied by a completed ~~JFS~~ODM **09405** (~~rev. 7/2005~~7/2014) entitled "Personal Needs Allowance Account Remittance Notice." The payment and completed ~~JFS~~ODM 09405 shall be mailed to the Ohio attorney general's office.

(c) If funeral and/or burial expenses for a deceased resident have not been paid, and all the resident's resources other than the PNA have been exhausted, the resident's PNA account funds shall be used to pay the funeral and/or burial expenses.

(d) If, sixty-one or more days after a resident dies, letters testamentary or letters of administration are issued, or an application for release from administration under section **2113.03** of the Revised Code is filed concerning the resident's estate, ~~ODJFS~~ODM shall transfer all the resident's PNA account funds received by the department to the administrator, executor, commissioner, or person who filed the application for release from administration, unless ~~ODJFS~~ODM is entitled to recover the money under section ~~5111.11~~**5162.21** of the Revised Code.

(I) Financial security.

A NF provider shall purchase a surety bond or provide a reasonable alternative as described in this rule in order to protect all resident funds deposited with and managed by the NF provider.

(1) Surety bond.

(a) A surety bond shall be executed by a licensed surety company pursuant to Chapters **1301**., **1341**., and **3929**. of the Revised Code.

(b) At a minimum, surety bond coverage shall protect at all times the full amount of resident funds deposited with the NF provider, including interest earned and refundable deposit fees.

(c) The surety bond shall provide for repayment of funds lost due to any failure of the NF provider, whether by commission, bankruptcy, omission, or otherwise, to hold, safeguard, manage, and account for resident funds.

(d) The surety bond shall designate either the NF provider, or ~~ODJFS~~ODM on behalf of the resident, as the obligee.

(e) If an entity purchases a surety bond that covers more than one of its facilities, the surety bond shall protect the full amount of all resident funds on deposit in all the entity's facilities.

(2) Reasonable alternative to the surety bond.

A reasonable alternative to the surety bond shall provide protection equivalent to that afforded by a surety bond. Neither self insurance nor deposit of funds in bank accounts protected by the federal deposit insurance corporation (FDIC) or a similar entity are acceptable alternatives to a surety bond. A NF provider electing not to purchase a surety bond shall submit a proposal for an alternative to ~~the ODJFS office of Ohio health plans (OHP)~~ODM for approval. An acceptable alternative shall meet all of the following criteria:

(a) At a minimum, protect at all times the full amount of resident funds deposited with the NF provider, including interest earned and refundable deposit fees; and

(b) Designate either ~~ODJFS~~ODM or the residents of the NF as the entity or entities that will collect payment for lost funds; and

(c) Guarantee repayment of funds lost due to any failure of the NF provider, whether by commission, bankruptcy, omission, or otherwise, to hold, safeguard, manage, and account for resident funds; and

(d) Be managed by a third party unrelated in any way to the NF provider or its management; and

(e) Not name the NF provider as a beneficiary.

(3) Provision of assurance to ~~ODJFS~~ODM.

A NF provider or entity who operates multiple facilities shall submit copies of either the multi-facility surety bond or a reasonable alternative to the multi-facility surety bond to ~~ODJFS~~ODM

for review and approval. If the NF provider, surety company, or issuer of an ~~ODJFS~~ODM-approved surety bond alternative cancels the surety bond or reasonable alternative to a surety bond, they shall notify ~~ODJFS~~ODM by certified mail thirty days prior to the effective date of cancellation.

(J) Limitations on charges to the PNA account.

(1) A NF provider shall not charge a resident's PNA account for items and services that the provider is required to furnish in order to participate in the medicare and medicaid programs, and that are included in medicare and medicaid payments made to the provider.

(2) A NF provider shall inform residents of the coverage and limitations of the medicare and medicaid programs. If a resident's representative is the payee for the resident's PNA account, the NF provider shall also explain the coverage and limitations to the representative.

(3) A NF provider shall not use a resident's PNA account funds to pay for costs associated with guardianship proceedings, including but not limited to the costs for assessments, medical exams, and filing fees.

(K) Items and services covered by medicare or medicaid.

(1) A NF provider shall not charge a resident's PNA account for items and services that the provider is required to furnish in order to participate in the medicare and medicaid programs.

(2) Items and services that may not be purchased with PNA account funds include, but are not limited to, the following:

(a) Nursing services; and

(b) Dietary services; and

(c) Activities programs; and

(d) Room and bed maintenance services; and

(e) Routine personal hygiene items and services required to meet the needs of the resident, including but not limited to hair hygiene supplies, comb, brush, bath soap, disinfecting soap or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, deodorant, incontinence care supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry; and

(f) Medically related social services; and

(g) Medical supplies such as irrigation trays, catheters, drainage bags, syringes, and needles; and

(h) Durable medical equipment; and

(i) Air conditioners, or charges to residents for the use of electricity; and

(j) Therapy or podiatry services; and

(k) Charges for telephone consultation by physicians or other personnel.

(L) Resident requests for items and services.

(1) A NF provider shall not charge a resident's PNA account for any item or service not requested by the resident, whether or not the item or service is requested by a physician.

(2) A NF provider shall not require a resident or the resident's representative to request an item or service as a condition for admission to or continued stay in the NF.

(3) When a resident requests an item or service for which a charge to the resident's PNA account will be made, the NF provider shall inform the resident that there will be a charge and the amount of the charge.

(M) Items and services that may be charged to the PNA account.

(1) If a resident clearly expresses a desire for a particular brand or item not available from the NF provider, PNA funds may be used as long as a comparable item of reasonable quality is available to the resident from the NF provider at no charge. The NF provider may charge the resident only the difference in cost between the available item and the resident's preferred item.

(2) Items and services that may be charged to a resident's PNA account include, but are not limited to, the following:

(a) Telephone; and

(b) Television or radio for personal use; and

(c) Personal comfort items, including smoking materials, notions, novelties, and confections; and

(d) Cosmetics and grooming items and services in excess of those for which payment is made under the medicaid or medicare programs, including hair cuts, permanent waves, hair coloring, and relaxing performed by barbers and beauticians; and

(e) Personal reading material; and

(f) Stationary or stamps; and

(g) Personal clothing; and

(h) Specialty laundry services such as dry cleaning, mending, or hand-washing; and

(i) Flowers or plants; and

(j) Gifts purchased on behalf of a resident; and

(k) Non-covered special care services such as privately hired nurses or nurse aides; and

(l) Social events or entertainment offered outside the scope of the NF provider's activities program; and

(m) Private rooms, except when therapeutically required for infection control or similar reasons; and

(n) Specially prepared or alternative food requested instead of food generally prepared by the NF provider; and

(o) Burial plots.

(N) Monitoring.

The CDJFS is responsible for monitoring PNA accounts. At least once a quarter, a designated CDJFS employee shall determine if a NF provider is following the provisions of this rule, and shall report any questions concerning inappropriate use or inadequate record keeping of PNA funds to ~~ODJFS~~ODM and to the Ohio department of health (ODH) for further action. Inappropriate use of PNA account funds by a payee or a NF provider does not, however, reduce the scope or duration of medicaid benefits for a medicaid recipient.

Effective: 03/22/2015

Five Year Review (FYR) Dates: 12/08/2014 and 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

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5160-3-17 Nursing Facilities (NFs): Payment Methodology for the Provision of Outlier Services

Formerly **5101:3-3-17 Payment Methodology for the Provision of Outlier Services in Nursing Facilities (NFs)**

NFTL 14-04

Effective Date: October 3, 2014

Most Current Prior Effective Date: **July 1, 2006**

(A) For the purposes of this rule:

(1) "Individual" means any person who is seeking or receiving medicaid coverage for placement in an Ohio medicaid-certified NF that is an approved outlier provider.

(2) "Individual plan (IP)" means a written description of the services to be provided to an individual, developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the individual's needs, as described by the comprehensive functional assessments.

(3) "Outlier services" are those clusters of services which have been determined by the Ohio department of ~~job and family services (ODJFS)~~medicaid (ODM) to require staffing ratios, certain costs, and capital investments beyond the levels otherwise addressed in Chapter ~~5101:3-3~~**5160-3** of the Administrative Code when delivered by outlier providers to individuals who have been prior authorized for the receipt of a category of service identified as an outlier.

(4) "Outlier prior authorization committee" means a committee organized and operated by ~~ODJFS~~ODM that makes outlier prior authorization determinations.

(5) "Outlier provider" means any NF or discrete unit of a NF identified as such, or identified and paid as such by ~~ODJFS~~ODM after June 30, 1993, or approved in accordance with section ~~5111.258~~**5165.153** of the Revised Code, that provides services only to individuals who have received prior authorization from the outlier prior authorization committee for the receipt of outlier services in that facility. ~~ODJFS~~ODM prior authorization of outlier services is contingent upon both the individual's documented need for that specific type of outlier service and evidence that the facility in which the individual is to receive services maintains the staffing ratios and ancillary and support items at levels sufficient for the provision of that type of outlier service, and has made the capital investments necessary for the provision of such care.

(B) In addition to information that must be submitted under rules ~~5101:3-3-43.1~~**5160-3-43.1** and ~~5101:3-3-20~~**5160-3-20** of the Administrative Code, an outlier provider must submit all of the following required information:

(1) In the initial year that a NF is approved as an outlier provider, the provider must submit, no later than ninety days after the effective date of the outlier provider agreement, each of the following:

(a) The projected cost report budget for the initial year of operation; and

(b) The current calendar year capital expenditure plan, including a detailed asset listing; and

(c) The current calendar year plan for basic staffing patterns, using a format to be approved by ~~ODJFS~~the department, that includes the staff schedule by shift, number of staff in each position, staff position descriptions, base wage rates, and a brief explanation of contingencies that may require adjustments to these basic staffing patterns.

(2) The following information must be submitted no later than ninety days after the end of the initial three months of operation as an outlier provider:

(a) A cost report for the period of the initial three months of service; and

(b) Current IPs for residents to be served in the period for which a rate is being established.

(3) In each calendar year subsequent to the year of the initial contracted rate, the following information must be submitted by the thirty-first of March:

(a) Current IPs for residents to be served in the period for which a rate is being established; and

(b) The actual year end cost report shall be submitted within the deadline specified in accordance with rule ~~5101:3-3-20~~5160-3-20 of the Administrative Code. The current calendar year cost report budget shall be submitted by the thirty-first of March of the current calendar year, in conjunction with the previous calendar year's actual cost report; and

(c) For-profit providers shall submit a balance sheet, income statement, and statement of cash flows for the outlier facility relating to the previous calendar year's actual cost report submitted in accordance with paragraph (B)(3)(b) of this rule; and

(d) Not-for-profit providers shall submit a statement of financial position, statement of activities, and statement of cash flows for the outlier facility relating to the previous calendar year's actual cost report submitted in accordance with paragraph (B)(3)(b) of this rule; and

(e) The current calendar year capital expenditure plan, including the detailed asset listing; and

(f) The current calendar year plan for basic staffing patterns, using a format to be approved by ~~ODJFS~~the department, that includes the staff schedule by shift, number of staff in each position, staff position descriptions, base wage rates, and a brief explanation of contingencies that may require adjustments to these basic staffing patterns; and

(g) Approved board minutes from the legal entity holding the provider agreement and all other related legal entities for the calendar year covered by the actual cost report submitted in accordance with paragraph (B)(3)(b) of this rule.

(C) Medicaid per diem rates for outlier providers shall be based upon reasonable and allowable costs using the following methodology:

(1) There shall be ~~six~~five components of the per diem rate: direct care, ancillary/support services, capital, tax costs, ~~franchise fee add-on~~ and quality payment.

(a) The direct care per diem shall be determined in accordance with section ~~5111.231~~**5165.19** of the Revised Code. The rate may be increased if deemed necessary by ~~ODJFS~~the department based on analysis of historical direct care costs if the provider had previously been a medicaid provider, a comparison of direct care costs and staffing ratios of facilities caring for individuals with similar needs, a comparison of payment rates paid by private insurers and/or other states, and an analysis of the impact on historical costs if there are plans to change the patient mix.

(b) The ancillary/support services per diem shall be determined in accordance with section ~~5111.24~~**5165.16** of the Revised Code. The rate may be increased due to increased expenses deemed necessary by ~~ODJFS~~the department for treatment of individuals requiring outlier services.

(c) The capital per diem shall be determined in accordance with section ~~5111.25~~**5165.17** of the Revised Code. Adjustments may be made for special high cost equipment or other capital expenditures deemed by ~~ODJFS~~the department to be necessary for treatment of individuals requiring outlier services.

(d) The tax costs per diem shall be determined in accordance with section ~~5111.242~~**5165.21** of the Revised Code.

~~(e) The franchise fee add-on shall be determined in accordance with section 5111.243 of the Revised Code.~~

~~(f)~~(e) The quality payment per diem shall be determined in accordance with ~~rule 5101:3-3-58 of the Administrative Code~~section **5165.25** of the Revised Code.

(2) The total prospective rate for NFs or discrete units of NFs providing outlier services, shall be established by combining the allowable direct, ancillary/support services, capital, tax costs, ~~franchise fee add-on~~ and quality payment per diems determined in accordance with paragraphs (C)(1)(a) to ~~(C)(1)(f)~~(C)(1)(e) of this rule.

(D) Those facilities approved by ~~ODJFS~~the department as outlier providers shall receive rates established in accordance with this rule for individuals ~~that~~who have been prior authorized by the outlier prior authorization committee. The outlier providers shall receive rates established in accordance with this rule effective on the first day of the month in which prior authorized outlier services were provided, but no earlier than the first day of the month in which the approved application for an outlier provider agreement was received by ~~ODJFS~~the department.

(1) ~~ODJFS~~The department will establish the initial contracted rate no later than ninety days after ~~ODJFS~~the department receives all the required information. The initial contracted rate will be implemented retroactively to the initial date services were provided pursuant to the outlier provider agreement.

(2) In each year subsequent to the year of the initial contracted rate, the contracted rate will be effective for the fiscal year beginning on the first of July and ending on the thirtieth day of June of the following calendar year.

(a) If a year end cost report was submitted under paragraph (B)(3)(b) of this rule, the new rate shall be determined under paragraph (C) of this rule.

(b) If all applicable timeframes have been met, but an actual year end cost report is not available, the new rate shall be equal to the product of the rate from the prior fiscal year and the adjustment factor determined under division (B) of section ~~5111.222~~**5165.15** of the Revised Code.

(c) ~~ODJFS~~The department will establish the contracted rate no later than the thirty-first day of July of the fiscal year for which the rate will be paid, unless the provider fails to submit all required information by the thirty-first of March.

Effective: 10/03/2014

Five Year Review (FYR) Dates: 07/01/2014 and 10/03/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 09/23/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02, 5165.153

Rule Amplifies: 5165.153

Prior Effective Dates: 7/1/06

Nursing Facilities (NFs): Relationship of NF Services to Other Covered Medicaid Services

NFTL 15-02

Effective Date: June 11, 2015

Most Current Prior Effective Date: **October 29, 2009**

This rule identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by a NF. Whenever reference is made to payment for services through the NF per diem, the rules governing such payment are set forth in Chapter **5160-3** of the Administrative Code.

(A) Dental services.

All covered dental services provided by licensed dentists are paid directly to the provider of the dental services in accordance with Chapter **5160-5** of the Administrative Code. Personal hygiene services related to dental services provided by facility staff or contracted personnel are paid through the NF per diem.

(B) Laboratory and x-ray services.

Costs incurred for the purchase and administration of tuberculin tests, and for drawing specimens and forwarding specimens to a laboratory, are paid through the NF per diem. All costs of laboratory and x-ray procedures covered under the medicaid program are paid directly to the laboratory or x-ray provider in accordance with Chapter **5160-11** of the Administrative Code.

(C) Medical supply services.

Costs of certain medical supplies are paid through the NF per diem, and others are paid directly to the medical supply provider as follows:

(1) Items that must be paid for through the NF per diem include:

(a) "Needed medical and program supplies," defined as those items that have a very limited life expectancy, such as atomizers, nebulizers, bed pans, catheters, electric pads, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits.

(b) "Needed medical equipment" (and repair of such equipment), defined as items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to an individual in the absence of illness or injury, and are appropriate for use in the facility. Such medical equipment items include hospital beds, wheelchairs other than custom wheelchairs , and intermittent positive-pressure breathing machines, except as noted in paragraph (C)(2) of this rule.

(c) Emergency stand-by oxygen.

(2) Items for which payment is made directly to the medical supply provider, in accordance with Chapter **5160-10** of the Administrative Code, include:

(a) Ventilators.

(b) "Prostheses," defined as devices that replace all or part of a body organ to prevent or correct physical deformity or malfunction, such as artificial arms or legs, electro-larynxes, and breast prostheses.

(c) "Orthoses," defined as devices that assist in correcting or strengthening a distorted part, such as arm braces, hearing aids and batteries, abdominal binders, and corsets.

(d) Contents of oxygen cylinders or tanks, including liquid oxygen; oxygen producing machines (concentrators) for specific use by an individual recipient; and costs of equipment associated with oxygen administration, such as carts, regulators/humidifiers, cannulas, masks, and demurrage.

(D) Pharmaceuticals.

(1) Costs for over-the-counter drugs including selected over-the-counter drugs set forth in paragraph (J) of rule **5160-9-03** of the Administrative Code and nutritional supplements are paid through the NF per diem.

(2) Pharmaceuticals for which payment is made directly to the pharmacy provider are subject to the limitations found in Chapter **5160-9** of the Administrative Code, the limitations established by the Ohio state board of pharmacy, and the following conditions:

(a) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient.

(b) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years. A receipt for drugs delivered to a NF must be signed by the facility representative at the time of delivery and a copy retained by the pharmacy.

(E) Physical therapy, occupational therapy, speech therapy, and audiology services.

Costs incurred for physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants are paid through the NF per diem.

(F) Physician services.

(1) A physician may be paid directly for the following services he or she provides to a resident of a NF:

(a) All covered diagnostic and treatment services in accordance with Chapter **5160-4** of the Administrative Code.

(b) All medically necessary physician visits in accordance with rule **5160-4-06** of the Administrative Code.

(c) All required physician visits as described in this rule when the services are billed in accordance with rule **5160-4-06** of the Administrative Code.

(i) Physician visits must be provided to a resident of a NF and must conform to the following schedule:

(A) The resident must be seen by a physician at least once every thirty days for the first ninety days after admission, and at least once every ninety days, thereafter.

(B) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(ii) For payment of the required physician visits, the physician must:

(A) Review the resident's total program of care including medications and treatments, at each visit required by paragraph (F)(1)(c)(i) of this rule;

(B) Write, sign, and date progress notes at each visit;

(C) Sign all orders; and

(D) Personally visit (see) the patient except as provided in paragraph (F)(1)(c)(iii) of this rule.

(iii) At the option of the physician, required physician visits may be delegated in accordance with paragraph (F)(1)(c)(iv) of this rule and **42 C.F.R. 483.40** (October 1, 2014).

(iv) Physician delegation of tasks.

(A) A physician may delegate tasks to a physician assistant or an APRN as defined by **Chapter 4730**. of the Revised Code and **Chapter 4730-1** of the Administrative Code for physician assistants, and **Chapter 4723**. of the

Revised Code and **Chapter 4723-8** of the Administrative Code for APRNs who are in compliance with the following criteria:

(i) Are acting within the scope of practice as defined by state law; and

(ii) Are practicing with a standard care arrangement entered into with each physician with whom the APRN collaborates in accordance with **section 4723.431** of the Revised Code. A copy of the standard care arrangement shall be retained on file at each NF where the nurse practices.

(B) A physician may not delegate a task when regulations specify that the physician must perform it personally, or when delegation is prohibited by state law or the facility's own policies.

(2) Services payable directly to the physician or APRN must:

(a) Be requested by the NF resident with the exception of the required visits defined in paragraph (F)(1)(c) of this rule; and

(b) Be documented by entries in the resident's medical records along with any symptoms and findings. Every entry must be signed and dated by the applicable physician or APRN.

(3) Services provided in the capacity of overall medical direction are payable only to a NF. Payment for such services may not be made directly to a physician.

(G) Podiatry services.

Costs of covered services provided by licensed podiatrists are paid directly to the authorized podiatric provider in accordance with **Chapter 5160-7** of the Administrative Code. Payment is limited to one visit per month that occurs in a NF setting. Other visits that occur within the same month are payable if those visits occur in a setting other than a NF.

(H) Psychologist services.

Costs incurred for the services of a licensed psychologist are paid through the NF per diem. No payment for psychologist services shall be made to a provider other than the NF, or a community mental health center certified by the Ohio department of mental health and addiction services (ODMHAS). Services provided by an employee of a community mental health center must be billed directly to medicaid by the community mental health center.

(I) Respiratory therapy services.

Costs incurred for physician-ordered administration of aerosol therapy that is rendered by a licensed respiratory care professional are paid through the NF per diem. No payment for respiratory therapy services shall be made to a provider other than the NF through the NF per diem.

(J) Transportation services.

Payment for transporting residents by ambulance or wheelchair van to receive medical services is made directly to the transportation supplier in accordance with **Chapter 5160-15** of the Administrative Code. Transportation of residents to receive medical services when the resident does not require an ambulance or wheelchair van is paid through the NF per diem.

(K) Vision care services.

All costs for covered vision care services, including examinations, dispensing, and the fitting of eyeglasses, are paid directly to authorized vision care providers in accordance with **Chapter 5160-6** of the Administrative Code.

Replaces: 5160-3-19

Effective: 06/11/2015

Five Year Review (FYR) Dates: 06/11/2020

Certification: CERTIFIED ELECTRONICALLY

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Rule Amplifies: 5165.01, 5165.47

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***Formerly* 5101:3-3-20 Nursing Facilities (NFs): Medicaid Cost Report Filing, Record Retention, and Disclosure Requirements**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: **March 19, 2012**

As a condition of participation in the Title XIX medicaid program, each NF and state operated ICF-MR shall file a cost report with the Ohio department of job and family services (ODJFS). The cost report, JFS 02524N "Medicaid Nursing Facility Cost Report" (rev. 09/2011) as found in appendix A to rule **5101:3-3-42.1** of the Administrative Code ~~for NFs, and JFS 02524 "Medicaid ICF-MR Cost Report" (rev. 01/2007) as found in appendix A to rule 5101:3-3-71.1 of the Administrative Code for ICFs-MR~~, including its supplements and attachments as specified under paragraphs (A) to (L) of this rule or other approved forms for state-operated ICFs-MR, must be filed electronically within ninety days after the end of the reporting period. Except as specified under paragraph (E) of this rule, the report shall cover a calendar year or the portion of a calendar year during which the NF or state operated ICF-MR participated in the medicaid program. In the case of a NF ~~or ICF-MR~~ that has a change of operator during a calendar year, the report by the new provider shall cover the portion of the calendar year following the change of operator encompassed by the first day of participation up to and including December thirty-first, except as specified under paragraph (G) of this rule. In the case of a NF or state operated ICF-MR that begins participation after January first and ceases participation before December thirty-first of the same calendar year, the reporting period shall be the first day of participation to the last day of participation. ODJFS shall issue the appropriate software and an approved list of vendors for an electronically submitted cost report no later than sixty days prior to the initial due date of the cost report. For reporting purposes NFs ~~and ICFs-MR, other than state-operated facilities,~~ shall use the chart of accounts for NFs ~~and ICFs-MR~~ as set forth in ~~rules~~rule **5101:3-3-42** ~~and 5101:3-3-71~~ of the Administrative Code ~~respectively~~, or relate its chart of accounts directly to the cost report.

(A) For good cause, as deemed appropriate by ODJFS, cost reports may be submitted within fourteen days after the original due date if written approval from ODJFS is received prior to the original due date of the cost report. Requests for extensions must be in writing and explain the circumstances resulting in the need for a cost report extension.

(1) For purposes of this rule, "original due date" means each facility's cost report is due ninety days after the end of each facility's reporting period. Unless waived by ODJFS, the reporting period ends as follows:

(a) On the last day of the calendar year for the health care facility's year end cost report, except as provided in a paragraph (G)(2) of this rule; or

(b) On the last day of medicaid participation or when the facility closes in accordance with paragraph (A)(1) of rule **5101:3-3-02** of the Administrative Code; or

(c) On the last day before a change of operator; or

(d) On the last day of the new facility's or new provider's first three full calendar months of participation under the medicaid program which encompasses the first day of medicaid participation.

(2) If a facility does not submit the cost report within fourteen days after the original due date, or by the extension date granted by ODJFS or submits an incomplete or inadequate report, ODJFS shall provide immediate written notice to the facility that its provider agreement will be terminated in thirty days unless the facility submits a complete and adequate cost report within thirty days of receiving the notice.

(3) During the thirty day termination period or any additional time allowed for an appeal of the proposed termination of a provider agreement, for each day a complete and adequate cost report is not received, the provider shall be assessed a late file penalty. The late file penalty shall be determined using the prorated medicaid days paid in the late file period multiplied by

the penalty. The penalty shall be two dollars per patient day adjusted each July first for inflation during the preceding twelve months as stated in division (A)(2) of section **5111.26** of the Revised Code. The late file penalty period will begin the date ODJFS issues its written notice and continue until the complete and adequate cost report is received by ODJFS or the facility is terminated from the medicaid program. The late file penalty shall be a reduction to the medicaid payment. No penalty shall be imposed during a fourteen-day extension granted by ODJFS as specified in paragraph (A) of this rule.

(B) An "Addendum for Disputed Costs" shall be an attachment to the cost report that a NF ~~or ICF-MR~~ may use to set forth costs the facility believes may be disputed by ODJFS. The costs stated on the addendum schedule are to have been applied to the other schedules or attachments as instructed by the cost report and/or chart of accounts for the cost report period in question (either in the reimbursable or the nonreimbursable cost centers). Any costs reported by the facility on the addendum may be considered by ODJFS in establishing the facility's prospective rate.

(C) ODJFS shall conduct a desk review of each cost report it receives. Based on the desk review, the department shall make a preliminary determination of whether the reported costs are allowable costs. Before issuing the determination ODJFS shall notify the facility of any information on the cost report that requires further support. The facility shall provide any documentation or other information requested by ODJFS and may submit any information that it believes supports the reported costs. ODJFS shall notify each NF ~~and ICF-MR~~ of any costs preliminarily determined not to be allowable and provide the reasons for the determination.

(1) The desk review is an analysis of the provider's cost report to determine its adequacy, completeness, and accuracy and reasonableness of the data contained therein. It is a process of reviewing information pertaining to the cost report without detailed verification and is designed to identify problems warranting additional review.

(2) A facility may revise the cost report within sixty days after the original due date without the revised information being considered an amended cost report.

(3) The cost report is considered accepted after the cost report has passed the desk review process.

(4) After final rates have been issued, a provider who disagrees with a desk review decision may request a rate reconsideration.

(D) Except as provided in paragraph (D)(1) of this rule and not later than three years after a provider files a cost report with ODJFS under section **5111.26** of the Revised Code, the provider may amend the cost report if the provider discovers a material error in the cost report or additional information to be included in the cost report. ODJFS shall review the amended cost report for accuracy and notify the provider of its determination.

(1) A provider may not amend a cost report if ODJFS has notified the provider that an audit of the cost report or a cost report of the provider for a subsequent cost reporting period is to be conducted under section **5111.27** of the Revised Code. The provider may, however, provide ODJFS information that affects the costs included in the cost report. Such information may not be provided after the adjudication of the final settlement of the cost report.

(2) ODJFS shall not charge interest under division (B) of section **5111.28** of the Revised Code based on any error or additional information that is not required to be reported under this paragraph. ODJFS shall review the amended cost report for accuracy and notify the provider of its determination in accordance with section **5111.27** of the Revised Code.

(E) The annual cost report submitted by state-operated facilities shall cover the twelve-month period ending June thirtieth of the preceding year, or portion thereof, if medicaid participation was less than twelve months.

(F) Cost reports submitted by county and state-operated facilities may be completed on accrual basis accounting and generally accepted accounting principles unless otherwise specified in Chapter **5101:3-3** of the Administrative Code.

(G) Three-month cost reports:

(1) Facilities and providers new to the medicaid program shall submit a cost report pursuant to paragraph (A)(1) of this rule for the period which includes the date of certification and subsequent three full calendar months of operations. The new provider of a facility that has a change of operator, on or after the effective date of this amendment shall submit a cost report within ninety days after the end of the facility's first three full calendar months after the change of operator.

(2) If a facility described in paragraph (G)(1) of this rule opens or changes operators on or after October second, the facility is not required to submit a year end cost report for that calendar year.

(H) Providers are required to identify all known related parties as set forth under paragraph (BB) of rule **5101:3-3-01** of the Administrative Code.

(I) Providers are required to identify all of the following:

(1) Each known individual, group of individuals, or organization not otherwise publicly disclosed who owns or has common ownership as set forth under paragraphs (BB) and (CC) of rule **5101:3-3-01** of the Administrative Code, in whole or in part, any mortgage, deed of trust, property or asset of the facility. When the facility or the common owner is a publicly owned and traded corporation, this information beyond basic identifying criteria is not required as part of the cost report but must be available within two weeks when requested. Publicly disclosed information must be available at the time of the audit; and

(2) Each corporate officer or director, if the provider is a corporation; and

(3) Each partner, if the provider is a partnership; and

(4) Each provider, whether participating in the medicare or medicaid program or not, which is part of an organization which is owned, or through any other device controlled, by the organization of which the provider is a part; and

(5) Any director, officer, manager, employee, individual, or organization having direct or indirect ownership or control of five per cent or more [see paragraph (H) of this rule], or who has been convicted of or pleaded guilty to a civil or criminal offense related to his involvement in programs established by Title XVIII (medicare), Title XIX (medicaid), or Title XX (social services) of the Social Security Act~~, as amended (through 1/1/07)~~; and

(6) Any individual currently employed by or under contract with the provider, or related party organization, as defined under paragraph (H) of this rule, in a managerial, accounting, auditing, legal, or similar capacity who was employed by ODJFS, the Ohio department of health, the office of attorney general, the Ohio department of aging, the Ohio department of mental retardation and developmental disabilities, the Ohio department of commerce or the industrial commission of Ohio within the previous twelve months.

(J) Providers are required to provide upon request all contracts in effect during the cost report period for which the cost of the service from any individual or organization is ten thousand dollars or more in a twelve-month period; or for the services of a sole proprietor or partnership where there is no cost incurred and the imputed value of the service is ten thousand dollars or more in a twelve-month period, the audit provisions of 42 C.F.R. 420 subpart (D) (effective 12/30/82), apply to these contractors.

(1) For purposes of this rule, "contract for service" is defined as the component of a contract that details services provided exclusive of supplies and equipment. It includes any contract which details services, supplies and equipment to the extent the value of the service component is ten thousand dollars or more within a twelve-month period.

(2) For purposes of this rule, "subcontractor" is defined as any entity, including an individual or individuals, who contract with a provider to supply a service, either to the provider or directly to the beneficiary, where medicaid reimburses the provider the cost of the service. This includes

organizations related to the subcontractor that have a contract with the subcontractor for which the cost or value is ten thousand dollars or more in a twelve-month period.

(K) Financial, statistical and medical records (which shall be available to ODJFS and to the U.S. department of health and human services and other federal agencies) supporting the cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the cost report is filed if ODJFS issues an audit report, or six years after all appeal rights relating to the audit report are exhausted.

(1) Failure to retain the required financial, statistical, or medical records, renders the provider liable for monetary damages of the greater amount:

(a) One thousand dollars per audit; or

(b) Twenty-five per cent of the amount by which the undocumented cost increased the medicaid payments to the provider, during the fiscal year.

(2) Failure to retain the required financial, statistical, or medical records to the extent that filed cost reports are unauditable shall result in the penalty as specified in paragraph (K)(1) of this rule. Providers whose records have been found to be unauditable will be allowed sixty days to provide the necessary documentation. If, at the end of the sixty days, the required records have been provided and are determined auditable, the proposed penalty will be withdrawn. If ODJFS, after review of the documentation submitted during the sixty-day period, determines that the records are still unauditable, ODJFS shall impose the penalty as specified in paragraph (K)(1) of this rule.

(3) Refusing legal access to financial, statistical, or medical records shall result in a penalty as specified in paragraph (K)(1) of this rule for outstanding medical services until such time as the requested information is made available to ODJFS.

(4) All requested financial, statistical, and medical records supporting the cost reports or claims for services rendered to residents shall be available at a location in the state of Ohio for facilities certified for participation in the medicaid program by this state within at least sixty days after request by the state or its subcontractors. The preferred Ohio location is the facility itself, but may be a corporate office, an accountant's office, or an attorney's office elsewhere in Ohio. This requirement, however, does not preclude the state or its subcontractors from the option of conducting the audit and/or a review at the site of such records if outside of Ohio.

(L) When completing cost reports, the following guidelines shall be used to properly classify costs:

(1) All depreciable equipment valued at five hundred dollars or more per item and a useful life of at least two years or more, is to be reported in the capital cost component set forth under the Administrative Code. The costs of equipment acquired by an operating lease, including vehicles, executed before December 1, 1992, may be reported in the ancillary/support cost component for NFs ~~and indirect care cost component for ICFs-MR~~ if the costs were reported as administrative and general costs on the facility's cost report for the reporting period ending December 31, 1992, until the current lease term expires. The costs of any equipment leases executed before December 1, 1992 and reported as capital costs, shall continue to be reported under the capital cost component. The costs of any new leases for equipment executed on or after December 1, 1992, shall be reported under the capital costs component. Operating lease costs for equipment, which result from extended leases under the provision of a lease option negotiated on or after December 1, 1992, shall be reported under the capital cost component.

(2) Except for employers' share of payroll taxes, workers compensation, employee fringe benefits, and home office costs, allocation of commonly shared expenses across cost centers shall not be allowed. Wages and benefits for staff including related parties who perform duties directly related to functions performed in more than one cost center which would be expended under separate cost centers if performed by separate staff may be expended to separate cost centers based upon documented hours worked, provided the facility maintains adequate documentation of hours worked in each cost center. For example, the salary of an aide who is assigned to

bathing and dressing chores in the early hours but works in the kitchen as a dietary aide for the remainder of the shift may be expended to separate cost centers provided the facility maintains adequate documentation of hours worked in each cost center.

(3) The costs of resident transport vehicles are reported under the capital cost component. Maintenance and repairs of these vehicles is reported under the ancillary/support cost component for NFs ~~and the indirect care cost component for ICFs-MR.~~

Effective: 01/10/2013

R.C. 119.032 review dates: 03/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.26

Rule Amplifies: 5111.26, 5111.261, 5111.27, 5111.28

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5160-3-22 Rate Recalculations, Interest on Overpayments, Penalties, Repayment of Overpayments, and Deposit of .Repayment of Overpayments for Nursing Facilities (NFs)

Formerly **5101:3-3-22 Rate Recalculations, Interest on Overpayments, Penalties, Repayment of Overpayments, and Deposit of .Repayment of Overpayments for Nursing Facilities (NFs)**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: **March 19, 2012**

(A) If the provider properly amends its cost report under rule **5101:3-3-20** of the Administrative Code, the Ohio department of job and family services (ODJFS) makes a finding based on an audit under section **5111.27** of the Revised Code, or ODJFS makes a finding based on an exception review of resident assessment information conducted under section 5111.27 of the Revised Code after the effective date of the rate for direct care costs that is based on the assessment information any of which results in a determination that the provider has received a higher rate than it was entitled to receive, ODJFS shall recalculate the provider's rate using the revised information. ODJFS shall apply the recalculated rate to the periods when the provider received the incorrect rate to determine the amount of the overpayment. The provider shall refund the amount of the overpayment. In addition to requiring a refund under this rule, ODJFS may charge the provider interest at the applicable rate specified in this rule from the time the overpayment was made.

(1) If the overpayment resulted from costs reported for calendar year 1993, the interest shall be no greater than one and one-half times the average bank prime rate.

(2) If the overpayment resulted from costs reported for subsequent calendar years:

(a) The interest shall be no greater than two times the average bank prime rate if the overpayment was equal to or less than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(b) The interest shall be no greater than two and one-half times the average bank prime rate if the overpayment was greater than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(3) ODJFS shall determine the average bank prime rate using statistical release H.15, "Selected Interest Rates," a weekly publication of the federal reserve board available at **http://www.federalreserve.gov/releases/H15/**, or any successor publication. If statistical release H.15, or its successor ceases to contain the bank prime rate information or ceases to be published, ODJFS shall request a written statement of the average bank prime rate from the federal reserve bank of Cleveland or the federal reserve board.

(B) ODJFS also may impose the following penalties and fines:

(1) If a provider does not furnish invoices or other documentation that ODJFS requests during an audit within sixty days after the request, no more than the greater of one thousand dollars per audit or twenty-five per cent of the cumulative amount by which the costs for which documentation was not furnished increased the total medicaid payments to the provider during the fiscal year for which the costs were used to establish a rate;

(2) If an owner or operator fails to provide notice of facility closure, voluntary withdrawal or voluntary termination of participation in the medicaid program, or change of operator as required by the Revised Code, no more than the current average bank prime rate plus four per cent of the last two monthly payments.

(3) ODJFS shall fine the provider of a nursing facility if the report of an audit conducted under division (B) of section **5111.27** of the Revised Code regarding a cost report for the nursing facility includes either of the following:

(a) Adverse findings that exceed three per cent of the total amount of medicaid-reimbursable costs reported in the cost report;

(b) Adverse findings that exceed twenty per cent of medicaid-reimbursable costs for a particular cost center reported in the cost report.

(4) A fine issued under paragraph (B)(3) of this rule shall equal the greatest of the following:

(a) If the adverse findings exceed three per cent but do not exceed ten per cent of the total amount of medicaid-reimbursable costs reported in the cost report, the greater of three per cent of those reported costs or ten thousand dollars;

(b) If the adverse findings exceed ten per cent but do not exceed twenty per cent of the total amount of medicaid-reimbursable costs reported in the cost report, the greater of six per cent of those reported costs or twenty-five thousand dollars;

(c) If the adverse findings exceed twenty per cent of the total amount of medicaid-reimbursable costs reported in the cost report, the greater of ten per cent of those reported costs or fifty thousand dollars;

(d) If the adverse findings exceed twenty per cent but do not exceed twenty-five per cent of medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of three per cent of the total amount of medicaid-reimbursable costs reported in the cost report or ten thousand dollars;

(e) If the adverse findings exceed twenty-five per cent but do not exceed thirty per cent of medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of six per cent of the total amount of medicaid-reimbursable costs reported in the cost report or twenty-five thousand dollars;

(f) If the adverse findings exceed thirty per cent of medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of ten per cent of the total amount of medicaid-reimbursable costs reported in the cost report or fifty thousand dollars.

(5) The department may not collect a fine issued under paragraph (B)(3) of this rule until all appeal rights relating to the audit report that is the basis for the fine are exhausted.

(C) If the provider continues to participate in the medicaid program, ODJFS shall deduct any amount that the provider is required to refund under this rule, and the amount of any interest charged or penalty imposed under this rule, from the next available payment from ODJFS to the provider. ODJFS and the provider may enter into an agreement under which the amount, together with interest, is deducted in installments from payments from ODJFS to the provider.

(D) Fines issued under paragraph (B)(3) of this rule and paid shall be deposited into the health care services administration fund created under section **5111.94** of the Revised Code. ODJFS shall transmit all other refunds and penalties issued under this rule to the treasurer of state for deposit in the general revenue fund.

Effective: 01/10/2013

R.C. 119.032 review dates: 03/01/2017

Certification: CERTIFIED ELECTRONICALLY

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Statutory Authority: 511.02

Rule Amplifies: 5111.27, 5111.271, 5111.28

Prior Effective Dates: 6/30/94 (Emer.), 11/1/94, 7/4/02, 2/2/06, 12/31/06, 3/19/12

5160-3-24 Nursing Facilities (NFs): Prospective Rate Reconsideration for Possible Calculation Errors

NFTL 15-01

Effective Date: March 22, 2015

Most Current Prior Effective Date: **July 1, 2006**

(A) A facility, group, or association may request a reconsideration of a prospective NF rate on the basis of a possible error in the calculation of the rate as follows~~;~~:

(1) A request for reconsideration of a prospective rate on the basis of a possible error in the calculation of the rate shall be filed with the Ohio department of ~~job and family services (ODJFS)~~medicaid (ODM) no more than thirty days after the later of the initial payment of the rate for which reconsideration is being requested or the date on the rate setting package notification~~receipt of the rate-setting calculation~~.

(2) The request for a reconsideration of a prospective rate on the basis of a possible error in the calculation of the rate shall be filed in accordance with the following procedures:

(a) The request for rate reconsideration shall be in writing; and

(b) The request shall be addressed to "Ohio Department of ~~Jobs and Family Services, Bureau of Long Term Care Facilities, Reimbursement Section, 30 East Broad Street, 33rd Floor,~~ Medicaid, Fiscal Operations - LTC Rate Methodology Unit, P.O. Box 182709, Columbus, Ohio 43215-3414"; and

(c) The request shall indicate that it is a request for rate reconsideration due to a possible error in the calculation of the rate; and

(d) The request shall include a detailed explanation of the possible error and the proposed corrected calculation; and

(e) The request shall include references to the relevant sections of the Revised Code and/or paragraphs of the Administrative Code as appropriate.

(3) ~~ODJFS~~ODM shall respond in writing within sixty days of receiving each written request for reconsideration of a prospective rate due to a possible error in the calculation of the rate. If ~~ODJFS~~ODM requests~~-~~additional information to determine whether a rate adjustment is warranted, the NF 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~~ODM shall respond in writing within sixty days of receiving the additional information to the request for reconsideration of a prospective rate due to a possible error in the calculation of the rate.

(4) If a rate adjustment is warranted as the result of a reconsideration of a prospective rate due to a possible error in calculation, the adjustment shall be implemented retroactively to the initial service date for which the rate is effective.

(B) ~~ODJFS's~~ODM's decision at the conclusion of the rate reconsideration process shall not be subject to any administrative proceedings under **Chapter 119**. or any other provision of the Revised Code.

Effective: 03/22/2015

Five Year Review (FYR) Dates: 12/08/2014 and 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

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Statutory Authority: 5165.02, 5165.38

Rule Amplifies: 5165.38

Prior Effective Dates: 7/1/06

5160-3-30.1 Appeal of the Franchise Permit Fee (FPF) Determination and Re-Determination

Formerly **5101:3-3-30.1 Appeal of the Franchise Permit Fee (FPF) Determination and Re-Determination**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: **March 19, 2012**

(A) When submitting an appeal of a FPF determination or re-determination for a nursing home or hospital long term care unit in accordance with section **3721.55** of the Revised Code, ~~or an appeal of a FPF determination for an intermediate care facility for the mentally retarded in accordance with section 5112.35 of the Revised Code,~~ a facility operator shall follow these procedures:

(1) The appeal shall be in writing and must be received by ODJFS not later than fifteen days after the date on which the FPF assessment notice was mailed.

(2) The appeal shall be submitted to ODJFS and addressed to the organization listed in the instructions that are sent with the assessment notice. If this address is invalid, the facility shall contact the bureau of long term care services and supports (BLTCSS).

(3) The appeal shall indicate that it is an appeal of the FPF due to a possible material error in determining the amount of the fee.

(4) The appeal shall include a detailed explanation of the possible material error and the proposed correction of the amount of the fee.

(5) The appeal shall include references to the relevant sections of the Revised Code or rules of the Administrative Code that support the position of the appeal.

(B) If a representative of a facility is unable to attend the hearing, the representative shall request a teleconference hearing at least five days prior to the scheduled hearing.

Effective: 01/10/2013

R.C. 119.032 review dates: 07/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 3721.58, 5112.39

Rule Amplifies: 3721.50, 3721.51, 3721.531, 3721.532, 3721.55

Prior Effective Dates: 9/30/93 (Emer.), 1/1/94, 1/12/96, 9/30/01, 2/11/02, 9/30/02, 9/30/03 (Emer.), 02/11/03, 4/12/04, 7/1/05, 12/30/05, 4/30/07, 10/15/10, 3/19/12

5160-3-30.4 Procedure for Terminating the Franchise Permit Fee (FPF) for Nursing Facilities (NFs), Nursing Homes (NHs), and Long Term Care Hospital Beds

Formerly **5101:3-3-30.4 Procedure for Terminating the Franchise Permit Fee (FPF) for Nursing Facilities (NFs), Nursing Homes (NHs), and Long Term Care Hospital Beds**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: **October 15, 2010**

(A) Definitions.

"Effective FPF termination date" (EFTD) means the date on which the centers for medicare and medicaid services (CMS) determines that the FPF does not qualify for federal financial participation.

(B) Determination of the FPF as an impermissible health care related tax.

If CMS determines that the FPF is an impermissible health care related tax, the Ohio department of job and family services (ODJFS) shall take all necessary actions to cease implementation of the FPF program, pursuant to ~~sections~~ section **3721.51** ~~and 5112.31~~ of the Revised Code.

(C) Notification.

ODJFS shall notify each facility previously assessed the FPF of the effective date of the termination of the FPF program, and what impact this change will have on the facility.

(D) Reconciliation procedure.

ODJFS shall conduct an accounting of the funds paid to or collected from each facility as a result of the FPF program and shall do all of the following:

(1) Reconcile FPFs paid by NFs, NHs, and hospitals~~, and ICFs-MR.~~

(a) The annual assessment of the FPF shall be prorated on a daily basis.

(b) FPF assessments for the days preceding the EFTD shall remain due and payable.

(c) Collection shall be pursued in accordance with sections **3721.54**~~,~~ and **3721.57**~~, 5112.34, and 5112.38~~ of the Revised Code.

(d) FPF assessments issued for days on and after the EFTD shall be rescinded.

(i) ODJFS shall issue refunds to NHs~~,~~ and hospitals~~, and ICFs-MR~~ for any FPF remittances representing payment for daily fees on or beyond the EFTD, unless a NF~~,~~ or skilled nursing facility/nursing facility (SNF/NF)~~, or ICF-MR~~ has already received medicaid payment for service dates described in paragraph (D)(3) of this rule.

(ii) The source of the refunds shall be the funds established by the FPF assessments as set forth in sections **3721.56**~~,~~ and **3721.561**~~, 5112.37, and 5112.371~~ of the Revised Code, if necessary, to each NH~~,~~ and hospital~~, or ICF-MR~~ assessed the FPF.

(2) Adjust NF ~~and ICF-MR~~ rates set by ODJFS that include reimbursement for FPF assessment payments by medicaid certified NFs~~,~~ and SNF/NFs~~, and ICFs-MR~~. ODJFS shall adjust the per diem rate of a NF ~~or ICF-MR~~ to remove any FPF reimbursement-related amount retroactively and/or prospectively from the rate for dates of service on and after EFTD.

(3) Reconcile paid claims for service dates on and following the EFTD with rates adjusted according to paragraph (D)(2) of this rule.

(a) Active providers.

(i) If claims have already been submitted to ODJFS and processed for dates of service on or after the EFTD, ODJFS shall offset the amount of overpayment received with the amount of refund due from paragraph (D)(1) of this rule.

(ii) If the offset results in amounts owed to the facility, refunds shall be issued.

(iii) If the offset results in amounts owed to ODJFS, the amount payable may be collected via offsets of future payments.

(b) Inactive providers.

(i) If claims have already been submitted to ODJFS and processed for dates of service on or after the EFTD by a NF~~,~~ or SNF/NF~~, or ICF-MR~~ provider that no longer participates in the medicaid program, ODJFS shall offset the amount of overpayment received with the amount of refund due from paragraph (D)(1) of this rule.

(ii) If the offset results in amounts owed to the facility, refunds shall be issued if the provider has furnished an adequate forwarding address.

(iii) If the offset results in amounts owed to ODJFS, the amount payable may be collected via direct payment from the provider.

(iv) Failure to provide payment may result in certification to the attorney general for collection as set forth in ~~sections~~ section **3721.57** ~~and 5112.38~~ of the Revised Code.

Effective: 01/10/2013

R.C. 119.032 review dates: 10/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 3721.58, 5111.02, 5112.39

Rule Amplifies: 3721.50, 3721.51, 3721.511, 3721.512, 3721.513, 3721.52, 3721.53, 3721.54, 3721.541, 3721.55, 3721.56, 3721.57, 3721.58

Prior Effective Dates: 9/30/93 (Emer.), 1/1/94, 9/30/01, 2/14/02, 4/12/04, 12/30/05, 10/15/10

5160-3-32 Debt Estimation Methodology for Change of Operator, Facility Closure, Voluntary Termination, Involuntary Termination, or Voluntary Withdrawal for Nursing Facilities (NFs)

Formerly **5101:3-3-32 Debt Estimation Methodology for Change of Operator, Facility Closure, Voluntary Termination, Involuntary Termination, or Voluntary Withdrawal for Nursing Facilities (NFs)**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: **March 19, 2012**

(A) The Ohio department of job and family services (ODJFS) shall use the debt estimation methodology set forth in this rule to estimate the exiting operator's actual and potential debts to ODJFS and the United States centers for medicare and medicaid services (CMS) under the medicaid program.

(B) ODJFS shall total the value of all of the following that are determined applicable in calculating the debt estimate:

(1) Overpayments determined due to ODJFS pursuant to section **5111.27** of the Revised Code, including the following:

(a) Overpayments owed to ODJFS for adjudicated final fiscal audit periods.

(b) Overpayments identified in proposed adjudication orders that have been issued but not adjudicated.

(c) Overpayment amounts for any outstanding periods where a final fiscal audit has not yet been issued. Such amounts are estimated by generating preliminary reports of amounts owed by the exiting operator for the applicable periods.

(2) Monies owed to ODJFS and CMS resulting from penalties authorized by federal and state law, including but not limited to the following:

(a) Civil monetary penalties (CMPs) imposed pursuant to 42 C.F.R. 488.430.

(b) Penalties assessed pursuant to section **5111.28** of the Revised Code for lack of proper notice of a change of operator, facility closure, voluntary termination, or voluntary withdrawal from the medicaid program.

(c) Late cost report filing penalties assessed pursuant to rule **5101:3-3-20** of the Administrative Code.

(d) Penalties assessed pursuant to rule **5101:3-3-22** of the Administrative Code when a provider fails to furnish invoices or other documentation that ODJFS requests during an audit.

(3) Interest monies owed to ODJFS pursuant to section **5111.28** of the Revised Code, and to CMS pursuant to 42 C.F.R. 488.442.

(4) Monies owed ODJFS and CMS pursuant to sections **5111.68** and **5111.685** of the Revised Code, including a final fiscal audit for the last fiscal year or portion thereof that the exiting operator participated in the medicaid program.

(5) Franchise permit fee (FPF) owed to ODJFS pursuant to section **3721.53** ~~or 5112.33~~ of the Revised Code. FPF owed to ODJFS shall include unpaid FPF for the following:.

(a) Amounts due for periods assessed or to be assessed but for which payment is not yet required pursuant to section **3721.53** ~~or 5112.33~~ of the Revised Code.

(b) Amounts due that are certified to the Ohio attorney general's office for collection, including penalties assessed pursuant to section **3721.54** ~~or 5112.34~~ of the Revised Code for failure to pay the full amount when due.

~~(6) Monies owed for recapture of excess depreciation for ICFs-MR.~~

~~(7)~~(6) Monies owed due to a credit balance.

~~(8)~~(7) Monies owed pursuant to successor liability or assumption of liability agreements the exiting operator entered into.

~~(9)~~(8) Other amounts ODJFS determines are applicable.

(C) The sum of the amounts determined owed, or estimated to be owed, to ODJFS and CMS pursuant to paragraphs (B)(1) to (B)(9) of this rule shall be the total estimated debt.

(D) ODJFS may release a portion of funds withheld pursuant to division (A) of section **5111.681** of the Revised Code if the funds withheld are materially greater than the debt calculated by the department in the initial debt summary report issued pursuant to section **5111.685** of the Revised Code.

Effective: 01/10/2013

R.C. 119.032 review dates: 03/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.689

Rule Amplifies: 3721.53, 3721.54, 5111.27, 5111.28, 5111.68, 5111.681, 5111.683, 5111.685

Prior Effective Dates: 8/31/10 (Emer.), 11/29/10, 3/19/12

5160-3-32.1 Debt Estimate and Debt Summary Report Procedure for Change of Operator, Facility Closure, Voluntary Termination, Involuntary Termination, or Voluntary Withdrawal for Nursing Facilities (NFs)

Formerly **5101:3-3-32.1 Debt Estimate and Debt Summary Report Procedure for Change of Operator, Facility Closure, Voluntary Termination, Involuntary Termination, or Voluntary Withdrawal for Nursing Facilities (NFs)**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: **March 19, 2012**

(A) Debt estimate.

For the purposes of division (C) of section **5111.68** of the Revised Code, the debt estimate is considered provided by the Ohio department of job and family services (ODJFS) on the date of mailing or date of personal service.

(B) Initial debt summary report.

(1) Whenever ODJFS issues an initial debt summary report pursuant to section **5111.685** of the Revised Code, ODJFS shall give notice to the affected party informing the affected party of the affected party's right to request a review. Notice shall be given by registered mail, return receipt requested, and shall include:

(a) A statement informing the affected party that the affected party is entitled to request a review of the initial debt summary report.

(b) A statement informing the affected party that if a request for review of the initial debt summary report is not submitted on or before thirty days after the mailing of the initial debt summary report, the initial debt summary report becomes the final debt summary report thirty-one days after the mailing of the initial debt summary report, and that the affected party may request, in accordance with **Chapter 119.** of the Revised Code, an adjudication hearing regarding a finding in the final debt summary report that pertains to an audit or alleged overpayment made under the medicaid program to the exiting operator. The adjudication shall be consolidated with any other uncompleted adjudication that concerns a matter addressed in the final debt summary report.

(2) ODJFS shall also mail a copy of the notice to the affected party's attorney or other representative of record. To qualify as an attorney or representative of record, the affected party or the attorney or representative must notify ODJFS, in writing, that the attorney or representative is to be designated the attorney or representative of record for purposes of receiving notice of an initial debt summary report. The notification must include the address where ODJFS should mail the notice to the attorney or representative of record. The mailing of notice to the affected party's attorney or representative is not deemed to perfect service of the notice. Failure to mail a copy of the notice to the attorney or representative of record will not result in failure of otherwise perfected service upon the affected party. In those instances where an affected party is a corporation doing business in Ohio or is incorporated in Ohio, the mailing of notice to the corporation's statutory agent pursuant to sections **1701.07** and **1703.19** of the Revised Code will perfect service.

(3) When any notice of an initial debt summary report is sent by registered mail pursuant to this rule is returned because the affected party fails to claim the notice, ODJFS shall send the notice by ordinary mail to the affected party at the affected party's last known address and shall obtain a certificate of mailing. Service by ordinary mail is complete when the certificate of mailing is obtained unless the notice is returned showing failure of delivery.

(4) If any notice of an initial debt summary report is sent by registered or ordinary mail is returned for failure of delivery, ODJFS shall make personal delivery of the notice by an employee or agent of ODJFS. An employee or agent of ODJFS may make personal delivery of the notice upon a party at any time.

(5) Refusal of delivery of an initial debt summary report by personal service or by mail is not failure of delivery and service is deemed to be complete at the time of personal refusal or at the time of receipt by ODJFS of the refused mail as demonstrated by the ODJFS time and date stamp. Failure of delivery occurs only when a mailed notice is returned by the postal authorities marked undeliverable, address or addressee unknown, or forwarding address unknown or expired.

(6) Any request for a review made as the result of notice of an initial debt summary report issued pursuant to paragraph (B) of this rule must be made in writing and mailed or delivered to the ODJFS office and address identified in the initial debt summary report within thirty calendar days of the following, as applicable:

(a) The time of mailing the notice if notice is given pursuant to paragraph (B)(1) of this rule;

(b) The date that service is complete if notice is given pursuant to paragraph (B)(3) or (B)(5) of this rule;

(c) The date of personal service.

(7) If a request for review is mailed to the ODJFS office and address identified in the initial debt summary report, the request is deemed to have been made as follows:

(a) If the request is mailed by certified mail, as of the date stamped by the U.S. postal service on its receipt form (PS form 3800 or any future equivalent postal service form).

(b) If the request is mailed by regular U.S. mail, as of the date of the postmark appearing upon the envelope containing the request.

(c) If the request is mailed by regular U.S. mail and the postmark is illegible or fails to appear on the envelope, as of the date of its receipt by ODJFS office identified in the initial debt summary report as evidenced by that office's time stamp.

(8) If a request for review is made by facsimile transmission or by electronic mail to the office identified in the initial debt summary report, the request is deemed to have been made as of the date of its receipt as evidenced by the receipt date generated by the facsimile transmission or the date of receipt shown in the source code of the electronic mail received by the office identified in the initial debt summary report.

(9) If a request for review is mailed, personally delivered, made by facsimile transmission, or made by electronic mail to a party or address other than the proper office identified in the initial debt summary report, the request is deemed to have been made as of the date of its receipt by the office identified in the initial debt summary report as evidenced by that office's time stamp.

(10) If a request for review is personally delivered to the office identified in the initial debt summary report, the request is deemed to have been made as of the date of its receipt as evidenced by that office's time stamp.

(11) All requests for review must clearly identify both the affected party involved and the initial debt summary report that is being contested.

(C) Revised debt summary report.

(1) Whenever ODJFS issues a revised debt summary report pursuant to section **5111.685** of the Revised Code, ODJFS shall give notice to the affected party informing the affected party of the affected party's right to submit additional information. Notice shall be given by registered mail, return receipt requested, and shall include:

(a) A statement informing the affected party that the affected party is entitled to submit additional information.

(b) A statement informing the affected party that if additional information is not submitted on or before thirty days after the mailing of the revised debt summary report, the revised debt summary report becomes the final debt summary report thirty-one days after the mailing of the revised debt summary report, and that the affected party may request, in accordance with **Chapter 119**. of the Revised Code, an adjudication hearing regarding a

finding in the final debt summary report that pertains to an audit or alleged overpayment made under the medicaid program to the exiting operator. The adjudication shall be consolidated with any other uncompleted adjudication that concerns a matter addressed in the final debt summary report.

(2) ODJFS shall also mail a copy of the notice to the affected party's attorney or other representative of record. To qualify as an attorney or representative of record, the affected party or the attorney or representative must notify ODJFS, in writing, that the attorney or representative is to be designated the attorney or representative of record for purposes of receiving notice of a revised debt summary report. The notification must include the address where ODJFS should mail the notice to the attorney or representative of record. The mailing of notice to the affected party's attorney or representative is not deemed to perfect service of the notice. Failure to mail a copy of the notice to the attorney or representative of record will not result in failure of otherwise perfected service upon the affected party. In those instances where an affected party is a corporation doing business in Ohio or is incorporated in Ohio, the mailing of notice to the corporation's statutory agent pursuant to sections **1701.07** and **1703.19** of the Revised Code will perfect service.

(3) When any notice of a revised debt summary report is sent by registered mail pursuant to this rule is returned because the affected party fails to claim the notice, ODJFS shall send the notice by ordinary mail to the affected party at the affected party's last known address and shall obtain a certificate of mailing. Service by ordinary mail is complete when the certificate of mailing is obtained unless the notice is returned showing failure of delivery.

(4) If any notice of a revised debt summary report sent by registered or ordinary mail is returned for failure of delivery, ODJFS shall make personal delivery of the notice by an employee or agent of ODJFS. An employee or agent of ODJFS may make personal delivery of the notice upon a party at any time.

(5) Refusal of delivery of a revised debt summary report by personal service or by mail is not failure of delivery and service is deemed to be complete at the time of personal refusal or at the time of receipt by ODJFS of the refused mail as demonstrated by the ODJFS time and date stamp. Failure of delivery occurs only when a mailed notice is returned by the postal authorities marked undeliverable, address or addressee unknown, or forwarding address unknown or expired.

(6) Any submission of additional information made as the result of notice of a revised debt summary report issued pursuant to paragraph (C) of this rule must be made in writing and mailed or delivered to the ODJFS office and address identified in the revised debt summary report within thirty calendar days of the following, as applicable:

(a) The time of mailing the notice if notice is given pursuant to paragraph (C)(1) of this rule;

(b) The date that service is complete if notice is given pursuant to paragraph (C)(3) or (C)(5) of this rule;

(c) The date of personal service.

(7) If a submission of additional information is mailed to the ODJFS office and address identified in the revised debt summary report, the request is deemed to have been made as follows:

(a) If the submission of additional information is mailed by certified mail, as of the date stamped by the U.S. postal service on its receipt form (PS form 3800 or any future equivalent postal service form).

(b) If the submission of additional information is mailed by regular U.S. mail, as of the date of the postmark appearing upon the envelope containing the request.

(c) If the submission of additional information is mailed by regular U.S. mail and the postmark is illegible or fails to appear on the envelope, as of the date of its receipt by ODJFS office identified in the revised debt summary report as evidenced by that office's time stamp.

(8) If a submission of additional information is made by facsimile transmission or by electronic mail to the office identified in the revised debt summary report, the submission is deemed to have been made as of the date of its receipt as evidenced by the receipt date generated by the facsimile transmission or the date of receipt shown in the source code of the electronic mail received by the office identified in the revised debt summary report.

(9) If a submission of additional information is mailed, personally delivered, made by facsimile transmission, or made by electronic mail to a party or address other than the proper office identified in the revised debt summary report, the request is deemed to have been made as of the date of its receipt by the office identified in the revised debt summary report as evidenced by that office's time stamp.

(10) If a submission of additional information is personally delivered to the office identified in the revised debt summary report, the request is deemed to have been made as of the date of its receipt as evidenced by that office's time stamp.

(11) All submissions of additional information must clearly identify both the affected party involved and the revised debt summary report that is being contested.

(D) Final debt summary report.

Rule **5101:6-50-03** of the Administrative Code shall apply if a party timely submits a request for review, and additional information in response to a revised debt summary report, and ODJFS issues a final debt summary report pursuant to section **5111.685** of the Revised Code. An adjudication on a final debt summary report shall be conducted only with respect to findings in the final debt summary report that pertain to an audit or alleged overpayment made under the medicaid program to the exiting operator. The adjudication shall be consolidated with any other uncompleted adjudication that concerns a matter addressed in the final debt summary report.

(E) Computation of time deadlines.

Section **1.14** of the Revised Code controls the computing of time deadlines imposed by this rule. The time within which an act is required by law to be completed is computed by excluding the first day and including the last day. When the last day falls on a Saturday, Sunday, or legal holiday, the act may be completed on the next succeeding day that is not a Saturday, Sunday, or legal holiday. When the last day to perform an act that is required by law is to be performed in a public office and that public office is closed to the public for the entire day, the act may be performed on the next succeeding day that is not a Saturday, Sunday, or legal holiday.

Effective: 01/10/2013

R.C. 119.032 review dates: 03/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.689

Rule Amplifies: 5111.68, 5111.685

Prior Effective Dates: 11/29/10, 3/19/12

5160-3-32.2 Successor Liability Agreements for Operators of Nursing Facilities (NFs)

Formerly **5101:3-3-32.2 Successor Liability Agreements for Operators of Nursing Facilities (NFs)**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: **November 29, 2010**

(A) Successor liability agreements entered into pursuant to section **5111.681** of the Revised Code are subject to approval by the Ohio department of job and family services (ODJFS).

(B) Successor liability agreements must be signed by the exiting operator, ODJFS, and the entity assuming liability pursuant to section **5111.681** of the Revised Code.

Effective: 01/10/2013

R.C. 119.032 review dates: 11/01/2015

CERTIFIED ELECTRONICALLY

Certification

12/21/2012

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.689

Rule Amplifies: 5111.681

Prior Effective Dates: 11/29/10

5160-3-39 Payment and Adjustment Process for Nursing Facilities (NFs)

Formerly **5101:3-3-39 Payment and Adjustment Process for Nursing Facilities (NFs)**

ICF-MRTL 12-04 / NFTL 12-04

Effective Date: January 10, 2013

Most Current Prior Effective Date: July 1, 2005

(A) Forms.

For dates of services preceding July 1, 2005, NFs shall submit the form "Nursing Facility Payment and Adjustment Authorization" (**JFS 09400**, rev. ~~12/2001~~10/2012) directly to the Ohio department of job and family services (ODJFS) for the reimbursement of services.

~~ICFs-MR shall submit the form "Nursing Facility Payment and Adjustment Authorization" (JFS 09400, rev. 12/2001) directly to the Ohio department of job and family services (ODJFS) for the reimbursement of services.~~

The county department of job and family services (CDJFS)~~,~~ and NFs~~, and ICFs-MR~~ shall use the "Facility/CDJFS Transmittal" (**JFS 09401**, rev. ~~5/2001~~4/2011) form to exchange information necessary to complete the billing process for payment.

(B) Notification of admission.

The facility shall notify the CDJFS using the **JFS 09401** form within five business days of admission of a new resident who is medicaid eligible or who has an application for medicaid that is pending even if care may initially be covered under a medicare benefit.

(C) Notification of death.

The NF ~~or ICF-MR~~ shall notify the CDJFS of the death of a medicaid resident by completing the **JFS 09401** and forwarding it to the CDJFS within five business days following the death of the resident. The CDJFS shall terminate medicaid eligibility within ten days after the receipt of the JFS 09401.

For dates of service preceding July 1, 2005, the CDJFS shall stop vendor payment within ten days after the receipt of the JFS 09401.

~~For dates of service commencing July 1, 2005 and after, the CDJFS shall stop the ICF-MR vendor payment within ten days after the receipt of the JFS 09401.~~

(1) The CDJFS shall complete and return the **JFS 09401**, when appropriate, to the NF ~~or ICF-MR~~ within ten days of the receipt of the JFS 09401 for any required payment adjustment.

(2) The NF ~~or ICF-MR~~ shall complete the **JFS 09400**, when appropriate (e.g., final payment adjustment), within thirty days of the receipt of the **JFS 09401** and submit it to the address listed on the bottom of form JFS 09400.

(D) Notification of discharge.

Discharge has the same meaning as defined in ~~rules 5101:3-3-59~~rule 5101:3-3-16.4 ~~and 5101:3-3-92~~ of the Administrative Code. The NF ~~or ICF-MR~~ shall notify the CDJFS within five business days of the discharge of a medicaid eligible resident by completing the JFS 09401 identifying the type of discharge, and forwarding the JFS 09401 to the CDJFS. The CDJFS shall adjust medicaid eligibility within ten days after the receipt of the JFS 09401.

For dates of service preceding July 1, 2005, the CDJFS shall stop vendor payment within ten days after the receipt of the JFS 09401.

~~For dates of service commencing July 1, 2005 and after, the CDJFS shall stop the ICF-MR vendor payment within ten days after the receipt of the JFS 09401.~~

(1) The CDJFS shall complete and return the JFS 09401, when appropriate, to the NF ~~or ICF-MR~~ within ten days after the receipt of the JFS 09401 for any required payment adjustment.

(2) The NF ~~or ICF-MR~~ shall complete the JFS 09400, when appropriate (e.g., final payment adjustment), within thirty days of the receipt of the JFS 09401 and submit to the address listed on the bottom of form JFS 09400.

(E) Notification of hospice enrollment.

If a NF resident on medicaid vendor payment elects to receive medicaid hospice services in accordance with rule **5101:3-56-03** of the Administrative Code, the NF shall notify the CDJFS by completing the **JFS 09401** and forwarding it to the CDJFS within five business days of receiving notice from the hospice agency that a resident elected hospice services. The CDJFS shall adjust medicaid eligibility within ten days after receipt of the JFS 09401 for the resident enrolled in hospice.

For dates of service preceding July 1, 2005, the CDJFS shall stop vendor payment within ten days after the receipt of the JFS 09401.

(1) The CDJFS shall complete and return the **JFS 09401**, when appropriate (e.g., final payment adjustment), to the NF within ten days of the receipt of the JFS 09401 for any required payment adjustment.

(2) The NF shall complete the **JFS 09400**, when appropriate, within thirty days of the receipt of the **JFS 09401** and submit it to the address on the bottom of form JFS 09400.

Effective: 01/10/2013

R.C. 119.032 review dates: 10/16/2012 and 01/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01

Prior Effective Dates: 12/1/94, 5/1/96, 7/1/97, 7/1/98, 9/1/02, 7/1/05

5160-3-39.1 Nursing Facilities (NFs): Claim Submission

NFTL 15-01

Effective Date: March 22, 2015

(A) Requirements for submitting claims for services not included in the NF per diem rate.

Notwithstanding the requirements set forth in paragraph (A)(2) of rule **5160-1-19** of the Administrative Code, NF providers shall submit medicare crossover claims and claims for medicaid reimbursement for allowable services that are not included in the NF per diem rate in accordance with the requirements set forth in rule 5160-1-19 of the Administrative Code.

(B) Requirements for submitting NF per diem claims.

(1) A NF provider submitting a claim for payment, either directly as a trading partner as defined in rule **5160-1-20** of the Administrative Code or through another trading partner, shall be a medicaid provider in an active enrollment status for all dates within the claim span and shall be eligible to provide nursing facility services for those dates.

(2) NF providers shall electronically submit claims for medicaid reimbursement, including adjustments, for services that are included in the NF per diem rate in one of the following formats:

(a) Electronic data interchange (EDI), in accordance with standards established under the health insurance portability and accountability act (HIPAA) (modified August 14, 2002), using the 837 health care claim institutional (837I) electronic format (2015), which is available on the National Uniform Billing Committee website at http://nubc.org/ subscriber/index.dhtml; or

(b) The medicaid information technology system (MITS) web portal.

(3) Claim submissions shall use the UB04 national uniform billing data specifications and shall be submitted in accordance with the correct national coding initiative and coding standards as set forth in the following guides and as described in **45 CFR 162.1000** and **45 CFR 162.1002** (October 1, 2014):

(a) Healthcare common procedure coding system;

(b) Current procedure terminology codebook; and

(c) International classification of diseases codebook.

(4) Trading partners who submit EDI claim transactions also shall follow the requirements set forth in paragraph (H) of rule **5160-1-19** of the Administrative Code.

(5) Claim submissions shall comply with the current version of the claim transaction requirements in this rule and as specified in the Ohio department of medicaid (ODM) 837I companion guide (May 12, 2014), which is available on the ODM website at http://medicaid.ohio.gov/PROVIDERS/ MITS/HIPAA5010Implementation .aspx.

(6) A single claim shall include days of service provided, including qualifying leave days, for a single individual within a single calendar month and shall not cross calendar months. If a provider determines that a claim that has been paid should have included additional per diem service days, the provider shall submit a timely adjustment claim correcting the entire calendar month's claim information.

(7) If a medicaid recipient in the NF has a patient liability obligation, the entire monthly amount of patient liability, as determined in accordance with Chapter **5160:1-3** of the Administrative Code, shall be reported by the NF on the recipient's monthly claim. If a recipient is admitted, discharged, transferred to another facility, or switched from medicare to medicaid mid-month, the entire monthly amount of patient liability shall still be reported on the claim for that month. The patient liability shall be applied as an offset against the amount medicaid would otherwise

reimburse for the claim. If the patient liability exceeds the amount medicaid would reimburse, the claim shall be processed with a payment of zero dollars.

(8) The treatment of lump sum payments and their disposition regarding medicaid eligibility are addressed in rule 5160:1-3-27.5 of the Administrative Code; however, if the county department of job and family services (CDJFS) and the recipient determine that the lump sum shall be assigned to the NF as payment for past per diem services received by the recipient, the NF provider shall do the following:

(a) Submit adjustment claims for as many prior months as are necessary to fully offset the amount of the lump sum payment that was assigned to the NF.

(b) If there are lump sum monies remaining after adjusting all prior payments, the NF provider shall apply the remaining lump sum balance to current and future claims. If the individual is discharged or passes away prior to exhausting the lump sum payment, the nursing facility shall return the balance to the individual or the individual's estate.

(9) Timely filing requirements.

(a) Original claim submission.

(i) A claim must be received by ODM within three hundred sixty-five days of the actual date the service was provided.

(ii) A claim received beyond three hundred sixty-five days of the actual date the service was provided will be denied except when the provisions of paragraph (B)(10) of this rule apply.

(iii) For purposes of this rule, the date of receipt will be determined by the date the claim is received in the web portal or the date the claim is recieved via EDI.

(b) Re-submission of a denied claim.

(i) A claim denied by ODM may be re-submitted for payment but the resubmission must be received by ODM no later than the later of the following dates:

(a) Three hundred sixty-five days from the actual date of service; or

(b) One hundred eighty days from the date the claim was denied, even if this date is beyond three hundred sixty-five days from the original date of service.

(ii) A re-submitted claim received beyond seven hundred thirty days from the actual date of service shall be denied.

(c) Adjustment to a previously paid claim, including a claim paid at zero dollars.

(i) When a provider identifies an underpaid claim, the provider shall submit an adjustment within one hundred eighty days of the date the underpaid claim was paid by ODM.

(ii) When a provider discovers it was overpaid on a claim, the provider shall submit an adjustment to ODM within sixty days of discovering the overpayment. ODM shall not accept a check from a provider in lieu of a claim adjustment in this situation.

(iii) If ODM identifies the need for a provider to adjust a claim, ODM shall notify the provider to make the adjustment. The provider shall make the adjustment within sixty days of notification. If the provider fails to make the adjustment, ODM shall either make the adjustment or void the claim as is appropriate for the fact pattern.

(iv) If within sixty days of the date ODM processes an adjustment, there are no outgoing payments for the provider against which the adjustment can be made, ODM shall issue an invoice to the provider for the resulting credit balance. The provider shall seek reconsideration or remit payment to ODM within sixty days of the date of the invoice. The provider shall include a copy of the invoice with the

payment. If the provider fails to include a copy of the invoice or remit full payment, the unpaid balance shall be certified to the Ohio attorney general for collection.

(d) A claim with prior payment by medicare or another insurance plan shall be submitted by the NF within one hundred eighty days from the date medicare or the insurance plan paid the claim to the NF.

(10) Exceptions to timely filing requirements.

(a) When submission of a claim is delayed due to the pendency of either an administrative hearing decision by ODJFS or an eligibility determination by a CDJFS, the claim must be received within one hundred eighty days from the date of the administrative hearing decision by the Ohio department of job and family services (ODJFS) or the eligibility determination by the CDJFS. The provider shall maintain all documentation supporting the information on the claim and shall produce the documentation upon request. In no case shall a delay in processing eligibility information under rule 5160:1-2-02 of the Administrative Code be a basis for denial of payment under this provision.

(b) When a claim cannot be submitted to ODM within three hundred sixty-five days of the actual date of service due to coordination of benefits delays with medicare and/or other third party payers, the claim must be received by ODM within one hundred eighty days from the date medicare or the other insurance plan paid the claim.

Effective: 03/22/2015

Five Year Review (FYR) Dates: 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5165.02

Rule Amplifies: 5165.47

Nursing Facilities (NFs): Placement Into Peer Groups

NFTL 15-01

Effective Date: March 22, 2015

Most Current Prior Effective Date: **July 1, 2006**

(A) NF peer groups shall be assigned according to sections ~~5111.231 and 5111.24~~**5165.16** and **5165.19** of the Revised Code based on the provider's geographical location and the number of licensed beds reported on the provider's annual cost report for the calendar year preceding the fiscal year for which the rate is established.

(1) For a provider new to the medicaid program, the Ohio department of ~~job and family services (ODJFS)~~medicaid (ODM) shall initially determine the number of beds in the facility from the number of licensed beds documented in the provider ~~agreement~~application as verified by the Ohio department of health (ODH). ~~ODJFS~~ODM shall subsequently determine the number of beds in the facility from the number of beds reported on the provider's annual cost report.

(2) In the case of a change of operator, the entering operator shall be assigned to the peer group that had previously been assigned to the exiting operator on the day immediately preceding the date on which the change of operator occurred. ~~ODJFS~~ODM shall subsequently determine the number of beds in the facility from the number of licensed beds reported on the entering provider's annual cost report.

(B) No adjustment will be made to the provider's placement in a peer group due to a change in bed size until the first day of the ~~next~~ fiscal year following the filing of an annual cost report that reflects the change.

Effective: 03/22/2015

Five Year Review (FYR) Dates: 12/08/2014 and 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5165.02

Rule Amplifies: 5165.16, 5165.17, 5165.19

Prior Effective Dates: 7/1/06

NFTL 14-05

Effective Date: November 6, 2014

Most Current Prior Effective Date: **January 31, 2014**

5160-3-42 - Appendix A, Chart of Accounts

(A) The Ohio department of medicaid (ODM) requires that all facilities file cost reports annually to comply with section **5165.10** of the Revised Code.

(1) The chart of accounts in table 1 to table 8 of **appendix A** to this rule is to establish the minimum level of detail to allow for cost report preparation.

(2) If the chart of accounts in appendix A to this rule is not used by the provider, it is the responsibility of the provider to relate its chart of accounts directly to the cost report.

(3) Where a chart of accounts number has sub-accounts that relate directly to a cost report line item, the provider shall capture the information requested so that the information will be broken out for cost reporting purposes.

(4) For example, when revenue accounts appear by payer type, it is required that those charges be reported by payer type where applicable; when salary accounts are differentiated between "supervisory" and "other", it is required that this level of detail be reported on the cost report where applicable.

(B) While the chart of accounts facilitates the level of detail necessary for medicaid cost reporting purposes, providers may find it desirable or necessary to maintain their records in a manner that allows for greater detail than is contained in the chart of accounts in appendix A to this rule.

(1) The chart of accounts in **appendix A** to this rule allows for a range of account numbers for a specified account.

(2) For example, account 1001 is listed for petty cash, with the next account, cash, beginning at account 1010. Therefore, a provider could delineate sub-accounts 1010-1, 1010-2, 1010-3, 1010-4, to 1010-9 as separate cash accounts. Providers need only use the sub-accounts applicable for their facility.

(C) Within the expense section (tables 5, 6, and 7), accounts identified as "salary" accounts are only to be used to report wages for facility employees.

(1) Wages are to include wages for sick pay, vacation pay and other paid time off, as well as any other compensation to be paid to the employee.

(2) Expense accounts identified as "contract" accounts are only to be used for reporting the costs incurred for services performed by contracted personnel employed by the facility to do a service that would otherwise be performed by personnel on the facility's payroll.

(3) Expense accounts identified as "purchased nursing services" are only to be used for reporting the costs incurred for personnel acquired through a nursing pool agency.

(4) Expense accounts designated as "other" can be used for reporting any appropriate nonwage expenses, including contract services and supplies.

(D) Completion of the cost report as required by section ~~5111.26~~**5165.10** of the Revised Code will require that the number of hours paid be reported (depending on facility type of control, on an accrual or cash basis) for all salary expense accounts. Providers' record keeping should include accumulating hours paid consistent with the salary accounts included within the chart of accounts in **appendix A** to this rule.

Effective: 11/06/2014

Five Year Review (FYR) Dates: 08/20/2014 and 11/06/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 10/27/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5165.01, 5165.10, 5165.1010, 5165.34, 5165.47

Prior Effective Dates: 3/29/85, 8/18/87, 1/20/90 (Emer.), 3/22/90, 10/1/91 (Emer.), 12/20/91, 7/1/93 (Emer.), 9/30/93 (Emer.), 12/30/93, 3/18/94, 12/28/95, 3/20/97 (Emer.), 5/22/97, 3/31/98 (Emer.), 4/27/98, 12/28/00, 9/30/01, 9/30/02, 7/1/05, 2/13/06, 12/31/06, 2/15/10, 1/20/12, 1/31/14

5160-3-42.1 Nursing Facilities (NFs): Medicaid Cost Report

NFTL 14-01

Effective Date: January 31, 2014

Most Current Prior Effective Date: **January 20, 2012**

The NF medicaid cost report must be filed in accordance with the requirements set forth in rules **5160-3-20** and **5160-3-42** of the Administrative Code using software that is available on the Ohio department of medicaid (ODM) website at least sixty days before the due date of the cost report for each cost reporting period.

Replaces: 5160-3-42.1

Effective: 01/31/2014

R.C. 119.032 review dates: 01/31/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 01/21/2014

Promulgated Under: 119.03

Statutory Authority: 5165.02

Rule Amplifies: 5165.01, 5165.10, 5165.1010, 5165.34, 5165.47

Prior Effective Dates: 12/30/77, 8/3/79, 7/1/80, 1/19/84, 3/29/85, 12/31/87 (Emer.), 3/30/88, 7/1/88, 12/20/88 (Emer.), 3/18/89, 12/28/89 (Emer.), 3/22/90, 10/1/90 (Emer.), 12/31/90, 10/1/91 (Emer.), 12/20/91, 12/30/91 (Emer.), 3/19/92, 6/30/92, 12/1/92, 6/26/93, 12/30/93 (Emer.), 5/22/97, 3/31/98 (Emer.), 4/27/98, 12/17/98, 9/12/03, 7/1/05, 2/13/06, 12/31/06, 2/15/10, 1/20/12

NFTL 15-01

Effective Date: March 22, 2015

Most Current Prior Effective Date: **February 9, 2006**

(A) A per diem for depreciation on buildings, components, and equipment used in the provision of patient care that are not reimbursable by medicaid directly to the medical equipment supplier, in accordance with rule ~~5101:3-3-19~~**5160-3-19** of the Administrative Code is an allowable cost.

(B) For purposes of determining if an expenditure should be capitalized, NF providers are to refer to the centers for medicare and medicaid services (CMS) publication 15-1, Chapter 1 entitled "Depreciation," (December 15, 2011), available on the internet at http://www.cms.gov/, and shall use the following guidelines ~~are utilized~~:

(1) Any expenditure for an item that costs five ~~hundred~~thousand dollars or more and has a useful life of two or more years per item must be capitalized and depreciated over the asset's useful life.

(2) A provider may use a capitalization policy less than five ~~hundred~~ thousand dollars per item, but is required to obtain prior approval from the Ohio department of ~~job and family services (ODJFS)~~medicaid (ODM) if the provider wishes to change its capitalization policy from its initial capitalization policy.

(C) In accordance with Chapter 1 of CMS publication 15-1, ~~All~~all capital assets shall be depreciated using the straight-line method of depreciation and salvage value shall be used to adjust capital asset values when calculating depreciation.

(D) For purposes of determining the useful life of a capital asset, ~~NFs~~NF providers shall use the guidelines in the revised 2013 edition of the american hospital association (AHA) publication entitled "Estimated Useful Lives of Depreciable Hospital Asssets," which is available on the internet at http://www.aha.org/,~~table as set forth in appendix A of this rule~~ or ~~a~~ different useful life guidelines if approved by ~~ODJFS~~ODM. If a capital asset is not reflected ~~on the table as set forth in appendix A of this rule~~in "Estimated Useful Lives of Depreciable Hospital Assets," ~~, the~~ internal revenue service (IRS) publication 946 "How to Depreciate Property" ~~(rev. 2004)~~ (rev. 2013), available on the internet at http://www.irs.gov/, shall be used for purposes of determining the useful life of that capital asset.

(E) For newly acquired assets in the month that a capital asset is placed into service, no depreciation expense is recognized as an allowable expense. A full month's depreciation expense is recognized in the month following the month the asset is placed into service.

(F) The disposal of assets shall be accounted for as follows:

(1) For assets not acquired through a change in ownership, in the month that the capital asset is disposed, if the capital asset is not fully depreciated, the allowable depreciation expense is the historical cost of the asset less the accumulated depreciation of the asset. At no time shall an asset be depreciated more than its adjusted basis; or

(2) For assets acquired through a change in ownership, there shall be no recognition of the disposal of individual assets. At the time of a subsequent change of ownership the disposal of all assets acquired through a change of ownership shall be recognized.

(G) Providers shall maintain the following property records:

(1) For assets not acquired through a change in ownership, detailed depreciation schedules listing each asset required; or

(2) For assets acquired through a change in ownership:

(a) Depreciation schedules on a lump sum basis for land, building, and equipment; and

(b) A list of all assets disposed after the change in ownership with the applicable dates of disposal.

Effective: 03/22/2015

Five Year Review (FYR) Dates: 12/08/2014 and 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5165.02

Rule Amplifies: 5165.17

Prior Effective Dates: 9/30/93, 7/4/02, 2/9/06

5160-3-42.4 Nursing Facilities (NFs): Nonreimbursable Costs

Formerly **5101:3-3-42.4 Nursing Facilities (NFs): Nonreimbursable Costs**

NFTL 12-02

Effective Date: March 19, 2012

Most Current Prior Effective Date: **February 15, 2010**

The following costs are not reimbursable to NFs through the NF per diem, except as specified under Chapter **5101:3-3** of the Administrative Code. Nonreimbursable costs include but are not limited to:

(A) Fines or penalties paid under sections **5111.271**, **5111.28**, **5111.35** to **5111.62**, and **5111.99** of the Revised Code.

(B) Disallowances made during the audit of the NF's cost report which are sanctioned through adjudication in accordance with **Chapter 119**. of the Revised Code.

(C) Costs which exceed prudent buyer tests of reasonableness which may be applied pursuant to the provisions of the provider reimbursement manual (centers for medicare and medicaid services (CMS) Publication 15-1, www.cms.hhs.gov/manuals), during the audit of the NF's cost report.

(D) ~~The costs of physical, occupational, and speech therapies provided by appropriately licensed therapists or therapy assistants. The cost of services provided by an appropriately licensed audiologist. These costs are non-reimbursable only through July 31, 2009. Beginning August 1, 2009 these costs are reimbursable through the NF per diem in the direct care cost center. This does not apply to maintenance therapies provided by nursing staff.~~

~~(E)~~(D) The costs of ancillary services rendered to NF residents by providers who bill medicaid directly. Ancillary services include but are not limited to: physicians, legend drugs, radiology, and laboratory. ~~The costs of oxygen (other than emergency stand-by oxygen) and custom wheelchairs are non-reimbursable costs through July 31, 2009. Beginning August 1, 2009 and forward report oxygen other than emergency stand-by oxygen in account number 6322 and report all custom wheelchairs and the related repairs in account number 7735.~~

~~(F)~~(E) Cost per case-mix units in excess of the applicable peer group ceiling for direct care cost.

~~(G)~~(F) Expenses in excess of the capital costs limitations.

~~(H)~~(G) Expenses associated with lawsuits filed against the Ohio department of job and family services (ODJFS) which are not upheld by the courts.

~~(I)~~(H) Cost of meals sold to visitors or public (i.e., meals on wheels).

~~(J)~~(I) Cost of supplies or services sold to nonfacility residents or public.

~~(K)~~(J) Cost of operating a gift shop.

Effective: 03/19/2012

R.C. 119.032 review dates: 12/15/2011 and 03/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 03/09/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.26, 5111.262

Rule Amplifies: 5111.20, 5111.26, 5111.262, 5111.271

Prior Effective Dates: 12/30/77, 8/3/79, 7/1/80, 1/1/84, 7/1/88 (Emer.), 9/25/88, 12/30/88 (Emer.), 3/31/89 (Emer.), 6/18/89, 10/1/89, 12/20/91, 9/30/93 (Emer.), 1/1/94, 12/17/98, 9/12/03, 2/9/06, 2/15/10

5160-3-43.1 Nursing Facility (NF) Case Mix Assessment Instrument: Minimum Data Set Version 3.0 (MDS 3.0)

Formerly **5101:3-3-43.1 Nursing Facility (NF) Case Mix Assessment Instrument: Minimum Data Set Version 3.0 (MDS 3.0)**

NFTL 10-03

Effective Date: October 1, 2010

Most Current Prior Effective Date: **October 1, 2006**

5101:3-3-43.1 - Appendix A

5101:3-3-43.1 - Appendix B

5101:3-3-43.1 - Appendix C

5101:3-3-43.1 - Appendix D

5101:3-3-43.1 - Appendix E

(A) As used in this rule:

(1) "Annual facility average case mix score" is the score used to calculate the facility's cost per case-mix unit.

(2) "Assessment reference date (ARD)" is the last day of the observation (or "look back") period that the MDS 3.0 assessment covers for the resident.

(3) "Care area assessment (CAA) process" is the mechanism to facilitate care planning decisions and includes care area triggers (CATs), assessment of a triggered care area to facilitate care planning decision making and completion of the CAA summary (on the MDS 3.0, section V, item V0200) titled CAAs and care planning.

(4) "Case mix report" is a report generated by the Ohio department of job and family services (ODJFS) and distributed to the provider on the status of all MDS 3.0 assessment data that pertains to the calculation of a quarterly, semiannual or annual facility average case mix score.

(5) "Comprehensive assessment" means an assessment that includes completion of not only the appropriate MDS 3.0 assessment type listed in paragraph (B)(2) of this rule and designated for use in Ohio but also completion of the CAA process.

(6) "Critical elements" are data items from a resident's MDS 3.0 that ODJFS verifies prior to determining a resident's resource utilization group, version III (RUG III) class.

(7) "Critical errors" are errors in the MDS 3.0 critical elements that prevent ODJFS from determining the resident's RUG III classification.

(8) "Default group" is RUG III group forty-five, the case mix group assigned to residents with MDS 3.0 records with inconsistent date fields, missing, incomplete, out of range or inaccurate data, including inaccurate resident identifiers any of which precludes grouping the record into RUG III groups one through forty-four.

(9) "Encoded," when used with reference to a record, means that the record has been recorded in electronic format. The record must be encoded in accordance with the United States centers for medicare and medicaid services (CMS) uniform data submission document and state specifications.

(10) "Filing date" is the deadline for submission of the NF's MDS 3.0 assessment data that will be used to calculate the preliminary facility quarterly average case mix score. The filing date is the fifteenth calendar day following the reporting period end date (RPED).

(11) "Medicare required assessment" means the MDS 3.0 specified for use in Ohio that is required only for facilities participating in the medicare prospective payment system but does not include the CAA process.

(12) "Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)" is the statutory authority for the RAI which specifies the minimum data set (MDS) of core elements for use in conducting assessments of nursing home residents. Assessments are federally mandated and must be performed for all residents of medicare and/or medicaid certified nursing homes.

(13) "Other medicare required assessment (OMRA)" is an unscheduled MDS 3.0 PPS assessment required to be completed during a resident's medicare "Part A" SNF covered stay based on the start or cessation of rehabilitation services.

(14) "PPS assessment" is the tool that skilled nursing facilities (SNFs) use to assess the clinical condition for each medicare resident receiving "Part A" SNF level care for reimbursement under the SNF PPS.

(15) "Quarterly facility average total case mix score" is the facility average case mix score based on both medicaid and non-medicaid resident data submitted for one reporting quarter and calculated pursuant to paragraph (B)(1) of rule 5101:3-3-43.3 of the Administrative Code.

(16) "Quarterly facility average medicaid case mix score" is the facility average case mix score based on only medicaid resident data submitted for one reporting quarter and calculated pursuant to paragraph (B)(2) of rule 5101:3-3-43.3 of the Administrative Code.

(17) "Quarterly review assessment" means an assessment that is normally conducted no less than once every three months using the MDS 3.0 designated for use in Ohio that does not include the CAA process.

(18) "Record" means a resident's encoded MDS 3.0 assessment as described in paragraphs (B)(1) to (B)(4) of this rule.

(19) "Relative resource weight" is the measure of the relative costliness of caring for residents in one case mix group versus another, indicating the relative amount and cost of staff time required on average for defined worker classifications to care for residents in a single case mix group. The methodology for calculating relative resource weights is described in paragraph (H) of rule 5101:3-3-43.2 of the Administrative Code.

(20) "Reporting period end date" (RPED) is the last day of each calendar quarter.

(21) "Reporting quarter" is the calendar quarter in which the MDS 3.0 is completed, as indicated by the assessment reference date in MDS 3.0 section A, item A2300, except as specified in paragraphs (C)(7) and (C)(8) of this rule.

(22) "Resident Assessment Instrument (RAI)" is the instrument used by NFs in Ohio to comply with 42 C.F.R. 483.20 (effective 8/11/09 http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?sid=2e0cc442b567f836691e8d460522a8a3 & c=ecfr&tpl=/ecfrbrowse/Title42/42tab_02.tpl) and provides a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities and identifies medical problems. The Ohio specified and federally approved instrument is composed of the MDS 3.0, and CAA process.

(23) "Resident case mix score" is the relative resource weight for the RUG III group to which the resident is assigned based on data elements from the resident's MDS 3.0 assessment.

(24) "Resident identifier code" is an alternative resident identifier if the resident does not have a social security number. The resident identifier code shall be reported in MDS 3.0 item S0150. The following method must be used to construct the identifier code. In the first three boxes, enter the first three letters of the resident's last name. In the next six boxes, enter the six digits of the resident's date of birth. Omit the century in the birth date.

(25) "RUG III" is the resource utilization groups, version III system of classifying NF residents into case mix groups described in paragraph (B) of rule 5101:3-3-43.2 of the Administrative Code. Resource utilization groups are clusters of NF residents, defined by resident characteristics, that correlate with resource use.

(26) "Semiannual facility average medicaid case mix score" is the average of a facility's two quarterly facility average medicaid case mix scores. It is used to establish the direct care rate and is calculated pursuant to paragraph (E) of rule 5101:3-3-43.3 of the Administrative Code.

(B) For the purpose of assigning a RUG III classification determining medicaid payment rates for NFs, ODJFS shall utilize the data from the MDS 3.0 as specified by the state and approved by CMS. Each NF shall assess all residents of medicaid-certified beds using the appropriate MDS 3.0 for assessment reference dates (ARDs) on or after October 1, 2010 as set forth in appendix A to this rule for a comprehensive assessment, or appendix D to this rule for a quarterly assessment, or appendix E to this rule for a PPS assessment. When the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) assessment (admission assessment, annual assessment, quarterly assessment, or significant change in status or a significant correction to a prior assessment) and medicare assessment time frames coincide, one assessment shall be used to satisfy both assessments. Admission assessments must be combined with either the medicare five day or medicare fourteen day assessment. For a resident who is not a new admission to the facility, the quarterly, the annual, and significant change in status assessments must be combined with any medicare assessment if the assessment reference date (ARD) is within the assigned medicare observation period. When combining the OBRA and medicare assessments, the most stringent requirement for MDS completion must be met. ODJFS may not utilize the data in the other medicare required assessments (OMRAs) for calculating case mix scores or determining medicaid payment rates.

(1) Comprehensive assessments, medicare-required assessments, quarterly review assessments and significant corrections of quarterly assessments must be conducted in accordance with the requirements and frequency schedule found at 42 C.F.R. 483.20.

(2) For a comprehensive assessment, NFs must use the Ohio specified MDS 3.0, including section S. The comprehensive assessment, as set forth in appendix A to this rule is completed upon admission, annually, and when a significant change in the resident's status has occurred or a significant correction to a prior comprehensive assessment is required. NFs must use the Ohio specified nursing home quarterly MDS 3.0 as set forth in appendix D to this rule including section S for the quarterly review assessment or a significant correction to a prior quarterly assessment. The nursing home PPS assessment (set forth in appendix E to this rule) must be used for all medicare required assessments.

(3) NFs must use the MDS 3.0 discharge item set as set forth in appendix B to this rule for any residents who transfer, or are discharged and the MDS 3.0 tracking record as set forth in appendix C to this rule for any residents entering or reentering or who died in the facility in accordance with 42 C.F.R. 483.20.

(4) NFs must use the MDS correction request in section X of the MDS 3.0 for modification or inactivation of MDS records that have been accepted into the national MDS database.

(C) All NFs must submit to the national database encoded, accurate, and complete MDS 3.0 data for all residents of medicaid certified NF beds, regardless of pay source or anticipated length of stay.

(1) MDS 3.0 data completed in accordance with paragraphs (B)(1) to (B)(4) of this rule must be encoded in accordance with 42 C.F.R. 483.20, CMS' uniform data submission document, and state record layout specifications.

(2) MDS 3.0 data must be submitted in an electronic format and in accordance with the frequency schedule found in 42 C.F.R. 483.20. The data may be submitted at any time during the reporting quarter that is permitted by instructions issued by the state. Except as provided in paragraph (D) of this rule, all records used in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score must be submitted by the filing date.

(3) If a NF submits MDS 3.0 data needed for determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score after the forty-fifth day after the RPED, ODJFS may assign a quarterly facility average total case mix score as set forth in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility

average medicaid case mix score as set forth in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(4) MDS 3.0 data submitted by a provider that can not be timely extracted by ODJFS from the CMS data server may result in assignment of a quarterly facility average total case mix score as set forth in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as set forth in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(5) The annual, semiannual, and quarterly facility average total case mix score and quarterly facility average medicaid case mix score will be calculated using the MDS 3.0 record in effect on the RPED for:

(a) Residents who were admitted to the medicaid certified NF prior to the RPED and continue to be physically present in the NF on the RPED; and

(b) Residents who were admitted to the medicaid certified NF on the RPED; and

(c) Residents who were temporarily absent on the RPED but are considered residents and for whom a return is anticipated from hospital stays, visits with friends or relatives, or participation in therapeutic programs outside the facility.

(6) Records for residents who were permanently discharged from the NF, transferred to another NF, or expired prior to or on the RPED will not be used for determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score.

(7) For a resident admitted within fourteen days prior to the RPED, and whose initial assessment is not due until after the RPED, both of the following shall apply:

(a) The NF shall submit the appropriate initial assessment as specified in the "Long-Term Care Facility Resident Assessment Instrument User's Manual version 3.0" issued by CMS (May 2010 http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp) and in 42 C.F.R. 483.20.

(b) The initial assessment, if completed and submitted timely in accordance with paragraphs (C)(1) and (C)(2) of this rule, shall be used for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score in the quarter the resident entered the facility even if the assessment reference date is after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code.

(8) For a resident who had at least one MDS 3.0 assessment completed before being transferred to a hospital, who then reenters the NF within fourteen days prior to the RPED, and has experienced a significant change in status that requires a comprehensive assessment upon reentry, the following shall apply:

(a) The NF shall submit a significant change assessment within fourteen days of reentry, as indicated by the MDS 3.0 assessment reference date (MDS 3.0, item A2300).

(b) The significant change assessment shall be used for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score for the quarter in which the resident reentered the facility even if the assessment reference date is after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code.

(D) Corrections to MDS 2.0 data with an ARD on or before September 30, 2010 must be made in accordance with the requirements in the "CMS Revised Long Term Care Resident Assessment Instrument User's Manual version 2.0", and the "State Operations Manual" issued by CMS (http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none &filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1201984 &intNumPerPage=10). Corrections to

MDS 3.0 data with an ARD on or after October 1, 2010 must be made in accordance with the requirements in the "Long-Term Care Facility Resident Assessment Instrument User's Manual version 3.0", and the "State Operations Manual" issued by CMS (Rev.1, May 21, 2004 **http://www.cms.gov/Manuals/IOM/**).

(1) For use in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score, the facility must transmit the corrections to the national database no later than forty-five days after the RPED.

(2) For use in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score, all significant correction assessments must contain an assessment reference date within the reporting quarter.

(3) The provider shall submit an accurate, encoded MDS 2.0 record for an ARD on or before September 30, 2010, or an accurate, encoded MDS 3.0 record for an ARD on or after October 1, 2010 for each resident in a medicaid certified bed on the RPED.

(a) The provider shall transmit MDS assessments that were completed timely but omitted from the previous transmissions and ODJFS shall use the resident case mix scores from the assessments for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score, if the assessments are transmitted no later than forty-five days after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code. If the assessments are not transmitted within forty-five days after the RPED, ODJFS may assign a default group for those records.

(b) The provider shall notify ODJFS within forty-five days of the RPED of any records for residents in medicaid certified beds on the RPED that were not completed timely and were not transmitted to the national database. ODJFS may assign default scores to those records as described in paragraph (F) of rule 5101:3-3-43.2 of the Administrative Code.

(c) The provider has forty-five days after the RPED to transmit the appropriate discharge assessment to the national database, if more residents are determined as being in the facility on the RPED than the number of its medicaid certified beds. If the facility does not correct the error within forty-five days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(d) The provider shall notify ODJFS within forty-five days of the RPED of any residents who were reported to be residents of the facility on the RPED, but who had actually been discharged prior to the RPED. If the provider fails to correct the error within forty-five days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(e) The provider has forty-five days after the RPED to submit appropriate modifications or discharge assessments to rectify any discrepancy between the records selected for determining the quarterly facility average total case mix score and the facility census on the RPED. If the facility does not correct the error(s) within forty-five days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(4) If the provider's number of records assigned to the default group in accordance with paragraphs (D)(3)(a) and (D)(3)(b) of this rule is greater than ten per cent, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the

Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

Replaces: 5101:3-3-43.1

Effective:

R.C. 119.032 review dates:

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5160-3-43.2 Resource Utilization Groups, Version III (RUG III): the Nursing Facility Case Mix Payment System

Formerly **5101:3-3-43.2 Resource Utilization Groups, Version III (RUG III): the Nursing Facility Case Mix Payment System**

NFTL 10-03

Effective Date: October 1, 2010

Most Current Prior Effective Date: **July 1, 2006**

5101:3-3-43.2 - Appendix A

5101:3-3-43.2 - Appendix B

5101:3-3-43.2 - Appendix C

5101:3-3-43.2 - Appendix D

5101:3-3-43.2 - Appendix E

The Ohio department of job and family services (ODJFS) shall pay each eligible nursing facility (NF) provider a per resident per day rate for direct care costs established prospectively for each facility. The department shall establish each provider's rate for direct care costs semiannually. Each provider's rate for direct care costs shall be based on a case mix payment system.

(A) The Ohio medicaid case mix payment system for direct care contains the following core components:

(1) As set forth in rule 5101:3-3-43.1 of the Administrative Code, a uniform resident assessment instrument (the minimum data set version 3.0, (MDS 3.0) including section S) and as set forth in appendix A to this rule, a database which provides the core data elements that are used to group residents into case mix categories;

(2) A methodology for grouping residents into case mix groups in a way that is clinically meaningful and uses criteria that sufficiently differentiates one group from another, as outlined in paragraphs (B) to (F) of this rule;

(3) The identification of those specific costs within the direct care cost category which will be affected by changes in case mix, as described in paragraph (G) of this rule.

(4) A means of measuring the relative costliness of caring for residents in one group versus another, known as "relative resource weights", as described in paragraph (H) of this rule.

(B) The medicaid provider case mix payment system shall use the methodology for grouping residents known as RUG III developed through the United States centers for medicare and medicaid services (CMS) multistate nursing home case-mix and quality demonstration project and described in this rule. Residents in each RUG III group utilize similar quantities and patterns of resources. The RUG III categories are listed in descending order of hierarchy. Based on the items in the MDS 3.0, if a resident meets the criteria for placement in more than one group, the resident will be placed in a group within the highest major category of resident types according to the hierarchy unless the activities of daily living (ADL) index score is not met for placement within the highest major category of resident types. The RUG III classification system includes the following seven mutually exclusive major categories of resident types from which forty-four RUG III groups are classified:

(1) Extensive care, which includes three groups;

(2) Special rehabilitation, which includes five resident subtypes and fourteen groups;

(3) Special care, which includes three groups;

(4) Clinically complex, which includes six groups;

(5) Impaired cognition, which includes four groups;

(6) Behavior problems, which includes four groups; and

(7) Reduced physical functioning, which includes ten groups. Residents without any of the characteristics which result in assignment to the higher categories comprise the last resident type.

(C) The RUG III classification system defines the criteria that are used to assign residents into one of the seven major categories of resident types. These criteria are summarized in paragraph (D) of this rule. Assignment of a resident to one of the RUG III groups within the major category is then based upon either or both of the following additional dimensions described below: resident functionality as measured by an ADL index score outlined in paragraph (C)(1) of this rule and additional problems or services required, outlined in paragraphs (C)(2) and (C)(3) of this rule.

(1) With the exception of the extensive care category, each group within a major category of resident types is identified by an ADL index score, which is computed using a special scoring technique. The ADL index score is based on four ADL variables (bed mobility, toileting, transfer and eating) and is calculated by assigning a score for the resident on each ADL variable and summing the scores. A resident's ADL index score may range from four to eighteen.

(a) The ADL scores for bed mobility, toileting, and transfer are as follows:

(i) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with a "-" for unknown, "0" for independent, "1" for supervision, or "7" for activity occurred only once or twice are assigned an ADL score of one for each ADL activity.

(ii) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with "2" for limited assistance are assigned an ADL score of three in each ADL activity.

(iii) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with "3" for extensive assistance, "4" for total dependence or "8" for "activity did not occur during entire 7 days" are assigned an ADL score of four in each ADL activity if they are coded on MDS 3.0 item (G0110A2), (G0110B2), or (G0110I2), respectively, as "-" for unknown, "0" for no set up or physical help from staff, "1" for setup help only, or "2" for "one person physical assist".

(iv) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with "3" for "extensive assistance," "4" for "total dependence," or "8" for "activity did not occur during entire 7 days" are assigned an ADL score of five in each ADL activity if they are coded on ADL support provided item (G0110A2), (G0110B2), or (G0110I2), respectively, as "3" for "two+ persons physical assist" or "8" for "ADL activity itself did not occur during entire period".

(b) The ADL score for eating is as follows:

(i) On the MDS 3.0 at section G: functional status, ADL self performance, item (G0110H1), residents coded with a "-" for unknown, "0" for independent, "1" for supervision, or "7" for activity occurred only once or twice are assigned an ADL score of one.

(ii) On the MDS 3.0 at section G: functional status, ADL self performance, item (G0110H1), residents coded with "2" for limited assistance are assigned an ADL score of two.

(iii) On the MDS 3.0 at section G: functional status, ADL self performance, item (G0110H1), residents coded with "3" for "extensive assistance", "4" for "total dependence" or "8" for "activity did not occur during entire 7 days" are assigned an ADL score of three. This score is also assigned if section K: swallowing/nutritional status, item (K0500A) for "parenteral/IV feeding" is checked. This score is also assigned if item (K0500B) for "feeding tube" is checked and if fifty-one per cent or

more of total calories are received through parenteral or tube feeding, item (K0700A) is coded "3", or twenty-six per cent to fifty per cent of total calories received through parenteral or tube feeding, item (K0700A) is coded "2", and fluid intake is five hundred one or more cubic centimeters (CCs) per day, item (K0700B) is coded "2".

(2) Symptoms of depression are used to determine groupings for those who qualify for the clinically complex category using the criteria outlined in paragraph (D)(6) of this rule.

(a) On the MDS 3.0 at section D: mood, "Should Resident Mood Interview be Conducted," item (D0100), for residents coding yes "1", the assessor will attempt to complete the interview. If the assessor is unable to complete the interview or if item D0100 is coded "0" no, the assessor will complete the "Staff Assessment of Resident Mood" (PHQ-9-OV©), item (D0500).

(b) The resident is assessed with symptoms of depression if a total severity score is greater than or equal to ten but not ninety-nine coded on the MDS 3.0 at section D: mood, total severity score, item (D0300).

(c) The total severity score is the sum of the frequency of the following symptoms on the MDS 3.0 section D: mood, resident mood interview (PHQ-9©), item (D0200):

(i) Little interest or pleasure in doing things (on MDS 3.0 at section D: mood, item (D0200A2)).

(ii) Feeling down, depressed, or hopeless (on MDS 3.0 at section D: mood, item (D0200B2)).

(iii) Trouble falling or staying asleep, or sleeping too much (on MDS 3.0 at section D: mood, item (D0200C2)).

(iv) Feeling tired or having little energy (on MDS 3.0 at section D: mood, item (D0200D2)).

(v) Poor appetite or overeating (on MDS 3.0 at section D: mood, item (D0200E2)).

(vi) Feeling bad about yourself-or that you are a failure or have let yourself or your family down (on MDS 3.0 at section D: mood, item (D0200F2)).

(vii) Trouble concentrating on things, such as reading the newspaper or watching television (on MDS 3.0 at section D: mood, item (D0200G2)).

(viii) Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual (on MDS 3.0 at section D: mood, item (D0200H2)).

(ix) Thoughts that you would be better off dead, or of hurting yourself in some way (on MDS 3.0 at section D: mood, item (D0200I2)).

(d) If the "Resident Mood Interview" (PHQ-9©) is not successfully completed, the staff assessment of resident mood (PHQ-9-OV©) on the MDS 3.0 section D: mood, item (D0500) is used to determine grouping for those who qualify for the clinically complex resource utilization group using the criteria outlined in paragraph (D)(6) of this rule.

(e) The resident is assessed with symptoms of depression if a total severity score is greater than or equal to ten coded (on the MDS 3.0 at section D: mood, item (D0600)). The total severity score is the sum of the frequency of the following symptoms:

(i) Little interest or pleasure in doing things (on the MDS 3.0 section D: mood, item (D0500A2)).

(ii) Feeling or appearing down, depressed, or hopeless (on the MDS 3.0 section D: mood, item (D0500B2)).

(iii) Trouble falling or staying asleep, or sleeping too much (on the MDS 3.0 section D: mood, item (D0500C2)).

(iv) Feeling tired or having little energy (on the MDS 3.0 section D: mood, item (D0500D2)).

(v) Poor appetite or overeating (on the MDS 3.0 section D: mood, item (D0500E2)).

(vi) Indicating that s/he feels bad about self, is a failure, or has let self or family down (on the MDS 3.0 section D: mood, item (D0500F2)).

(vii) Trouble concentrating on things, such as reading the newspaper or watching television (on the MDS 3.0 section D: mood, item (D0500G2)).

(viii) Moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that s/he has been moving around a lot more than usual (on the MDS 3.0 section D: mood, item (D0500H2)).

(ix) States that life isn't worth living, wishes for death, or attempts to harm self (on the MDS 3.0 section D: mood, item (D0500I2)).

(x) Being short-tempered, easily annoyed (on the MDS 3.0 section D: mood, item (D0500J2)).

(3) Restorative nursing programs, current toileting program or trial, and/or bowel toileting program are used to determine grouping within three categories of resident types which are impaired cognition, behavior problems, and reduced physical function and in classifying residents into the low intensity resident subtype of the rehabilitation category.

(a) Two or more of the following activities, each occurring within the timeframes described in paragraph (C)(3)(b) of this rule places an individual in a higher resource use group within the impaired cognition, behavior problems, or reduced physical functioning categories and in classifying residents into the low intensity resident subtype of the rehabilitation category:

(i) Passive range of motion and/or active range of motion (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500A) or (O0500B));

(ii) Splint or brace assistance (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500C));

(iii) Training and skill practice in any of the following:

(a) Walking and/or bed mobility (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500F) or (O0500D)),

(b) Transfer (on the MDS 3.0, at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500E)),

(c) Dressing and/or grooming (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500G)),

(d) Eating and/or swallowing (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500H)),

(e) Amputation/prostheses care (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500I)),

(f) Communication (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500J)),

(iv) Current toileting program or trial, and/or bowel toileting program (on the MDS 3.0 at section H: bladder and bowel, item (H0200C) or (H0500)). The current toileting program or trial at item (H0200C) must be managed four or more days of the seven day look back period.

(b) Each restorative nursing program must be performed at least six days a week for at least fifteen minutes a day to be counted. The current toileting program or trial at item (H0200C) must be managed four or more days of the seven day look back period.

(D) The RUG III criteria for classification into the seven major categories and the forty-four groups is listed below:

(1) The extensive care category includes residents who have a RUG III ADL index score of seven through eighteen and is determined by the two sets of qualifiers set forth in paragraphs (D)(1)(a) and (D)(1)(b) of this rule.

(a) The presence of extensive treatments received are the initial qualifiers for the extensive care category. The following clinical indicators are the initial qualifiers. If the initial qualifiers are met but the ADL index score is four, five or six the record shall be placed in the special care category SSA.

(i) Parenteral/IV feeding (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500A)),

(ii) Suctioning, including nasopharyngeal or tracheal aspiration (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100D1 "while NOT a resident") and/or (O0100D2 "while a resident")),

(iii) Tracheostomy care (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100E1 "while NOT a resident") and/or (O0100E2 "while a resident")),

(iv) Ventilator or respirator (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100F1 "while NOT a resident") and/or (O0100F2 "while a resident")), and

(v) IV medications (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100H1 "while NOT a resident") and/or (O0100H2 "while a resident")).

(b) Once the resident has qualified for the extensive care category, a secondary set of qualifiers determines the RUG III grouping. The qualifiers are:

(i) Parenteral/IV feeding (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500A)),

(ii) IV medications (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100H1 "while NOT a resident) and/or (O0100H2 "while a resident")),

(iii) Eligible for special care (as described in paragraph (D)(4) of this rule,

(iv) Eligible for clinically complex (as described in paragraph (D)(6) of this rule) or

(v) Eligible for impaired cognition (as described in paragraph (D)(8) of this rule.

(2) The extensive care category has three groups of residents who meet one or more of the secondary extensive qualifiers listed in paragraph (D)(1) of this rule:

(a) Class "SE3" residents are in RUG III group one and meet four or five of the secondary qualifiers.

(b) Class "SE2" residents are in RUG III group two and meet two or three of the secondary qualifiers.

(c) Class "SE1" residents are in RUG III group three and meet zero or one of the secondary qualifiers.

(3) The special rehabilitation category is split into five resident subtypes and has fourteen groups. Therapies refers to any combination of physical therapy, occupational therapy, or speech-language pathology and audiology services. On the MDS 3.0, at section O: special treatments, procedures, and programs, items (O0400A4), (O0400B4), and (O0400C4), the number of days each type of therapy is administered for fifteen minutes or more in the last seven calendar days is recorded. On the MDS 3.0, at section O: special treatments, procedures, and programs, items (O0400A1 through O0400A3), (O0400B1 through O0400B3), and (O0400C1 through O0400C3), the total number of minutes each type of therapy is provided for individual, concurrent, and group therapy in the last seven days is recorded.

(a) Ultra high intensity multidisciplinary rehabilitation is the first subtype for residents who receive:

(i) Seven hundred twenty minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least one type of therapy for five or more days per week and at least fifteen minutes per day; and

(iii) At least one type of therapy three or more days per week and at least fifteen minutes per day.

(b) The ultra high intensity rehabilitation subtype has three groups:

(i) Class "RUC" residents are in RUG III group four and have an ADL index score of sixteen to eighteen.

(ii) Class "RUB" residents are in RUG III group five and have an ADL index score of nine through fifteen.

(iii) Class "RUA" residents are in RUG III group six and have an ADL index score of four through eight.

(c) Very high intensity rehabilitation is the second subtype for residents who receive:

(i) Five hundred minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least one type of therapy for five or more days per week and at least fifteen minutes per day.

(d) The very high intensity rehabilitation subtype has three groups.

(i) Class "RVC" residents are in RUG III group seven and have an ADL index score of sixteen through eighteen.

(ii) Class "RVB" residents are in RUG III group eight and have an ADL index score of nine through fifteen.

(iii) Class "RVA" residents are in RUG III group nine and have an ADL index score of four through eight.

(e) High intensity rehabilitation is the third subtype for residents who receive:

(i) Three hundred twenty-five minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least one type of therapy for five or more days per week and at least fifteen minutes per day.

(f) The high intensity rehabilitation subtype has three groups.

(i) Class "RHC" residents in RUG III group ten have an ADL index score of thirteen through eighteen.

(ii) Class "RHB" residents in RUG III group eleven have an ADL index score of eight through twelve.

(iii) Class "RHA" residents in RUG III group twelve have an ADL index score of four through seven.

(g) Medium intensity rehabilitation is the fourth subtype for residents who receive:

(i) One hundred fifty minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least five days per week of any combination of rehabilitation therapy.

(h) The medium intensity rehabilitation subtype has three groups.

(i) Class "RMC" residents in RUG III group thirteen have an ADL index score of fifteen through eighteen.

(ii) Class "RMB" residents in RUG III group fourteen have an ADL index score of eight through fourteen.

(iii) Class "RMA" residents in RUG III group fifteen have an ADL index score of four through seven.

(i) Low intensity rehabilitation is the fifth subtype for residents who receive the following:

(i) Forty-five minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least three days per week of any combination of rehabilitation therapy; and

(iii) At least two types of restorative nursing programs each provided at least six days per week, current toileting program or trial managed for four or more days of the seven days, or bowel toileting program. Programs counted for the rehabilitation category are listed in paragraphs (C)(3)(a)(i) to (C)(3)(a)(iv) of this rule.

(j) The low intensity rehabilitation subtype has two groups.

(i) Class "RLB" residents in RUG III group sixteen have an ADL index score of fourteen through eighteen.

(ii) Class "RLA" residents in RUG III group seventeen have an ADL index score of four through thirteen.

(4) Except as set forth in paragraph (D)(4)(d) of this rule, the special care category includes residents who have a RUG III ADL index score of seven through eighteen and either:

(a) Have one or more of the following conditions:

(i) Cerebral palsy (on the MDS 3.0 at section I: active diagnoses, item (I4400)), with an ADL index score greater than or equal to ten;

(ii) Surgical wound(s) or open lesion(s) other than ulcers, rashes, cuts (on the MDS 3.0 at section M: skin conditions, item (M1040E) or (M1040D)) and surgical wound care (on the MDS 3.0 at section M: skin conditions, item (M1200F)) or application of nonsurgical dressings with or without topical medications other than to feet or application of ointments/medications other than to feet (on the MDS 3.0 section M: skin conditions, items (M1200G or M1200H));

(iii) Fever with vomiting, pneumonia, weight loss, dehydrated, or feeding tube with percent intake by artificial route qualifiers. On the MDS 3.0 at section J: health conditions, item (J1550A) is checked and at least one of the following: At section J: item (J1550B) is checked, or at section I: active diagnoses item (I2000) is checked, or at section K: weight loss, item (K0300) is scored "1" or "2", or at section J: health conditions item (J1550C) is checked or at section K: swallowing/nutritional status, item (K0500B) is checked and fifty-one per cent or

more of total calories are received through parenteral or tube feeding intake (item (K0700A) is coded "3") or twenty-six per cent to fifty per cent of total calories received through parenteral or tube feeding intake (item (K0700A) is coded "2") and fluid intake is five hundred one or more cubic centimeters (CCs) per day item (K0700B) is coded "2";

(iv) Multiple sclerosis (on the MDS 3.0 at section I: active diagnoses, item (I5200)) with an ADL index score greater than or equal to ten;

(v) Stage three or four pressure ulcer or unstageable pressure ulcer-slough and/or eschar (on the MDS 3.0 at section M: skin conditions, items (M0300C1), (M0300D1), or (M0300F1)) and two or more selected skin and ulcer treatments (on the MDS 3.0 at section M: skin conditions, items (M1200A), pressure reducing device for chair, or (M1200B) pressure reducing device for bed, (M1200C) turning/repositioning program, (M1200D) nutrition or hydration intervention to manage skin problems, (M1200E) ulcer care, (M1200G) application of nonsurgical dressings (with or without topical medications) other than to feet or (M1200H) application of ointments/medications other than to feet) or two or more ulcers of any type (on the MDS 3.0 at section M: skin conditions, item (M0300A), (M0300B1), (M0300C1), (M0300D1), (M0300F1), or (M1030) number of venous and arterial ulcers and two or more selected skin and ulcer treatments (on the MDS 3.0 at section M: skin conditions, item (M1200A), pressure reducing device for chair, or (M1200B) pressure reducing device for bed, (M1200C) turning/repositioning program, (M1200D) nutrition or hydration intervention to manage skin problems, (M1200E) ulcer care, (M1200G) application of nonsurgical dressings (with or without topical medications) other than to feet or (M1200H) application of ointments/medications other than to feet);

(vi) Quadriplegia (on the MDS 3.0 at section I: active diagnoses, item (I5100)), with an ADL index score greater than or equal to ten; or

(b) Receive one or more of the following types of special care:

(i) Seven days of respiratory therapy (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0400D2)),

(ii) Radiation treatment (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100B1 "while NOT a resident") and/or (O0100B2 "while a resident)), or

(iii) Feeding tube (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500B)) with parenteral or tube feeding intake (on the MDS 3.0 at section K: parenteral or tube feeding intake item (K0700A) is coded "3" or item (K0700A) is coded "2" and item (K0700B) is coded "2" and aphasia (on the MDS 3.0 section I, active diagnoses, item (I4300)).

(c) Meet the conditions for the extensive care category but have a RUG III ADL index score of four, five, or six.

(d) If the ADL index score is four, five or six the record shall be placed in the clinically complex category CA1.

(5) The special care category has three groups.

(a) Class "SSC" residents in RUG III group eighteen have an ADL index score of seventeen through eighteen.

(b) Class "SSB" residents in RUG III group nineteen have an ADL index score of fifteen through sixteen.

(c) Class "SSA" residents in RUG III group twenty have an ADL index score of seven through fourteen.

(6) The clinically complex category includes residents who have at least one of the following conditions or are receiving at least one of the following treatments:

(a) Burns (on the MDS 3.0 at section M; skin conditions, item (M1040F)),

(b) Comatose (on the MDS 3.0 at section B: hearing, speech, and vision, item (B0100) is scored "1", and at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), (G0110H1), and (G0110I1) are scored "4" for total dependence or "8" for activity did not occur during entire seven days).

(c) Diabetes mellitus (on the MDS 3.0 at section I: active diagnoses, item (I2900)) and injections on seven days (on the MDS 3.0 at section N: medications, item (N0300)) and physician order changes on two or more days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0700)).

(d) Dehydrated (on the MDS 3.0 at section J: health conditions, item (J1550C)),

(e) Hemiplegia or hemiparesis (on the MDS 3.0 at section I: active diagnoses, item (I4900)), with an ADL index score greater than or equal to ten,

(f) Internal bleeding (on the MDS 3.0 at section J: health conditions, item (J1550D)),

(g) Pneumonia (on the MDS 3.0 at section I: active diagnoses, item (I2000)),

(h) Infection of the foot, diabetic foot ulcer(s) or other open lesion(s) on the foot (on the MDS 3.0 at section M: skin conditions, items (M1040A), (M1040B) or (M1040C)) and application of dressings to feet (with or without topical medications) (on the MDS 3.0 at section M: skin conditions, item (M1200I)),

(i) Septicemia (on the MDS 3.0 at section I: active diagnoses, item (I2100)),

(j) Feeding tube (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500B)) and fifty-one per cent or more of total calories are received through parenteral or tube feeding intake, item (K0700A) is coded "3" or twenty-six per cent to fifty per cent of total calories received through parenteral or tube feeding, item (K0700A) is coded "2" and fluid intake is five hundred one or more cubic centimeters (CCs) per day, item (K0700B) is coded "2",

(k) Chemotherapy (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100A1 "while NOT a resident") and/or (O0100A2 "while a resident")),

(l) Dialysis (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100J1 "while NOT a resident") and/or (O0100J2 "while a resident")),

(m) Physician order changes on four or more days in the last fourteen days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0700)) and physician examinations of one or more days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0600) or physician order changes on two or more days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0700)) and physician examinations on two or more days (on the MDS 3.0 section O: special treatments, procedures, and programs, item (O0600)),

(n) Oxygen therapy (on the MDS at section O: special treatments, procedures, and programs, items (O0100C1 "while NOT a resident") and/or (O0100C2 "while a resident")),

(o) Transfusions (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100I1 "while NOT a resident") and/or (O0100I2 "while a resident")),

(p) Meet the conditions for the special care categories but have a RUG III ADL index score of four, five or six.

(7) The clinically complex category has six groups.

(a) Class "CC2" residents in RUG III group twenty-one have an ADL index score of seventeen through eighteen and have symptoms of depression as described in paragraph (C)(2) of this rule.

(b) Class "CC1" residents in RUG III group twenty-two have an ADL index score of seventeen through eighteen and do not have symptoms of depression as described in paragraph (C)(2) of this rule.

(c) Class "CB2" residents in RUG III group twenty-three have an ADL index score of twelve through sixteen and have symptoms of depression as described in paragraph (C)(2) of this rule.

(d) Class "CB1" residents in RUG III group twenty-four have an ADL index score of twelve through sixteen and do not have symptoms of depression as described in paragraph (C)(2) of this rule.

(e) Class "CA2" residents in RUG III group twenty-five have an ADL index score of four through eleven and have symptoms of depression as described in paragraph (C)(2) of this rule.

(f) Class "CA1" residents in RUG III group twenty-six have an ADL index score of four through eleven and do not have symptoms of depression as described in paragraph (C)(2) of this rule.

(8) The impaired cognition category includes residents with a RUG III ADL index score of four through ten, and a "Brief Interview for Mental Status" (BIMS) score less than or equal to nine or a cognitive performance scale of three through six. The BIMS score ranges from zero to fifteen and is based on resident responses to seven questions. On the MDS 3.0 at section C: cognitive patterns, "Should Brief Interview for Mental Status" be conducted, item (C0100), for residents coding yes "1", the assessor will attempt to complete the BIMS. If coded "0" no, the cognitive performance scale described in paragraph (D)(8)(b) of this rule is computed to determine impaired cognition.

(a) The BIMS is based on 3 qualifiers: repetition of three words, temporal orientation, and recall. The summation of the following qualifiers on the MDS 3.0 at section C: cognitive patterns, summary score, item (C0500) determine the BIMS score for the impaired cognition category:

(i) Repetition of three words (on the MDS 3.0 at section C: cognitive patterns, item (C0200)),

(ii) Able to report correct year (on the MDS 3.0 at section C: cognitive patterns, item (C0300A)),

(iii) Able to report correct month (on the MDS 3.0 at section C: cognitive patterns, item (C0300B)),

(iv) Able to report correct day of week (on the MDS 3.0 at section C: cognitive patterns, item (C0300C)),

(v) Able to recall "sock" (on the MDS 3.0 at section C: cognitive patterns, item (C0400A)),

(vi) Able to recall "blue" (on the MDS 3.0 at section C: cognitive patterns, item (C0400B)),

(vii) Able to recall "bed" (on the MDS 3.0 at section C: cognitive patterns, item (C0400C)).

(b) If the BIMS cannot be completed, the cognitive performance scale is computed to determine impaired cognition. The cognitive performance scale values range from zero to six and are based on three qualifiers: the presence or absence of coma, self-performance in eating and the summation of an impairment count and a severity count which

evaluates the resident using the MDS 3.0 variables. These three qualifiers, evaluated in the following manner, determine the resident's cognitive performance scale for the impaired cognition category:

(i) On the MDS 3.0 at section B: hearing, speech, and vision, item (B0100) residents coded with a "one" for comatose, section G: functional status-ADL self performance, items (G0110A1), (G0110B1), (G0110H1), and (G0110I1) are scored "4" for total dependence or "8" for activity did not occur during entire seven days, and in section C: cognitive patterns, cognitive skills for daily decision making item (C1000) is not coded "-", "0", "1" or "2", the cognitive performance scale is assigned a score of six.

(ii) On the MDS 3.0 at section C: cognitive patterns, cognitive skills for daily decision making item (C1000), residents coded with a "3" for severely impaired and section G: functional status, ADL self-performance, eating item (G0110H1), is coded "4" for total dependence or "8" for activity did not occur during entire seven days, the cognitive performance scale is assigned a score of six. If section G, eating item (G0110H1) is coded "-" for unknown, "0" for independent, "1" for supervision, "2" for limited assistance, or "3" for extensive assistance, the cognitive performance scale is assigned a score of five.

(iii) The summation of the impairment count and severity count are used in assigning values of one through four on the cognitive performance scale and are calculated as follows:

(a) The impairment count identifies deficits in three key cognitive areas and is determined by summing the scores for the following variables:

(i) Short term memory, on the MDS 3.0 at section C: cognitive patterns, item (C0700) residents coded "1" for a memory problem are assigned a score of one.

(ii) Cognitive skills for daily decision making, on the MDS 3.0 at section C: cognitive patterns, item (C1000), residents coded with a "1" for modified independence or "2" for moderately impaired are assigned a score of one.

(iii) Makes self understood, on the MDS 3.0 at section B: hearing, speech, and vision, item (B0700), residents coded "1" for usually understood, "2" for sometimes understood or "3" for rarely/never understood are assigned a score of one.

(b) The severity count identifies the deficit level of residents with moderate to severe impairment in cognitive skills for daily decision making (C1000) and in makes self understood (B0700). This count is determined by summing the scores for the following variables:

(i) On the MDS 3.0 at section C: cognitive patterns, cognitive skills for daily decision making, item (C1000), residents coded with a "2" for moderately impaired are assigned a score of one.

(ii) On the MDS 3.0 at section B: hearing, speech, and vision, makes self understood, item (B0700), residents coded with "2" for sometimes understood or "3" for rarely/never understood are assigned a score of one.

(c) If the total for the impairment count is two or three and the total for the severity count is two, the cognitive performance scale is assigned a score of four.

(d) If the total for the impairment count is two or three and the total for the severity count is one, the cognitive performance scale is assigned a score of three.

(e) If the total for the impairment count is two or three and the total of the severity count is zero, the cognitive performance scale is assigned a score of two. Residents would not qualify for the impaired cognition category.

(f) If the total of the impairment count is one, the cognitive performance scale is assigned a score of one. Residents would not qualify for the impaired cognition category.

(9) The impaired cognition category has four groups.

(a) Class "IB2" residents in RUG III group twenty-seven have an ADL index score of six through ten and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(b) Class "IB1" residents in RUG III group twenty-eight have an ADL index score of six through ten and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(c) Class "IA2" residents in RUG III group twenty-nine, have an ADL index score of four through five and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(d) Class "IA1" residents in RUG III group thirty have an ADL index score of four through five and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(10) The behavior problems category includes residents with a RUG III ADL index score of four through ten, and

(a) Have hallucinations and/or delusions (on the MDS 3.0 at section E: behavior, items (E0100A) or (E0100B)), or

(b) Problem displayed in any one of the following on four or more days per week:

(i) Wandering (on the MDS 3.0 at section E: behavior, item (E0900)), or

(ii) Verbal behavioral symptoms directed toward others (on the MDS 3.0 at section E: behavior, item (E0200B)), or

(iii) Physical behavioral symptoms directed toward others (on the MDS 3.0 at section E: behavior, item (E0200A)), or

(iv) Other behavioral symptoms not directed toward others (on the MDS 3.0 at section E: behavior, item (E0200C)), or

(v) Rejection of care (on the MDS 3.0 at section E: behavior, item (E0800)).

(11) The behavior problems category has four groups.

(a) Class "BB2" residents in RUG III group thirty-one have an ADL index score of six through ten and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(b) Class "BB1" residents in RUG III group thirty-two have an ADL index score of six through ten and receive only one or no restorative nursing programs six days or more per week,

current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(c) Class "BA2" residents in RUG III group thirty-three have an ADL index score of four through five and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(d) Class "BA1" residents in RUG III group thirty-four have an ADL index score of four through five and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(12) The reduced physical function category has ten groups and includes residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the impaired cognition or behavior problems categories but have a RUG III ADL index score of more than ten.

(a) Class "PE2" residents in RUG III group thirty-five have an ADL index score of sixteen through eighteen and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(b) Class "PE1" residents in RUG III group thirty-six have an ADL index score of sixteen through eighteen and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(c) Class "PD2" residents in RUG III group thirty-seven have an ADL index score of eleven through fifteen and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(d) Class "PD1" residents in RUG III group thirty-eight have an ADL index score of eleven through fifteen and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(e) Class "PC2" residents in RUG III group thirty-nine have an ADL index score of nine or ten and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(f) Class "PC1" residents in RUG III group forty have an ADL index score of nine or ten and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(g) Class "PB2" residents in RUG III group forty-one have an ADL index score of six through eight and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(h) Class "PB1" residents in RUG III group forty-two have an ADL index score of six through eight and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(i) Class "PA2" residents in RUG III group forty-three have an ADL index score of four or five and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(j) Class "PA1" residents in RUG III group forty-four have an ADL index score of four or five and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed four or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(E) A list of the MDS 3.0 data elements used to group residents in the RUG III classification system is set forth in appendix A to this rule. The ADL index scoring system is set forth in a table in appendix B to this rule. A description of classification branches in the RUG III system is summarized in the table set forth in appendix C to this rule. A graphic description of the RUG III classification system is set forth in appendix D to this rule.

(F) The RUG III classification system has forty-four different groups. All MDS 3.0 data elements related to the RUG III classification system must be completed before a resident can be classified. Residents whose MDS 3.0 forms contain missing or out-of-range responses to data elements used to determine the RUG III classification shall be assigned by default into a forty-fifth group. Corrections to MDS 3.0 data can be made only as described in paragraph (D) of rule 5101:3-3-43.1 of the Administrative Code.

(G) The relationship between resident characteristics and resource utilization, as measured by staff time for the registered nurses (RNs), licensed practical nurses (LPNs), and nurse aides (NAs) worker classifications, was analyzed for the RUG III system to identify characteristics which differentiate resource use among residents. Staff time and assessment data were collected by the federal multistate nursing home case-mix and quality demonstration project for the purpose of establishing common nursing staff times associated with all resident categories that are standard across residents, nursing staff, facilities, units and states. Resident specific and resident non-specific time for each worker classification (RN, LPN, and NA) was averaged for each of the forty-four RUG III groups.

(H) Each of the forty-four RUG III groups is assigned a relative resource weight. This weight indicates the relative amount of staff time required on average for all three worker classifications listed in paragraph (G) of this rule to deliver care to residents in that RUG III group.

(1) The relative resource weight is calculated as follows using the average minutes per worker classification per RUG III group provided by the United States department of health and human services, and three-year averages, beginning with calendar year 1989, of RN, LPN, and NA wages in Ohio medicaid certified NFs as reported to ODJFS.

(a) By setting the NA wage weight at one, wage weights for RNs and LPNs are calculated by dividing the NA wage into the RN or LPN wage.

(b) To calculate the total weighted minutes for each RUG III group, the wage weight for each worker classification is multiplied by the average number of minutes that classification of workers spends caring for a resident in the RUG III group and the products are summed.

(c) The RUG III group with the lowest total weighted minutes receives a relative resource weight of one. Relative resource weights are calculated by dividing the lowest group's total weighted minutes into each group's total weighted minutes. Weight calculations are rounded to the fourth decimal place.

(2) The lowest weight for the forty-four RUG III groups is used as the weight for the forty-fifth default group.

(3) Relative resource weights for the forty-five NF case-mix RUG III groups are set forth in appendix E to this rule.

(4) Except as provided in paragraph (H)(4)(b) of this rule, relative resource weights may be recalibrated using wage weights based on three-year statewide averages of RN, LPN, and NA wages in Ohio NFs as reported on the long term care facility medicaid cost report for NFs, and minutes per worker classification per RUG III group as follows:

(a) Upon receipt of revised worker classification minutes from the United States department of health and human services, ODJFS shall recalibrate the relative resource weights based on the revised minutes and the averages of RN, LPN, and NA wages from cost

report data from the most recent three calendar years, to be effective at the beginning of the next state fiscal year.

(b) ODJFS may recalibrate the relative resource weights at least once every ten years, using the most current worker classification minutes from the United States department of health and human services and the average worker classification wages, to be effective at the beginning of the next state fiscal year. When recalibrating the relative resource weights, as permitted by paragraph (H)(4)(b) of this rule ODJFS shall use cost report wage data from the most recent three calendar years available ninety days prior to the start of the fiscal year.

(c) ODJFS may recalibrate relative resource weights more frequently if significant variances in wage ratios between worker classifications occur.

(d) After recalibrating relative resource weights under paragraph (H)(4)(a), (H)(4)(b), or (H)(4)(c) of this rule, ODJFS shall use the recalibrated relative resource weights to calculate the semiannual NF case mix score effective for the start of the fiscal year and to recalculate the annual NF case mix score for the calendar year preceding the fiscal year.

Replaces: 5101:3-3-43.2

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5160-3-43.3 Calculation of Quarterly, Semiannual and Annual Nursing Facility (NF) Average Case Mix Scores

Formerly **5101:3-3-43.3 Calculation of Quarterly, Semiannual and Annual Nursing Facility (NF) Average Case Mix Scores**

NFTL 10-03

Effective Date: October 1, 2010

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(A) The definitions of all terms used in this rule are the same as set forth in rules 5101:3-3-01, 5101:3-3-43.1 and 5101:3-3-43.4 of the Administrative Code.

(B) The Ohio department of job and family services (ODJFS) shall process resident assessment data submitted by NFs in accordance with rule 5101:3-3-43.1 of the Administrative Code and shall classify residents using the resource utilization groups, version III (RUG III) classification system to determine resident case mix scores in accordance with rule 5101:3-3-43.2 of the Administrative Code. These resident case mix scores, based on relative resource weights as set forth in appendix E of rule 5101:3-3-43.2 of the Administrative Code, are used to establish two quarterly facility average case mix scores each quarter.

(1) The first quarterly facility average case mix score shall be calculated using all records selected for the quarter and shall be the quarterly facility average total case mix score.

(2) The second quarterly facility average case mix score shall be calculated using only the records selected for the quarter that ODJFS identifies as medicaid records and shall be the quarterly facility average medicaid case mix score.

(C) ODJFS shall calculate a quarterly facility average total case mix score for all providers meeting the following requirements:

(1) In accordance with rule 5101:3-3-43.1 of the Administrative Code, the provider submitted resident assessment information by the filing date, and the data included resident assessments for all residents in medicaid certified beds as of the reporting period end date, and

(a) The provider's resident assessment data submitted timely for that reporting quarter provided sufficient information for accurately classifying at least ninety per cent of all residents in medicaid certified beds into RUG III groups one through forty-four, or

(b) The provider's resident assessment data submitted timely and corrected timely, in accordance with the procedures outlined in rule 5101:3-3-43.1 of the Administrative Code for correcting incomplete or inaccurate information, for that reporting quarter, provided sufficient information for accurately classifying at least ninety per cent of all residents in medicaid certified beds into RUG III groups one through forty-four; and

(c) There were no errors as described in paragraph (D) of rule 5101:3-3-43.1 of the Administrative Code that prevented ODJFS from verifying the records to be used in determining the quarterly facility average total case mix score.

(d) The prospective payment system (PPS) other medicare required assessments (OMRAs) may not be selected for calculating case mix scores due to the inability to assign the record to a RUG III classification.

(2) The quarterly facility average total case mix score for providers that submitted their minimum data set version ~~2.0~~3.0 (MDS ~~2.0~~3.0) data in compliance with paragraph (C)(1) of this rule shall be calculated as follows:

(a) All resident case mix scores for the quarter, including resident case mix scores in the forty-fifth RUG III group, are added together; then

(b) The sum of resident case mix scores is divided by the total number of residents.

(3) If a provider does not comply with paragraph (C)(1) of this rule, ODJFS shall assign the NF a penalty score. The penalty score for the quarterly facility average total case mix score shall be a score that is five per cent less than the quarterly facility average total case mix score for the preceding calendar quarter.

(a) If the facility was subject to an exception review, in accordance with rule 5101:3-3-43.4 of the Administrative Code, for the preceding quarter, the assigned quarterly total 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 facility average total case mix score for the preceding calendar quarter, the assigned quarterly facility average total case mix score shall be the score that is five per cent less than the score assigned for the preceding quarter.

(D) ODJFS shall calculate a quarterly facility average medicaid case mix score for all providers meeting the following requirements:

(1) The provider's resident assessment data submitted timely for that reporting quarter provide sufficient information for classifying at least ninety per cent of records identified as medicaid records into RUG III groups one through forty-four, or

(a) The provider's resident assessment data submitted timely and corrected timely, in accordance with the procedure outlined in rule 5101:3-3-43.1 of the Administrative Code for correcting incomplete or inaccurate information, for that reporting quarter, provided sufficient information for accurately classifying at least ninety per cent of all residents into RUG III groups one through forty-four; and

(b) There were no errors as described in paragraph (D) of rule 5101:3-3-43.1 of the Administrative Code that prevented ODJFS from verifying the records to be used in determining the quarterly facility average medicaid case mix score.

(2) ODJFS shall identify a MDS ~~2.0~~3.0 as a medicaid record if the MDS ~~2.0~~3.0 meets the following requirements:

(a) The MDS ~~2.0~~3.0 is not completed to meet the requirements for a medicare part A stay.

(b) The social security number (SSN) on the MDS ~~2.0~~3.0 matches a SSN on the medicaid recipient master file (RMF) and

(c) The assessment reference date (ARD) on the MDS ~~2.0~~3.0 falls within the recipient's medicaid eligibility span.

(3) The quarterly facility average medicaid case mix score for providers that submitted their MDS ~~2.0~~3.0 data in compliance with paragraph (C)(1) of this rule shall be calculated as follows:

(a) Medicaid resident case mix scores for the quarter, including resident case mix scores in the forty-fifth RUG III group, are added together; then

(b) The sum of medicaid resident case mix scores is divided by the total number of medicaid residents.

(4) If a provider does not comply with paragraph (D)(1) of this rule, ODJFS ~~shall~~may assign the NF a penalty score. The penalty score for the quarterly facility average medicaid case mix score ~~shall~~may be a score that is five per cent less than the quarterly facility average medicaid case mix score for the preceding calendar quarter.

(a) If the facility was subject to an exception review, in accordance with rule 5101:3-3-43.4 of the Administrative Code, for the preceding quarter, the assigned quarterly facility average medicaid case mix score ~~shall~~may 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 facility average medicaid case mix score for the preceding calendar quarter, the assigned quarterly facility average medicaid case mix

score ~~shall~~may be the score that is five per cent less than the score assigned for the preceding quarter.

(5) ODJFS shall use a facility's assigned penalty score to calculate the semiannual facility average medicaid case mix score.

(E) This paragraph describes the method for calculating the semiannual facility average medicaid case mix score.

(1) The semiannual facility average medicaid case mix score for the payment period beginning the first day of July for a given fiscal year shall be the average of the quarterly facility average medicaid case mix score from the preceding December and March reporting quarters. If a facility does not have a quarterly facility average medicaid case mix score for both the December and March reporting quarters, the median annual average case mix score for the NF's peer group shall be assigned as the semiannual facility average medicaid case mix score to determine the direct care rate.

(2) The semiannual facility average medicaid case mix score for the payment period beginning the first day of January for a given fiscal year shall be the average of the quarterly facility average medicaid case mix score from the preceding June and September reporting quarters. If a facility does not have a quarterly facility average medicaid case mix score for both the June and September reporting quarters, the median annual average case mix score for the NF's peer group shall be assigned as the semiannual facility average medicaid case mix score to determine the direct care rate.

(F) ODJFS shall calculate the annual facility average case mix score as follows:

(1) The annual facility average case mix score shall be calculated only for facilities with at least two quarterly facility average total case mix scores meeting the requirements of paragraphs (C)(1) and (C)(2) of this rule. In addition for any score meeting the requirements of paragraphs (C)(1) and (C)(2) that was adjusted, the adjusted score will be substituted according to the following hierarchy:

(a) Adjusted quarterly facility average total case mix scores established by a rate reconsideration decision resulting from an exception review of resident assessment information conducted before the effective date of the rate; or

(b) Adjusted quarterly facility average total case mix scores as a result of exception review findings.

(2) If ODJFS assigned a facility a quarterly facility average total case mix score in accordance with paragraph (C)(3) of this rule, said assigned score will not be used to calculate the provider's annual facility average case mix score.

(3) The qualifying case mix scores shall be summed and divided by the total number of quarters of qualifying scores to arrive at the annual facility average case mix score.

(G) For each provider that submits MDS ~~2.0~~3.0 data in a given week, ODJFS shall send the "Case Mix Report" containing the following four components:

(1) The "Provider Detail Listing of Successfully Grouped Records," identifies records that were successfully grouped by ODJFS. The report will include all records received, even if the records will not be used in the quarterly score calculation;

(2) The "Critical Error Summary," that identifies the provider's records that will be assigned into the default group forty-five unless they are corrected before the end of the reporting quarter in accordance with rule 5101:3-3-43.1 of the Administrative Code.

(3) The "Provider Detail Listing of Records with Critical Errors," provides detail for each record listed on the "Critical Error Summary" identifying the failed edits.

(4) The "Discharge and Reentry Tracking Form Summary," that identifies all discharge assessments and reentry tracking forms that were received by ODJFS.

(H) ODJFS shall provide two preliminary "Calculation of Facility Case Mix Scores" reports. The first report will reflect records submitted up to the quarterly filing date. The second report will reflect records submitted up to approximately ~~three~~two weeks prior to the quarterly corrections deadline. Both reports will include a calculation of the quarterly facility average total case mix score and the quarterly facility average medicaid case mix score. Providers may file corrections to the extent permitted by rule 5101:3-3-43.1 of the Administrative Code.

(I) After the quarterly corrections deadline specified in rule 5101:3-3-43.1 of the Administrative Code, ODJFS shall provide a final "Calculation of Facility Case Mix Scores" report. The report will include a calculation of the quarterly facility average total case mix score and the quarterly facility average medicaid case mix score.

(J) Following the determination of the two quarterly facility average medicaid case mix scores used to calculate the semiannual medicaid case mix scores effective July first and January first of the fiscal year, ODJFS shall provide a "Semiannual Medicaid Case Mix Score Calculation Report" to each provider.

(K) Following the calculation of the annual facility average case mix score, ODJFS shall provide an "Annual Facility Average Case Mix Score Calculation Report" to each provider.

Effective:

R.C. 119.032 review dates: 07/14/2010

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.231, 5111.232

Prior Effective Dates: 4/15/93 (Emer.), 7/1/93, 7/1/94 (Emer.), 9/30/94, 4/20/95, 7/1/98, 1/1/03, 7/1/05, 2/13/06, 7/1/06

5160-3-43.4 Exception Review Process for Nursing Facilities (NFs)

Formerly **5101:3-3-43.4 Exception Review Process for Nursing Facilities (NFs)**

NFTL 10-03

Effective Date: October 1, 2010

Most Current Prior Effective Date: **April 1, 2007**

5101:3-3-43.4 - Appendix A

5101:3-3-43.4 - Appendix B

(A) The definitions of all terms not defined in this rule are the same as set forth in rules 5101:3-3-01 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) ~~2.0~~ 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 ~~2.0~~ 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 ~~2.0~~ 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 ~~rehabilitation/restorative care~~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 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 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 ~~2.0~~ 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 ~~2.0~~ 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 ~~2.0~~ assessments and new assessments following an inactivation, submitted by the facility after notification of the exception review.

(9) A "verifiable MDS ~~2.0~~ record" is a provider's completed MDS ~~2.0~~ assessment form, based on facility supplied MDS ~~2.0~~ 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 ~~2.0~~ record" is a provider's completed MDS ~~2.0~~ assessment form, based on facility supplied MDS ~~2.0~~ 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 ~~2.0~~ 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 ~~2.0~~ 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 ~~2.0~~, 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 ~~2.0~~ 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 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 ~~Facilities~~Services and Supports, ~~Case Mix~~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.

Effective:

R.C. 119.032 review dates: 07/14/2010

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.27

Prior Effective Dates: 10/1/94, 7/1/98, 7/1/02, 2/2/06, 7/1/06, 4/1/07

5160-3-57 Nursing Facilities (NFs): Tax Cost Add-On

Formerly **5101:3-3-57 Tax Cost Add-On for Nursing Facilities (NFs)**

NFTL 14-04

Effective Date: October 3, 2014

Most Current Prior Effective Date: **July 1, 2006**

(A) ~~ODJFS~~The Ohio department of medicaid (ODM) shall pay a provider a per resident per day rate for tax costs determined under section ~~5111.242~~**5165.21** of the Revised Code.

(B) If a provider does not have a cost report filed with ~~ODJFS~~ODM for the applicable calendar year used to determine the rate for tax costs under section ~~5111.242~~**5165.21** of the Revised Code, the NF provider shall be paid a rate for tax costs that is the median rate for tax costs for the facility's peer group determined in division (C) of section ~~5111.24~~**5165.16** of the Revised Code.

Effective: 10/03/2014

Five Year Review (FYR) Dates: 07/01/2014 and 10/03/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 09/23/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5165.21

Prior Effective Dates: 7/1/06

***Formerly* 5101:3-3-64 Nursing Facility Payment for Medicare Part A Cost Sharing**

ICF-MRTL 12-01 / NFTL 12-02

Effective Date: March 19, 2012

Most Current Prior Effective Date: July 1, 2005

(A) For nursing facility services the nursing facility provides on or after January 1, 2012, ~~purposes of this rule, the "medicaid maximum allowable amount"~~ "medicaid maximum allowable amount" means one hundred ~~nine~~ per cent of the nursing ~~facility's~~ facility's medicaid rate on the date that the service was provided.

(B) For qualified medicare beneficiaries (QMB) including QMB plus as defined in rule 5101:3-1-05.2 of the Administrative Code and medicaid consumers admitted to a nursing facility as a medicare part A benefit, the Ohio department of job and family services (ODJFS) will pay as cost sharing for nursing facility services the lesser of:

(1) The coinsurance amount as provided by the medicare part A plan; or

(2) The medicaid maximum allowable ~~reimbursement rate~~amount for the identified service or services minus the medicare part A plan's payment to a nursing facility for the same service or services. If the medicare part A plan's payment to a nursing facility for a service or services identified is greater than the medicaid maximum allowable amount, ODJFS will pay nothing for the same identified service or services.

(C) The medicaid provider is ultimately responsible for accurate and valid reporting of medicaid claims submitted for payment. Providers submitting medicare part A crossover claims to the medicaid program must be able to provide upon request documentation that supports that the information provided on the claim matches the information on the part A plan's remittance advice.

Effective: 03/19/2012

R.C. 119.032 review dates: 12/15/2011 and 03/01/2017

Certification: CERTIFIED ELECTRONICALLY

Date: 03/09/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.225

Prior Effective Dates: 7/1/05

5160-3-64.1 Nursing Facilities (NFs): Payment for Cost-Sharing Other Than Medicare Part A

Formerly **5101:3-3-64.1 Nursing Facility (NF) Payment for Cost-Sharing Other Than Medicare Part A**

NFTL 14-04

Effective Date: October 3, 2014

Most Current Prior Effective Date: **October 29, 2009**

(A) For medicaid eligible NF residents, the NF per diem rate includes medicaid payments for medicare or other third-party insurance cost-sharing, including coinsurance or deductible payments, associated with services that are included in the NF per diem.

(B) Neither the medicaid eligible NF resident nor the Ohio department of ~~job and family services (ODJFS)~~medicaid (ODM) is responsible for any medicare or other third-party insurance cost-sharing, including coinsurance or deductibles, associated with services that are included in the NF per diem.

Effective: 10/03/2014

Five Year Review (FYR) Dates: 07/01/2014 and 10/03/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 09/23/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5165.47

Prior Effective Dates: 7/31/09 (Emer.), 10/29/09

Nursing Facilities (NFs): Rates for Providers with an Initial Date of Certification On or After July 1, 2006

NFTL 15-01

Effective Date: March 22, 2015

Most Current Prior Effective Date: **July 1, 2006**

(A) The Ohio department of ~~job and family services (ODJFS)~~medicaid (ODM) shall determine the initial rate for the fiscal year in which the NF begins participation in the medicaid program for a NF with a first date of licensure and subsequent certification on or after July 1, 2006, including a NF that replaces one or more existing facilities, or a NF with a first date of licensure before that date that was initially certified for the medicaid program on or after that date under section ~~5111.254~~**5165.151** of the Revised Code.

(1) If the number of beds in the replacement facility is greater than the number of beds in the replaced facility, the case mix score shall be equal to the weighted average of the semiannual case mix score used for the replaced beds on the last day of service at the replaced facility and the median annual average case mix score for the NF's peer group for the additional beds.

(2) If a rate for direct care costs is determined under section ~~5111.254~~**5165.151** of the Revised Code for a NF using the median annual average case mix score for the NF's peer group, the rate shall be redetermined to reflect the NF's actual semiannual case mix score determined under section ~~5111.232~~**5165.192** of the Revised Code after the NF submits its first two quarterly assessment data that qualify for use under paragraph (E) of rule ~~5101:3-3-43.3~~**5160-3-43.3** of the Administrative Code. If the NF's quarterly submissions do not qualify for use in calculating a case mix score, ~~ODJFS~~ODM shall continue to use the median annual average case mix score for the NF's peer group in lieu of the NF's semiannual case mix score until the NF submits two consecutive quarterly assessment data that qualify for use in calculating a case mix score.

(B) After the end of the fiscal year in which the NF began participation in the medicaid program, the rates for the second fiscal year and subsequent fiscal years shall be set in accordance with division (A) of section ~~5111.222~~**5165.15** of the Revised Code.

Effective: 03/22/2015

Five Year Review (FYR) Dates: 12/08/2014 and 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5165.02

Rule Amplifies: 5165.151

Prior Effective Dates: 7/1/06

5160-3-65.1 Nursing Facilities (NFs): Rates for Providers that Change Provider Agreements

NFTL 15-01

Effective Date: March 22, 2015

(A) For an entering NF operator that begins participation in the medicaid program on and after November 1, 2006, the NF operator's initial rate shall be the rate the exiting operator would have received had the exiting operator continued to participate in the medicaid program with the exception of the quality incentive payment, which shall be the statewide median as calculated by the department according to section **5165.25** of the Revised Code.

(B) The rate determined in paragraph (A) of this rule shall not be subject to adjustment until the following fiscal year.

(C) After the end of the fiscal year in which the NF began participation in the medicaid program, the rates for the second fiscal year and subsequent fiscal years shall be set in accordance with sections **5165.01** to **5165.49** of the Revised Code. The rate for direct care costs shall be redetermined to reflect the entering operator's actual semiannual case mix score determined under section **5165.192** of the Revised Code after the NF submits its first two quarterly assessment data that qualify for use under paragraph (E) of rule **5160-3-43.3** of the Administrative Code.

Replaces: 5160-3-65.1

Effective: 03/22/2015

Five Year Review (FYR) Dates: 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5165.02, 5165.516

Rule Amplifies: 5165.15, 5165.516

Prior Effective Dates: 7/1/06, 11/1/06

5160-3-99 Payment Methodology for State-Operated Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)

Formerly **5101:3-3-99 Payment Methodology for State-Operated Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)**

OAC 5160-3-99 This rule is maintained in the Community Access Manual, located in the Ohio Health Plans - Provider collection.

Ohio Revised Code

The Ohio Revised Code section of the Long Term Care manual has been removed. Ohio Revised Code cited in this manual can be accessed at LAWriter Ohio Laws and Rules (**http://codes.ohio.gov/**) website.