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Ohio Administrative Code

Rule 5123-7-20 Intermediate care facilities for individuals with intellectual disabilities - resident assessment classification system based on administration of the individual assessment form.

Effective: July 8, 2018

(A) Purpose

This rule sets forth a method and process for determining the per resident/per day rate paid to an intermediate care facility for individuals with intellectual disabilities (ICFIID) for direct care costs using the individual assessment form pursuant to sections 5124.195 to 5124.198 of the Revised Code.

(B) Definitions

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

(1) "Annual facility average case mix score" means the ICFIID's average case mix score of all qualifying quarters in a calendar year.

(2) "Case mix score" means the measure of the relative direct care resources needed to provide care and rehabilitation to a resident of an ICFIID using the individual assessment form.

(3) "Correction submission due date" means the deadline for an ICFIID to submit corrected individual assessment form data to the department. The correction submission due date applies to corrections submitted in electronic format for facility level errors and resident record changes.

(4) "Cost per case mix unit" is calculated by dividing an ICFIID's desk-reviewed, actual, allowable, per diem direct care costs for the calendar year preceding the fiscal year in which the rate will be paid by the annual facility average case mix score for the calendar year preceding the fiscal year in which the rate will be paid.

(5) "Facility level errors" means errors which must be corrected before a facility average case mix

score can be calculated and include:

(a) Failure to electronically submit the certification of individual assessment form data by the correction submission due date.

(b) Incomplete or inaccurate data are submitted to the department.

(c) The number of individual assessment form records processed is more than the reported number of residents in medicaid-certified beds on the reporting period end date.

(6) "Filing date" means the deadline for initial quarterly electronic submission and certification of an ICFIID's individual assessment form data, which is the fifteenth calendar day following the reporting period end date.

(7) "Individual assessment form" means the instrument used to assess the needs and circumstances of an individual with developmental disabilities for the purpose of calculating an ICFIID's direct care costs pursuant to sections 5124.195 to 5124.198 of the Revised Code.

(8) "Ohio developmental disabilities profile" means the instrument used to assess the needs and circumstances of an individual with developmental disabilities for the purpose of calculating an ICFIID's direct care component rate pursuant to sections 5124.19 to 5124.193 of the Revised Code.

(9) "Peer group" means one of the following groups of ICFIID:

(a) "Peer group 1-B" includes each ICFIID with a medicaid-certified capacity exceeding eight.

(b) "Peer group 2-B" includes each ICFIID with a medicaid-certified capacity not exceeding eight, other than an ICFIID that is in peer group 3-B.

(c) "Peer group 3-B" includes each ICFIID to which all of the following apply:

(i) The ICFIID is first certified as an ICFIID after July 1, 2014;

(ii) The ICFIID has a medicaid-certified capacity not exceeding six;

(iii) The ICFIID has a contract with the department that is for fifteen years and includes a provision for the department to approve all admissions to, and discharges from, the ICFIID; and

(iv) The ICFIID's residents are admitted to the ICFIID directly from a department-operated ICFIID or have been determined by the department to be at risk of admission to a department-operated ICFIID.

(10) "Processing quarter" means the quarter that follows the reporting quarter and is the quarter in which the department receives the individual assessment form data for the reporting quarter.

(11) "Quarterly facility average case mix score" means the facility average case mix score based on individual assessment form data submitted for one reporting quarter.

(12) "Record" means a resident's individual assessment form data processed by the department.

(13) "Relative resource weight" means the measure of the relative costliness of caring for residents in one case mix classification versus another, indicating the relative amount and cost of staff time required on average for defined job types to care for residents in a single case mix classification.

(14) "Reporting period end date" means the last day of each calendar quarter.

(15) "Reporting quarter" means the quarter which precedes the processing quarter.

(16) "Resident assessment classification system" means the system for classifying residents of an ICFIID into case mix classifications that reflect clusters of residents, defined by resident characteristics determined using data from the individual assessment form, that explain resource use.

(17) "Resident case mix score" means the relative resource weight for the classification to which a resident is assigned based on data elements from the resident's individual assessment form.

(C) Calculating direct care costs

For a period of three years commencing on the effective date of this rule, the department shall calculate for each eligible ICFIID, two separate per resident/per day rates for direct care costs using data from:

(1) Administration of the individual assessment form to residents of the ICFIID in accordance with this rule; and

(2) Administration of the Ohio developmental disabilities profile to residents of the ICFIID in accordance with rules 5123-7-33 and 5123:2-7-32 of the Administrative Code.

(D) Resident assessment classification system

(1) The department shall use the resident assessment classification system to classify residents of an ICFIID based on data from the individual assessment form. Residents in each classification utilize similar quantities and patterns of resources. Based upon the data collected in the individual assessment form, a resident that meets the criteria for placement in more than one classification shall be placed in the highest classification according to the hierarchy. Residents without characteristics resulting in assignment to the higher classifications shall be placed in the sixth classification.

(2) The resident assessment classification system defines criteria used to assign residents to one of six mutually exclusive classifications listed in descending order of the hierarchy:

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

(i) Parenteral therapy on all shifts (on the individual assessment form at the medical domain section, item 24 is scored "4"),

(ii) Tracheostomy care/suctioning on all shifts (on the individual assessment form at the medical domain section, item 25 is scored "4"),

(iii) Oxygen and respiratory therapy on all shifts (on the individual assessment form at the medical

domain section, item 27 is scored "4"),

(iv) Oral medication administered more than eight times in a twenty-four-hour day (on the individual assessment form at the medical domain section, item 29a is scored "3"),

(v) Topical medication administered more than eight times in a twenty-four-hour day (on the individual assessment form at the medical domain section, item 29b is scored "3"),

(vi) Injections of medication administered more than eight times in a twenty-four-hour day (on the individual assessment form at the medical domain section, item 29c is scored "3"),

(vii) Medication administered more than eight times in a twenty-four-hour day using a method other than oral, topical, or injection (on the individual assessment form at the medical domain section, item 29d is scored "3"), and/or

(viii) Utilization of out-of-home health care requiring over thirty days of staff time on average per year (on the individual assessment form at the medical domain section, item 31 is scored "3").

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

(i) Aggressive behavior (on the individual assessment form at the behavior domain section, item 14 is scored "3"),

(ii) Self-injurious behavior (on the individual assessment form at the behavior domain section, item 17 is scored "3"), and/or

(iii) Acute suicidal behavior (on the individual assessment form at the behavior domain section, item 21 is scored "3").

(c) The high adaptive needs and chronic behaviors classification includes residents requiring a specific level of staff assistance/supervision for one or more personal care and safety needs described

in paragraphs (D)(2)(c)(i) to (D)(2)(c)(vi) of this rule and exhibiting one or more of the behaviors described in paragraphs (D)(2)(c)(vii) to (D)(2)(c)(x) of this rule that require frequent or continual staff intervention as defined in the individual assessment form instructions:

(i) Eating (on the individual assessment form at the adaptive skills domain section, item 1 is scored "2" for needing hands-on assistance),

(ii) Toileting (on the individual assessment form at the adaptive skills domain section, item 2 is scored either "3" for as a rule does not indicate the need to toilet and requires assistance with wiping, or "4" for requires colostomy, ileostomy, or urinary catheter),

(iii) Dressing (on the individual assessment form at the adaptive skills domain section, item 5 is scored "3" for requiring hands-on assistance and/or constant supervision to complete the tasks, or tasks must be done completely by staff for the resident),

(iv) Turning and positioning more than twelve times in a twenty-four-hour period (on the individual assessment form at the adaptive skills domain section, item 6 is scored "4"),

(v) Mobility requiring the help of one or more persons (on the individual assessment form at the adaptive skills domain section, item 7 is scored "3"),

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

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

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

(ix) Disruptive behavior requiring continual staff intervention as defined in the individual

assessment form (on the individual assessment form at the behavior domain section, item 19 is scored "4"), and/or

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

(d) The high adaptive needs and non-significant behaviors classification includes residents requiring a specific level of staff assistance/supervision for one or more personal care and safety needs described in paragraphs (D)(2)(c)(i) to (D)(2)(c)(vi) of this rule.

(e) The chronic behaviors and typical adaptive needs classification includes residents exhibiting one or more of the behaviors described in paragraphs (D)(2)(c)(vii) to (D)(2)(c)(x) of this rule that require frequent or continual staff intervention as defined in the individual assessment form instructions.

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

(E) Relative resource weights

(1) Analysis of staff time and resident assessment data, collected in a work measurement study of Ohio medicaid-certified ICFIID for the purpose of establishing common staff times associated with all resident classifications that are standard across residents, staff, facilities, and units, determined that the job classifications listed in paragraphs (E)(1)(a) to (E)(1)(h) of this rule are job types that perform activities that vary by case mix classification established using the individual assessment form. Job types determined not to be positions participating in activities that vary by case mix classification are not used to calculate the relative resource weights as described in paragraph (E)(2) of this rule.

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

(b) Licensed practical nurses;

(c) Occupational therapists;

(d) Program specialists;

(e) Qualified intellectual disability professionals;

(f) Registered nurses;

(g) Social workers/counselors; and

(h) Speech therapists.

(2) Each of the six resident classifications is assigned a relative resource weight. The relative resource weight indicates the relative amount and cost of staff time required on average for the job types listed in paragraphs (E)(1)(a) to (E)(1)(h) of this rule to deliver care to residents in that classification. The relative resource weight was calculated using the average minutes of care per job type per classification as determined during the work measurement study, and the averages of the wages by job type as reported on the cost report. By setting the wage weight at one for the job type receiving the lowest hourly wage, wage weights for the other job types are calculated by dividing the lowest wage into the wage of each of the other job types. To calculate the total weighted minutes for each classification, the wage weight for each job type is multiplied by the average number of minutes staff of that job type spend caring for a resident in that classification, and the products are summed. The classification with the lowest total weighted minutes receives a relative resource weight of one. Relative resource weights are calculated by dividing the total weighted minutes of the lowest classification into the total weighted minutes of each classification. Weight calculations are rounded to the fourth decimal place. Relative resource weights for the resident classifications are:

(a) Chronic medical = 2.0888.

(b) Overriding behaviors = 1.9206.

(c) High adaptive needs and chronic behaviors = 1.8935.

(d) High adaptive needs and non-significant behaviors = 1.7434.

(e) Chronic behaviors and typical adaptive needs = 1.3593.

(f) Typical adaptive needs and non-significant behaviors = 1.000.

(3) Except as provided in paragraph (E)(3)(a) of this rule, relative resource weights may be recalibrated using wage weights based on three-year statewide averages of wages of the job types listed in this rule as reported on the cost report, and minutes of care per job type per resident assessment classification.

(a) The department may recalibrate the relative resource weights no more often than every three years, using the minutes of care per job type per classification from the most current work measurement study and the wages per job type per hour, to be effective at the beginning of the next state fiscal year. When recalibrating the relative resource weights, the department shall use cost report wage data from the most recent three calendar years available ninety calendar days prior to the start of the fiscal year.

(b) The department may recalibrate relative resource weights more frequently if significant variances in wage ratios between job types occur.

(c) The department may rebase the relative resource weights through the deletion or addition of job types or with revised minutes of care per job type by conducting a new work measurement study, if significant changes in the job types or work roles of the job types occur, or following a change in state policy which would significantly affect statewide case mix of the ICFIID population.

(d) After recalibrating or rebasing relative resource weights in accordance with paragraph (E)(3)(a), (E)(3)(b), or (E)(3)(c) of this rule, the department shall use the recalibrated or rebased relative resource weights to recalculate the annual facility average case mix score for the calendar year preceding the fiscal year.

(F) Collection and submission of individual assessment form data

(1) The department shall process individual assessment form data submitted by an ICFIID and classify residents using the resident assessment classification system to determine resident case mix scores. These resident case mix scores, based on relative resource weights as set forth in paragraph (E) of this rule, are used to establish the quarterly facility average case mix score. The method for determining the quarterly facility average case mix score is described in paragraph (G)(4) of this rule.

(2) The individual assessment form shall be administered by ICFIID staff authorized by the department. In order to become authorized, ICFIID staff shall attend and successfully complete a training session conducted or approved by the department that includes a demonstration.

(3) Each ICFIID shall use the individual assessment form software provided by the department at no cost to complete and electronically submit to the department through the department's website (http://dodd.ohio.gov) a quarterly case mix assessment for each resident of the ICFIID, regardless of payment source or anticipated length of stay, to reflect the resident's condition on the reporting period end date, which is the last day of the calendar quarter. The electronic data shall be submitted in the exact layout provided in the individual assessment form software.

(4) The following shall be considered residents of the ICFIID on the reporting period end date:

(a) Residents admitted or transferred to the ICFIID prior to or on the reporting period end date and physically residing in the ICFIID on the reporting period end date; and

(b) Residents temporarily absent on the reporting period end date but for whom the ICFIID is receiving payment from any source to hold a bed for the resident during a hospital stay, visit with friends or relatives, or participation in therapeutic programs outside the facility in accordance with rule 5123:2-7-08 of the Administrative Code.

(5) The following shall not be considered residents of the ICFIID on the reporting period end date:

(a) Residents discharged from the ICFIID prior to or on the reporting period end date; and

(b) Residents transferred to another ICFIID prior to or on the reporting period end date; and

(c) Residents who die prior to or on the reporting period end date.

(6) An ICFIID shall complete and electronically submit a certification of individual assessment form data with the quarterly submission of individual assessment form data identifying the name of the ICFIID, its provider number, the total number of beds the ICFIID has certified by the Ohio department of health for medicaid, total number of residents in the ICFIID as of the reporting period end date for whom the ICFIID must submit an individual assessment form, and the name of the authorized staff member who administered the individual assessment form for each resident. The certification of individual assessment form data shall be electronically submitted to the department no later than the fifteenth day of the month following the reporting period end date.

(7) The annual facility average case mix score calculated in accordance with this rule is used in conjunction with the lesser of the ICFIID's cost per case mix unit or the maximum allowable cost per case mix unit, adjusted by the inflation rate, to establish the direct care rate, as outlined in sections 5124.195 to 5124.198 of the Revised Code. The ICFIID's cost per case mix unit is calculated using the annual facility average case mix score. The method for determining the annual facility average case mix score is described in paragraph (H) of this rule.

(G) Quarterly facility average case mix score

(1) The department shall establish each ICFIID's rate for direct care costs using data from the individual assessment form, annually pursuant to sections 5124.195 to 5124.198 of the Revised Code. The department shall assign a quarterly facility average case mix score or cost per case mix unit used to establish an ICFIID's rate for direct care costs if the ICFIID fails to certify individual assessment form data in accordance with this rule or fails to correct facility level errors. Before taking such action, the department shall permit the ICFIID a reasonable period of time to correct the information, as described in paragraph (G)(3)(c) of this rule. To set the rate, the department shall:

(a) Calculate the ICFIID's cost per case mix unit;

(b) Multiply the lesser of the ICFIID's cost per case mix unit or the maximum cost per case mix unit for the ICFIID's peer group determined pursuant to division (C) of section 5124.195 of the Revised

Code by the ICFIID's annual average case mix score for the calendar year preceding the fiscal year for which the rate is set begins; and

(c) Multiply the amount determined in accordance with paragraph (G)(1)(b) of this rule by the inflation factor specified in division (D) of section 5124.195 of the Revised Code.

(2) The department shall calculate and use the actual quarterly facility average case mix score described in paragraph (G)(4) of this rule for determining the direct care rate if:

(a) The ICFIID submits individual assessment form data by the filing date and includes assessments for all residents of the ICFIID as of the reporting period end date;

(b) In accordance with the procedures outlined in paragraph (G)(3) of this rule for correcting inaccurate information, the ICFIID timely submits and timely corrects individual assessment form data for that reporting quarter; and

(c) The ICFIID's submission and certification of individual assessment form data does not contain facility level errors or such errors have been timely corrected.

(3) After the department has processed the ICFIID's individual assessment form data for a reporting quarter, the department shall make available the "Case Mix Provider Summary Report" to the ICFIID. The ICFIID may correct errors or omissions identified by either the department or the ICFIID by sending in a modification submission and submitting corrections to the department along with an amended certification of individual assessment form data.

(a) The department shall notify an ICFIID of a missing or incomplete certification of individual assessment form data.

(b) The department may notify an ICFIID of its initial quarterly submission through two documents:

(i) The "Submission Tracking Summary" report which shows the status of the individual assessment form data after initial processing by the department.

(ii) The "Detailed Listing of Successfully Grouped Assessments" report which is a list of individual assessment form records that were grouped into resident assessment classification system groups one through six.

(c) The department shall allow forty-five calendar days after the reporting period end date for an ICFIID to make corrections and return them to the department. Timeliness of the submission to the department shall be determined by the electronic submission date.

(d) Corrections received by the department shall be used in computing the quarterly facility average case mix score, in accordance with the conditions outlined in paragraph (G)(2) of this rule.

(e) The department shall process corrections submitted in electronic format if the file format is the same as used by the department.

(f) Changes made on the individual assessment form modification submission data element entries must be consistent with changes made to the original individual assessment form maintained at the ICFIID.

(4) The quarterly facility average case mix score for an ICFIID that submitted individual assessment form data and modifications timely, and has no facility level errors is calculated by:

(a) Adding together all residents' relative resource weights for the quarter; and

(b) Dividing the sum of relative resource weights by the total number of residents.

(5) The department may assign a quarterly facility average case mix score that is five per cent less than the ICFIID's quarterly facility average case mix score for the preceding calendar quarter instead of using the quarterly facility average case mix score calculated based on the ICFIID's submitted information as described in paragraph (G)(4) of this rule.

(a) If the ICFIID was subject to an exception review conducted pursuant to rule 5123-7-30 of the Administrative Code for the preceding calendar quarter, the assigned quarterly facility average case mix score shall be the score that is five per cent less than the score determined by the exception

review.

(b) If the ICFIID was assigned a quarterly facility average case mix score for the preceding calendar quarter, the assigned quarterly facility average case mix score shall be the score that is five per cent less than that score assigned for the preceding quarter.

(6) The department may assign a cost per case mix unit that is five per cent less than the ICFIID's calculated or assigned cost per case mix unit for the preceding calendar year if the ICFIID has fewer than two acceptable quarterly facility average case mix scores.

(H) Annual facility average case mix score

(1) The annual facility average case mix score is used to compute the cost per case mix unit for the ICFIID and the peer group maximum cost per case mix unit for the purpose of calculating direct care rates pursuant to sections 5124.195 to 5124.198 of the Revised Code. Individual assessment form data for all four quarters of the calendar year shall be used to calculate the annual facility average case mix score.

(a) The department-assigned facility average case mix scores shall be omitted from the ICFIID's annual average case mix score calculation.

(b) The annual facility average case mix score shall be calculated from no fewer than two acceptable quarterly facility average case mix scores. Acceptable quarterly facility average case mix scores shall be summed and divided by the total number of quarters of acceptable scores. Acceptable quarterly facility average case mix scores for the purposes of calculating the annual facility average case mix score include, in order of hierarchy:

(i) Adjusted quarterly facility average case mix scores as a result of exception review findings, or

(ii) Quarterly facility average case mix scores calculated based on the ICFIID's submitted information as described in paragraph (G)(4) of this rule.

(2) If at least two acceptable quarterly facility average case mix scores are not available, the

department shall assign the cost per case mix unit in accordance with paragraph (G)(6) of this rule.