5160-3-17 **Nursing facilities (NFs): ~~Payment~~payment methodology for the provision of outlier services~~in nursing facilities (NFs)~~.**

(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:

R.C. 119.032 review dates: 07/01/2014

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5165.153
Rule Amplifies:	5165.153
Prior Effective Dates:	7/1/06