CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Level of Care

Rule Number(s): 5160-3-10 (new), 5160-3-14 (rescinded) and 5160-3-14 (new) are being submitted for analysis.

The following rules are attached for information purposes only: 5160-3-05 (new), 5160-3-05 (rescinded), 5160-3-06 (new), 5160-3-06 (rescinded), 5160-3-08 (new), 5160-3-08 (rescinded), 5160-3-09 (new).

Date: March 10, 2015

Rule Type:

- X New
- ☐ Amended
- X 5-Year Review
- X Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

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1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Level of Care Overview

   An individual seeking Medicaid payment for a nursing facility stay or who is seeking enrollment on a home and community based services (HCBS) waiver must first be assessed to determine their level of care (LOC) needs. A nursing facility-based level of care is necessary for Medicaid payment for a nursing facility stay or HCBS waiver enrollment. Currently, both children and adults are assessed using the same criteria and process. The criteria and process are out dated and allow for low inter-rater reliability between assessors. Two assessors completing the same assessment for one individual could yield different results. In addition, current rule allows for a variety of assessment forms to be used which has created inconsistent results across the State. The criteria have been re-defined and the process for determining one's level of care is described in the rules listed below.

   OAC 5160-3-10 (New)

   This proposed new OAC rule 5160-3-10 establishes a process for determining level of care for a child. Currently, in the State of Ohio, children who are assessed for a level of care are assessed using the criteria and process designed for the adult population. This rule sets forth the age specific process for determining a level of care for a child. In addition, this rule will mandate the use of a specific level of care assessment, either the ODM 10126 "Child Comprehensive Assessment Tool" (CCAT) for children who seek waiver services or ODM 10128 "Child Level of Care Questionnaire" for children who seek Medicaid payment for a nursing facility stay. The rule will also identify an electronic system for submission of the assessment.

   OAC 5160-3-14 (Rescinded/New)

   This OAC rule 5160-3-14 establishes a process for determining level of care. Currently, in the State of Ohio, children and adults who are assessed for a level of care are assessed using the process as defined in the current OAC rule 5160-3-14. The current version of the rule allows for the use of the JFS 03697 "Level of Care Assessment" or alternative form. Proposed changes to the rule are outlined below.

   Changes to rule 5160-3-14 include:

   - State agency name references, form numbers, and rule number references were updated to reflect statutory and Administrative Code changes.

- Clarified that this rule is specific to the adult population.
- Removed unnecessary references to ICF-MR level of care.
- Added the use of an ODM approved assessment instrument to determine the need for less than twenty-four hour support in order to prevent harm due to a cognitive impairment, when diagnosed by a physician.
- Added the need for a face to face level of care assessment when an individual seeking a nursing facility-based level of care appears to meet solely on the basis of a need for twenty-four hour support in order to prevent harm due to a cognitive impairment.
- Replaced the usage of the JFS 03697, "Level of Care Assessment" or alternative form to determine level of care with the ODM 10125 "Adult Comprehensive Assessment Tool" (ACAT) or ODM 10127 "Adult Level of Care Questionnaire."
- Added the usage of LOTISS to complete a level of care request.
- Removed the requirement for a physician certification on the JFS 03697.
- Updated necessary supporting documentation requirements.
- Reorganized the paragraphs of the rule for a more logical flow.

2. Please list the Ohio statute authorizing the Agency to adopt this regulation.

Ohio Revised Code Section 5164.02 and Section 5166.02.

3. Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
If yes, please briefly explain the source and substance of the federal requirement.

Yes. An assessment of an individual's level of care is needed for two different purposes:

- To allow Medicaid payment for a nursing facility stay; and
- For enrollment onto a Medicaid home and community based services (HCBS) waiver.

Medicaid Payment for a Nursing Facility Stay

Nursing facility services are required to be provided by state Medicaid programs for individuals age 21 or older who need them. States may not limit access to the service, or make it subject to waiting lists, as they may for HCBS waivers. Need for nursing facility services is defined by states, all of whom have established nursing facility-based level of care criteria. State level of care requirements must provide access to individuals who meet the coverage criteria defined in Federal law and regulation.

Medicaid HCBS Waivers

In order for the Centers for Medicare and Medicaid Services (CMS) to approve a 1915(c) HCBS waiver, a state must make certain assurances concerning the operation of the waiver. As described in 42 C.F.R. 441.302., states are required to conduct a level of care assessment initially and annually thereafter. The level of care criteria for waiver services mirrors that for a nursing facility stay because an HCBS waiver is a service provided in the community in lieu of a nursing facility stay.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These rules are consistent with federal requirements. They define specific processes for meeting waiver program eligibility requirements and payment to nursing facilities as required by CMS.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The public purpose of this regulation is to ensure that individuals residing in a nursing facility are having their needs met in the least restrictive setting possible. In addition, it is the responsibility of the Ohio Department of Medicaid (ODM) to ensure Medicaid funding (both state and federal dollars) is being spent appropriately on care for individuals with needs that can be met safely in a community setting or in a nursing facility.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   Successful outcomes are measured through a finding of compliance with these standards.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   - Ohio Department of Aging
   - Ohio Department of Developmental Disabilities
   - Ohio Department of Mental Health and Addiction Services
   - Ohio Department of Health

- Ohio Hospital Association
- Providers, ODM-Administered Home and Community-Based Services
- Providers, ODM Managed Care Plans
- Ohio Council of Behavioral Health & Family Services Providers
- Statewide Provider Oversight Contractor, Public Consulting Group Inc. (PCG)
- Directors, County Departments of Job and Family Services
- Directors, Area Agencies on Aging
- Superintendents, County Boards of Developmental Disabilities
- Directors, Centers for Independent Living
- Academy of Senior Health Sciences, Inc.
- Ohio Health Care Association
- Linking Employment, Abilities & Potential (LEAP)
- Ohio Long Term Care Ombudsmen
- Chairperson, Ohio Olmstead Task Force
- President/CEO, Ohio Council for Home Care and Hospice
- President/CEO, Midwest Care Alliance
- AARP
- Disability Rights Ohio
- Ohio Provider Resource Association
- Leading Age Ohio
- Midwest Care Alliance
- Catholic Social Services of Miami Valley
- Transitional Living Centers, Inc.

8. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

The proposed amended rules were distributed on February 6, 2015 to the stakeholders included in question 7 and were reviewed during a stakeholder meeting held on February 10, 2015. Stakeholders were given ten days for additional review and response. Those stakeholders provided comments and questions that were addressed by ODM. The comments and questions lead to rule revisions.

Revisions include: specifying the credentials of a "qualified assessor," adding the use of technology to communicate within the IADL of telephoning, adding that upon the issuance of an adverse determination the resulting face-to-face visit must be performed by a registered nurse. Other minor changes to the phrasing of the rule were made as well, but did not impact the intent of the rule.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   No scientific data was used to develop the rules or the measurable outcomes of the rules.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    ODM and the Inter-Agency workgroup considered alternative rule language as part of the rule amendment process and settled upon language which was mutually agreed upon and best suited to accomplish the purposes of the rule.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    A performance-based regulation is not deemed appropriate for this process.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    Because the nursing facility-based level of care process is administered solely by ODM, the rules specific to this level of care are not duplicated by any existing regulation in Ohio. All regulation regarding nursing facility-based level of care are promulgated by ODM. The regulation was reviewed by ODM's legal and legislative staff to ensure that there is no duplication within the rules.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    ODM is coordinating with the Department of Developmental Disabilities (DODD) to implement new rules for a smooth and uniform transition throughout Ohio. ODM is engaging stakeholders throughout the process and will provide extensive training related to the rule changes for all impacted parties.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

The businesses impacted by these rules are hospitals, nursing facilities, Ohio Department of Aging (ODA) contracted PASSPORT Administrative Agencies and Ohio Department of Medicaid (ODM) contracted case management agencies.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

OAC 5160-3-10 (New)

Any hospital discharging a child, to a nursing facility must complete the ODM 10128 "Child Level of Care Questionnaire" to determine level of care and to request Medicaid payment for that nursing facility stay. A nursing facility accepting a child from the community, must complete the ODM 10128 to request Medicaid payment for the nursing facility stay. An ODM contracted Case Management Agency must complete the ODM 10126 "Child Comprehensive Assessment Tool" (CCAT) in order to assess the needs of the child and determine level of care for nursing facility-based HCBS waiver services.

OAC 5160-3-14 (New)

Any hospital discharging an adult, to a nursing facility must complete the ODM 10127 "Adult Level of Care Questionnaire" to determine level of care and to request Medicaid payment for that nursing facility stay. A nursing facility accepting an adult from the community will need to complete the ODM 10127 to request Medicaid payment for the nursing facility stay. An ODM contracted Case Management Agency or ODA contracted PASSPORT Administrative Agency (PAA) must complete the ODM 10125 "Adult Comprehensive Assessment Tool" (ACAT) in order to assess the needs of the adult and determine level of care for nursing facility-based HCBS waiver services.

OAC 5160-3-14 (Rescinded)

Any hospital discharging an individual, to a nursing facility must complete the JFS 03697 "Level of Care Assessment" or alternative form to request Medicaid payment for that nursing facility stay. A nursing facility accepting an individual from the community must complete

the JFS 03697 or alternative form to request Medicaid payment for the nursing facility stay. An ODM contracted case management agency or ODA contracted PAA must complete the JFS 03697 "Level of Care Assessment" or alternative form in order to assess the needs of the individual and determine level of care for nursing facility-based HCBS waiver services.

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

In an effort to quantify the adverse impact of these rules, we contacted and received feedback from: the Ohio Hospital Association, the Ohio Health Care Association, Leading Age Ohio, the Ohio Department of Aging (ODA) and ODM case management agency contract managers. Additional entities were contacted, but failed to provide feedback prior to submission of the BIA.

In addition, we learned through our extensive assessment testing processes that the average time to complete the ODM 10126 "Child Comprehensive Assessment Tool" (CCAT) and ODM 10125 "Adult Comprehensive Assessment Tool" (ACAT) was approximately two hours and thirty minutes per assessment. The average time to complete the ODM 10128 "Child Level of Care Questionnaire" and ODM 10127 "Adult Level of Care Questionnaire" was approximately one hour per assessment. Based on these timeframes, and the feedback received from the entities mentioned above we can estimate the cost per assessment for the various entities to be as follows.

In addition, it should be noted that the estimates below are based upon either a paper form completed manually or via a Microsoft Word fillable document. When the forms are automated in the Linking Ohioans to Information, Services and Supports (LOTISS) system, we anticipate that the timeframes for completion will be significantly shorter.

OAC 5160-3-10 (New)

Hospitals – Hospitals throughout the state will submit the ODM 10128 "Child Level of Care Questionnaire" to request Medicaid payment for a nursing facility stay for a child who is being discharged from the hospital. This is a very rare occurrence. Based on the average timeframe of one hour to complete the ODM 10128 and the average hourly salary of a hospital employee submitting the form ($26.11/hour) we can estimate that the average cost for a hospital completing this form would be approximately $26.11 per form.

Nursing Facilities – Nursing facilities throughout the state will submit the ODM 10128 "Child Level of Care Questionnaire" to request Medicaid payment for a nursing facility stay for a child. This is a very rare occurrence. Based on the average timeframe of one hour to complete the ODM 10128 and the average hourly salary of a nursing facility employee completing the form ($22.03/hour), we can estimate that the average cost for a nursing facility to complete this form would be approximately $22.03 per form.

PASSPORT Administrative Agencies – There are thirteen PASSPORT Administrative Agencies (PAA) in different regions of the state. These agencies are contracted with ODA to perform case management work for ODA administered HCBS waivers and to perform desk reviews of the level of care forms submitted by hospitals or nursing facilities. The PAAs are reimbursed for all costs associated with this work. For children requesting Medicaid payment for a nursing facility stay, the PAA will be required to complete the desk review process using the ODM 10128 "Child Level of Care Questionnaire." Based on fiscal year 2014 figures, the average cost to complete the JFS 03697 or alternative form, via desk review was $6.43 per assessment. We do not believe that these costs will increase due to the new assessment tools. ODM anticipates that the new automated assessments will be quicker and more efficient than today's processes.

Case Management Agencies – There are currently three case management agencies contracted with ODM to perform case management work for ODM administered HCBS waivers. As part of their contract, case management agencies are required to perform an assessment initially and thereafter on an annual basis. All three agencies are paid per assessment. Both CareStar and the Council on Aging are paid $215 per assessment. CareSource is paid $182 per assessment in the Cleveland region and $232.59 per assessment in the Marietta region. These contracts are competitively bid and negotiated through the contracts and acquisitions process.

OAC 5160-3-14 (New)

Hospitals – Hospitals throughout the state will submit the ODM 10127 "Adult Level of Care Questionnaire" to request Medicaid payment for a nursing facility stay for an adult who is being discharged from the hospital. Based on the average timeframe of one hour to complete the ODM 10127 and the average hourly salary of a hospital employee submitting the form ($26.11/hour) we can estimate that the average cost for a hospital completing this form would be approximately $26.11 per form.

Nursing Facilities – Nursing facilities throughout the state will submit the ODM 10127 "Adult Level of Care Questionnaire" to request Medicaid payment for a nursing facility stay for an adult. Based on the average timeframe of one hour to complete the ODM 10127 and

the average hourly salary of a nursing facility employee completing the form ($22.03/hour), we can estimate that the average cost for a nursing facility to complete this form would be approximately $22.03 per form.

PASSPORT Administrative Agencies – There are thirteen PASSPORT Administrative Agencies (PAA) in different regions throughout the state. These agencies are contracted with ODA to perform case management work for ODA administered HCBS waivers and to perform desk reviews of the level of care forms submitted by hospitals or nursing facilities. The PAAs are reimbursed for all costs associated with this work. Based on fiscal year 2014 reimbursement information, the average HCBS waiver assessment cost was $215 per assessment. For an adult requesting Medicaid payment for a nursing facility stay, the PAA must complete the desk review process of the ODM 1012 "Adult Level of Care Questionnaire." Based on fiscal year 2014 figures, the average cost to complete the JFS 03697 or alternative form, via desk review was $6.43 per assessment. We do not believe that these costs will increase due to the new assessment tools. ODM anticipates that the new automated assessments will be quicker and more efficient than today's processes.

Case Management Agencies – There are currently three case management agencies contracted with ODM to perform case management work for ODM administered HCBS waivers. As part of their contract, case management agencies are required to perform an assessment initially and thereafter on an annual basis. All three agencies are paid per assessment. Both CareStar and the Council on Aging are paid $215 per assessment. CareSource is paid $182 per assessment in the Cleveland region and $232.59 per assessment in the Marietta region. These contracts are competitively bid and negotiated through the contracts and acquisitions process.

OAC 5160-3-14 (Rescinded)

Hospitals – Hospitals throughout the state submit the JFS 03697 "Level of Care Assessment" or alternative form to request Medicaid payment for a nursing facility stay for an individual who is being discharged from the hospital. Based on the average timeframe of thirty minutes to complete the JFS 03697 or alternative form and the average hourly salary of a hospital employee submitting the form ($26.11/hour) we can estimate that the average cost for a hospital completing this form is approximately $13.06 per form.

Nursing Facilities – Nursing facilities throughout the state submit the JFS 03697 or alternative form to request Medicaid payment for a nursing facility stay for an individual. Based on the average timeframe of thirty minutes to complete the JFS 03697 or alternative form, and the average hourly salary of a nursing facility employee submitting the form ($22.03/hour), we can estimate that the average cost for a nursing facility to complete this

form is approximately $11.02 per form. Nursing facilities also provided feedback related to the amount of time it takes to attain the required physician's signature which could be several days to a week, therefore holding up the process.

PASSPORT Administrative Agencies – There are thirteen PASSPORT Administrative Agencies (PAA) in different regions throughout the state. These agencies are contracted with ODA to perform case management work for ODA administered HCBS waivers and to perform desk reviews of the level of care forms submitted by hospitals or nursing facilities. The PAAs are reimbursed for all costs associated with this work. Based on fiscal year 2014 reimbursement information, the average HCBS waiver assessment cost was $215 per assessment. For an adult requesting Medicaid payment for a nursing facility stay, the PAA must complete the desk review process of the JFS 03697 or alternative form. Based on fiscal year 2014 figures, the average cost to complete the JFS 03697 or alternative form, via desk review was $6.43 per assessment.

Case Management Agencies – There are currently three case management agencies contracted with ODM to perform case management work for ODM administered HCBS waivers. As part of their contract, case management agencies are required to perform an assessment initially and thereafter on an annual basis. All three agencies are paid per assessment. Both CareStar and the Council on Aging are paid $215 per assessment. CareSource is paid $182 per assessment in the Cleveland region and $232.59 per assessment in the Marietta region. These contracts are competitively bid and negotiated through the contracts and acquisitions process.

15. **Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?**

    The intent of a level of care determination process is to ensure an individual's needs can safely be met either in a nursing facility or in the community via a home and community based services waiver. It is important that the individual's needs are met in the least restrictive setting possible. Any adverse impact on the provider community is consistent with other Ohio Medicaid provider practices related to ensuring the safety and well-being of the individuals served by the Medicaid program.

Regulatory Flexibility

16. **Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**

Not applicable for this program.

17. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

    Not applicable for this program.

18. **What resources are available to assist small businesses with compliance of the regulation?**

    ODM is working diligently to design and implement a training program for all impacted entities. This training is scheduled to begin in April 2015 and will continue on even after implementation of the new rules and automated system. We are looking into several methods of training delivery including in-person, web-based and train-the-trainer methods. We have a dedicated training coordinator to implement the training program.