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Rule Number(s): ___**5160-3-10 (new), 5160-3-14 (rescinded) and 5160-3-14 (new) are being submitted for analysis.**_____

The following rules are attached for information purposes only: 5160-3-05 (new), 5160-3-05 (rescinded), 5160-3-06 (new), 5160-3-06 (rescinded), 5160-3-08 (new), 5160-3-08 (rescinded), 5160-3-09 (new)._____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: __**July 11, 2017**_____

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X Rescinded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

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIOhio@governor.ohio.gov

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 be assessed to determine their level of care (LOC). A nursing facility-based level of care is necessary for Medicaid payment for a nursing facility stay or HCBS waiver enrollment. Current rules allow for a variety of assessment forms to be used by an assessor when determining an individual's LOC. The LOC rules now require, in addition to other changes, that assessors use one form or tool for making the determination. The changes are 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.

   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 an ODM automated system to complete a level of care request.
- Removed the requirement for a physician certification on the JFS 03697.
- Updated necessary supporting documentation requirements.

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 (ODA)
   - Ohio Department of Developmental Disabilities (DODD)
   - Ohio Department of Mental Health and Addiction Services (MHAS)
   - Ohio Department of Health (ODH)
   - 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 initially drafted in 2015 and therefore the majority of stakeholder review was completed during that year. The 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.

   The proposed amended rules were revised in 2017 and distributed for review by nursing facility provider associations including the Ohio Health Care Association, the Academy of Senior Health Sciences, Inc. and Leading Age Ohio. During 2017 inter-agency meetings, staff from ODM's partner state agencies were provided opportunity to review, including DODD, MHAS, ODA, and ODH. Those stakeholders provided comments that were addressed by ODM. No comments lead to rule revisions.

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?**

   Scientific data is not applicable to level of care policies and therefore 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?**

    The level of care criteria and determination process have historically been promulgated in the Ohio Administrative Code; however ODM did consider alternative regulations to implement these rule changes. Due to the tie between the level of care determination process and eligibility for Medicaid payment of nursing facility services and Medicaid HCBS waiver programs, ODM made the decision to continue to provide these regulations via Administrative Code.

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 will continue to engage 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 Home Care waiver 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. This rule requires that a level of care assessment is completed by a licensed social worker (LSW), licensed independent social worker (LISW), or registered nurse (RN). 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. This rule requires that a level of care assessment is completed by a licensed social worker (LSW), licensed independent social worker (LISW), or registered nurse (RN). 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. This rule requires that a level of care assessment is completed by a licensed social worker (LSW), licensed independent social worker (LISW), or registered nurse (RN). 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.

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 as described in the following paragraphs listed by rule.

Estimates below are based upon either a paper form completed manually or via a Microsoft Word fillable document. When the forms are automated in an automated 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 forty-five minutes 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 $19.58 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 forty-five minutes 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 $16.52 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 2016 figures, the average cost to complete the JFS 03697 or alternative form, via desk review was $7.79 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. CareStar is paid $270 per assessment in the Cincinnati area, the Columbus area and the Marietta area. The Council on Aging is paid $251 per assessment in the Cincinnati area. CareSource is paid $290.30 per assessment in the Cleveland region, $279.60 in the Columbus area, and $291.80 per assessment in the Marietta region. These contracts are competitively bid and negotiated through the contracts and acquisitions process.

Licensure fees
Licensure costs are as follows:

- Licensed Social Worker (LSW) bi-annual $60.00
- Licensed Independent Social Worker (LISW) bi-annual $75
- Registered Nurse (RN) bi-annual $65

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 forty-five minutes 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 $19.58 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 forty-five minutes 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 $16.52 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 2016 reimbursement information, the average HCBS waiver assessment cost was $254 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 2016 figures, the average cost to complete the JFS 03697 or alternative form, via desk review was $7.79 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. CareStar is paid $270 per assessment in the Cincinnati area, the Columbus area and the Marietta area. The Council on Aging is paid $251 per assessment in the Cincinnati area. CareSource is paid $290.30 per assessment in the Cleveland region, $279.60 in the

Columbus area, and $291.80 per assessment in the Marietta region. These contracts are competitively bid and negotiated through the contracts and acquisitions process.

Licensure fees
Licensure costs are as follows:

- Licensed Social Worker (LSW) bi-annual $60.00
- Licensed Independent Social Worker (LISW) bi-annual $75
- Registered Nurse (RN) bi-annual $65

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 forty-five 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 $19.58 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 forty-five 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 $16.52 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 2016 reimbursement information, the average HCBS waiver assessment cost was $254 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 $7.79 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. CareStar is paid $270 per assessment in the Cincinnati area, the Columbus area

and the Marietta area. The Council on Aging is paid $251 per assessment in the Cincinnati area. CareSource is paid $290.30 per assessment in the Cleveland region, $279.60 in the Columbus area, and $291.80 per assessment in the Marietta region. These contracts are competitively bid and negotiated through the contracts and acquisitions process.

Licensure fees
Licensure costs are as follows:

- Licensed Social Worker (LSW) bi-annual $60.00
- Licensed Independent Social Worker (LISW) bi-annual $75
- Registered Nurse (RN) bi-annual $65

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 has developed recorded trainings for all impacted entities that can be used during initial training scheduled to begin in September of 2017, as well as later for new staff. ODM will provide some trainings in person for use of the automated system. Access to the tools is web-

based, meaning a provider can access them via the internet. Should a provider have issues with accessing the tools via the internet, ODM will provide the tools for use on other electronic devices or to be completed on paper. Users who need to receive a copy of the ODM 10125, ODM 10126, or ODM 10127 in a format other than the web-based version can request it via email at ODM_Business_Services@medicaid.ohio.gov.

5160-3-05 **Level of care definitions.**

(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 to level of care rules 5160-3-06, 5160-3-08, 5160-3-09, 5160-3-10 and 5160-3-14 of the Administrative Code.

(B) Definitions.

(1) "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 activities:

(a) "Bathing" means the ability of an individual to cleanse one's body. Bathing includes the processes of applying cleansing agent, rinsing, and drying one's body.

(b) "Dressing" means the ability of an individual 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 and includes the following three components:

(i) Getting food into one's mouth;

(ii) Chewing; and

(iii) Swallowing.

(d) "Grooming" means the ability of an individual to care for one's appearance and includes the following three components:

(i) Hair care, including:

(a) Washing one's hair; or

(b) Brushing or combing one's hair.

(ii) Nail care, including:

(a) Cutting fingernails; or

(b) Cutting toenails.

(iii) Oral hygiene.

(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) "Transfers inside the house" 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 eliminate and dispose of bodily waste and includes the following four components:

(i) Using a toilet, bedpan or urinal;

(ii) Changing incontinence supplies or feminine hygiene products;

(iii) Cleansing self; and

(iv) Managing an ostomy or catheter.

(2) "Adult" means an individual age twenty-one years or older.

(3) "Adult comprehensive assessment tool (ACAT)" means the person-centered comprehensive case management and level of care assessment used to determine an adult's level of care and to assess the needs of the adult.

(4) "Adult level of care questionnaire" means the person-centered assessment used to determine an adult's nursing facility-based level of care.

(5) "Adverse level of care determination" means a determination that an individual does not meet the criteria for a specific level of care.

(6) "Age-appropriate ADL" means the ability of a child within a specific age group to perform ADLs, as described in the child comprehensive assessment tool (CCAT), which are based upon the average developmental milestones of children who do not have disabilities.

(7) "Age-appropriate instrumental activity of daily living (IADL)" means the ability of a child within a specific age group to perform IADLs, as described in the CCAT, which are based upon the average developmental milestones of children who do not have disabilities.

(8) "Assistance" means the hands-on provision of help in the initiation and/or completion of a task.

(9) "Child" means an individual age birth through twenty years of age.

(10) "Child comprehensive assessment tool (CCAT)" means the person-centered comprehensive case management and level of care assessment used to determine a child's level of care and to assess the needs of the child.

(11) "Child level of care questionnaire" means the person-centered assessment used to determine a child's nursing facility-based level of care.

(12) "Current diagnoses" means a written medical determination by a physician or other licensed health professional acting within their applicable scope of practice.

(13) "Delayed face-to-face visit" means an in-person evaluation 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.

(14) "Desk review" means a level of care determination process that is not conducted in person.

(15) "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 providing referrals to the individual as appropriate; it is not conducted by a desk review only.

(16) "Individual" means a medicaid recipient or a medicaid applicant for which medicaid eligibility has not yet been determined.

(17) "Instrumental activity of daily living (IADL)" means a task that allows an individual to live independently in the community. For the purposes of this rule, the term "IADL" includes the following 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;

(ii) Telephoning, including the use of technology to connect to community services; and

(iii) Transfers outside the house.

(b) "Housework" 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 six components:

(i) Cleaning and storing dishes;

(ii) Cleaning the bathroom;

(iii) Dusting;

(iv) Picking up clutter to ensure clear pathways and unblocked exits;

(v) Sweeping and mopping floors; and

(vi) Taking out trash.

(c) "Meal preparation" means the ability of an individual to prepare or cook food for oneself and includes the following three components:

(i) Cutting food;

(ii) Opening packages; and

(iii) Preparing food.

(d) "Money management" means the ability of an individual to manage his or her finances.

(e) "Personal laundry" means the ability of an individual to wash and dry clothing and household items by machine or by hand.

(f) "Shopping" means the ability of an individual to obtain or purchase necessary items.

(18) "Less than twenty-four hour support" means that an individual does not require the presence of another person during a portion of a twenty-four hour period of time, or the individual only requires 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 assessment" means an evaluation by the Ohio department of medicaid (ODM) or its designee of an individual's physical, mental, social and emotional status, using the processes described in rules 5160-3-10, 5160-3-14 and 5123:2-8-01 of the Administrative Code to compare the criteria for all of the possible levels of care as described in rules 5160-3-06, 5160-3-08, 5160-3-09 and 5123:2-8-01 of the Administrative Code.

(20) "Level of care determination" means the decision about whether an individual meets the criteria for a level of care based on the level of care assessment.

(21) "Level of care validation" means the process to confirm that an individual has a current nursing facility-based level of care via information contained within an ODM or Ohio department of aging information technology system.

(22) "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.

(23) "Medication self-administration" means the ability of an individual to self-administer all forms of over-the-counter and prescription medication.

(24) "Need" means the inability of an individual to complete a necessary and applicable task independently, safely, and consistently.

(a) For a child, the need is expected to last for six months or longer.

(b) An individual does not have a need when any of the following apply:

(i) The individual is not willing to complete a task or the task does not apply to the individual.

(ii) The task can be completed with the use of available assistive devices and accommodations.

(iii) For a child, the need is not expected to last six months or longer.

(25) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code. A facility that has submitted an application packet for medicaid certification to ODM 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 nursing facility for the purposes of this rule.

(26) "Nursing facility-based level of care" means the intermediate and skilled levels of care, as described in rules 5160-3-08 and 5160-3-09 of the Administrative Code.

(27)) "Nursing facility-based level of care program" means a fee-for-service nursing facility stay, an HCBS medicaid waiver that requires a nursing facility-based level of care, or other medicaid program that requires a nursing facility-based level of care.

(28) "Nursing facility-based medicaid waiver program" means an HCBS medicaid waiver that requires a nursing facility-based level of care.

(29) "Preadmission screening and resident review (PASRR)" means the requirements mandated by section 1919(e)(7) of the Social Security Act as in effect on February 8, 2006 and implemented in accordance with rules 5160-3-15, 5160-3-15.1, 5160-3-15.2, 5122-21-03 and 5123:2-14-01 of the Administrative Code.

(30) "Qualified assessor" means a registered nurse or licensed independent social worker (LISW) or licensed social worker (LSW) who possesses a current, valid and unrestricted license with the applicable Ohio licensure board.

(31) "Skilled nursing services" means specific tasks that must, in accordance with Chapter 4723. of the Revised Code, be provided by a licensed practical nurse at the direction of an RN or by an RN directly.

(32) "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.

(33) "Supervision" means any of the following:

(a) Reminding an individual to perform or complete an activity;

(b) Prompting an individual while the individual performs or completes an activity; or

(c) Being present with an individual while the individual performs an activity to ensure the individual's health and safety.

(34) "Twenty-four hour support" means that an individual requires the continuous presence of another person throughout the entire day and night during a twenty-four hour period of time.

(35) "Unstable medical condition" means clinical signs and symptoms are present in an individual and a physician or other licensed health professional acting within his or her applicable scope of practice has determined that:

(a) 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 frequent monitoring or adjustment of the treatment regimen;

(b) Changes in the individual's medical condition are uncontrollable or unpredictable and may require immediate interventions; and

(c) 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: 5160-3-05

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5165.04
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, 3/17/12

5160-3-06 **Criteria for the protective level of care.**

(A) This rule describes the criteria for an adult to be considered to have a protective level of care. This rule applies to children only when the child is age eighteen through twenty years, and is a residential state supplement (RSS) applicant as defined in rule 5122-36-02 of the Administrative Code.

(B) An adult will be considered to have a protective level of care when the adult has a need for:

(1) Less than twenty-four hour support 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, and as determined by an Ohio department of medicaid (ODM) approved assessment instrument; or

(2) Assistance with at least three instrumental activities of daily living (IADL) as described in paragraph (D) of this rule; and either

(a) Supervision of one activity of daily living (ADL) as described in paragraph (C) of this rule; or

(b) Supervision of medication self-administration.

(C) For the purposes of meeting the criteria described in paragraph (B)(2) of this rule, an adult has a need in an ADL when:

(1) The adult requires supervision of bathing in at least one of the following three components:

(a) Applying cleansing agent;

(b) Rinsing; or

(c) Drying.

(2) The adult 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.

(3) The adult requires supervision of eating in at least one of the following three components:

(a) Getting food into his or her mouth;

(b) Chewing; or

(c) Swallowing.

(4) The adult requires supervision of grooming in all of the following three components:

(a) Hair care, including:

(i) Washing one's hair; or

(ii) Brushing or combing one's hair.

(b) Nail care, including:

(i) Cutting fingernails; or

(ii) Cutting toenails.

(c) Oral hygiene;

(5) The adult requires supervision of mobility in at least one of the following three components:

(a) Bed mobility;

(b) Locomotion; or

(c) Transfers inside the house.

(6) The adult requires supervision of toileting in at least one of the following four components:

(a) Using a toilet, bedpan, or urinal;

(b) Changing incontinence supplies or feminine hygiene products;

(c) Cleansing self; or

(d) Managing an ostomy or catheter.

(D) For the purposes of meeting the criteria described in paragraph (B) of this rule, an adult has a need in an IADL when:

(1) The adult requires assistance with community access in at least one of the

following three components:

(a) Accessing transportation;

(b) Telephoning, including the use of technology to connect to community services; or

(c) Transfers outside the house.

(2) The adult requires assistance with housework in at least three of the following six components:

(a) Cleaning and storing dishes;

(b) Cleaning the bathroom;

(c) Dusting;

(d) Picking up clutter to ensure clear pathways and unblocked exits;

(e) Sweeping and mopping floors; or

(f) Taking out the trash.

(3) The adult requires assistance with meal preparation in at least one of the following three components:

(a) Cutting food;

(b) Opening packages; or

(c) Preparing food.

(4) The adult requires assistance with money management.

(5) The adult requires assistance with personal laundry.

(6) The adult requires assistance with shopping.

Replaces: 5160-3-06

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5165.04
Prior Effective Dates:	9/24/93 (Emer.), 12/24/93, 7/1/08, 3/19/12

5160-3-08 **Criteria for nursing facility-based level of care for an adult.**

(A) This rule describes the criteria for an adult to be considered to have a nursing facility-based level of care. A nursing facility-based level of care includes the intermediate and skilled levels of care.

(B) An adult will be considered to have an intermediate level of care when the adult is first considered to have a protective level of care, in accordance with rule 5160-3-06 of the Administrative Code, and the adult has a need for a minimum of one of the following as described in the ODM 10125 "Adult Comprehensive Assessment Tool" (11/2017) or the ODM 10127 "Adult Level of Care Questionnaire" (11/2017):

(1) Assistance with the completion of a minimum of two activities of daily living (ADL), as described in paragraph (C) of this rule;

(2) Assistance with the completion of a minimum of one ADL, and assistance with medication self-administration;

(3) A minimum of one skilled nursing service or skilled rehabilitation service; or

(4) Twenty-four hour support 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, and as determined by an Ohio department of medicaid (ODM) approved assessment instrument.

(C) For the purposes of meeting the criteria described in paragraph (B)(1) of this rule, an adult has a need in an ADL when:

(1) The adult requires assistance with bathing in at least one of the following three components:

(a) Applying cleansing agent;

(b) Rinsing; or

(c) Drying.

(2) The adult 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.

(3) The adult requires assistance with eating in at least one of the following three components:

(a) Getting food into the mouth;

(b) Chewing; or

(c) Swallowing.

(4) The adult requires assistance with grooming in all of the following three components:

(a) Hair care, including:

(i) Washing one's hair; or

(ii) Brushing or combing one's hair.

(b) Nail care, including:

(i) Cutting fingernails; or

(ii) Cutting toenails.

(c) Oral hygiene.

(5) The adult requires assistance with mobility in at least one of the following three components:

(a) Bed mobility;

(b) Locomotion; or

(c) Transfers inside the house.

(6) The adult requires assistance with toileting in at least one of the following four components:

(a) Using a toilet, bedpan, or urinal;

(b) Changing incontinence supplies or feminine hygiene products;

(c) Cleansing self; or

(d) Managing an ostomy or catheter.

(D) An adult will not be considered to have an intermediate level of care as described in

paragraph (C) of this rule when an adult has a developmental disability as defined in section 5126.01 of the Revised Code, or meets the developmental disabilities level of care criteria as described in rule 5123:2-8-01 of the Administrative Code.

(E) An adult will be considered to have a skilled level of care when the adult is first considered to have an intermediate level of care, in accordance with paragraph (C) of this rule and the adult:

(1) Requires a minimum of one of the following:

(a) One skilled nursing service as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code within the day on no less than seven days per week; or

(b) One skilled rehabilitation service as defined in paragraph (B)(32) of rule 5160-3-05 of the Administrative Code within the day on no less than five days per week.

(2) Has an unstable medical condition as defined in paragraph (B)(35) of rule 5160-3-05 of the Administrative Code.

(F) When an adult has a skilled level of care as described in paragraph (E) of this rule, the adult may request placement in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) that provides services to individuals who have a skilled level of care. When an adult with a skilled level of care requests placement in an ICF-IID, the following apply:

(1) The adult may be determined to have a developmental disabilities level of care as described in rule 5123:2-8-01 of the Administrative Code; and

(2) The ICF-IID must provide written certification that the services provided in the facility are appropriate to meet the needs of an adult who meets the criteria for a skilled level of care.

(G) When an adult is enrolled on a nursing facility-based medicaid waiver program and is being re-assessed for continued enrollment in accordance with rules 5160-46-02, 5160-58-02.2, 5160-31-03, and 5160-33-03 of the Administrative Code, the adult may continue to be enrolled on the medicaid waiver program notwithstanding paragraph (D) of this rule, when all waiver eligibility criteria are met and the following conditions are met:

(1) The adult was considered to have a skilled level of care when initially enrolled on the medicaid waiver program; and

(2) At re-assessment the adult is considered to have an intermediate level of care as described in paragraph (C) of this rule.

Replaces: 5160-3-08

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5165.04
Prior Effective Dates:	7/1/80, 11/10/83, 10/1/93 (Emer.), 12/31/93, 7/1/08, 3/19/12

5160-3-09 **Criteria for nursing facility-based level of care for a child.**

(A) This rule describes the criteria for a child to be considered to have a nursing facility-based level of care. A nursing facility-based level of care includes the intermediate and skilled levels of care.

(B) The child must be assessed using the age-appropriate criteria for the child's age as of the date of the assessment.

(C) A child will be considered to have an intermediate level of care when:

(1) A child from birth through age five months requires each of the following:

(a) Assistance with at least one of the following age-appropriate activities of daily living (ADL) as described in the ODM 10126 "Child Comprehensive Assessment Tool" (11/2017) or the ODM 10128 "Child Level of Care Questionnaire" (11/2017):

(i) Dressing, which means the child has physical characteristics that make dressing very difficult such as contractures, extreme hypotonic, or extreme hypertonia; or

(ii) Eating, which means the child requires more than one hour per feeding or the child requires more than three hours per day for feeding or eating.

(b) At least one skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, at least two days per week.

(2) A child from age six months through age eleven months requires each of the following:

(a) Assistance with at least two of the following age-appropriate ADLs as described in the ODM 10126 or the ODM 10128:

(i) Bathing, which means the child needs adaptive equipment;

(ii) Dressing, which means the child has physical characteristics that make dressing very difficult such as contractures, extreme hypotonic, or extreme hypertonia;

(iii) Eating, which means the child requires more than one hour per feeding or requires more than three hours per day for feeding or eating; or

(iv) Mobility, which means the child is unable to maintain a sitting position when placed or is unable to move himself or herself by rolling, crawling or creeping.

(b) At least one skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, at least two days per week.

(3) A child from age twelve months through age seventeen months requires each of the following:

(a) Assistance with at least two of the following age-appropriate ADLs as described in the ODM 10126 or the ODM 10128:

(i) Bathing, which means the child needs adaptive equipment or is non-cooperative during bathing which results in the child requiring alternative bathing methods;

(ii) Dressing, which means the child has physical characteristics that make dressing very difficult such as contractures, extreme hypotonic, or extreme hypertonia;

(iii) Eating, which means the child requires more than one hour per feeding or requires more than three hours per day for feeding or eating; or

(iv) Mobility, which means the child is unable to crawl, creep, pull to stand, sit alone, or requires a stander or someone to support the child's weight in a standing position.

(b) At least one skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, at least two days per week.

(4) A child from age eighteen months through age twenty-three months requires each of the following:

(a) Assistance with at least two of the following age-appropriate ADLs as described in the ODM 10126 or the ODM 10128:

(i) Bathing, which means the child needs adaptive equipment or is non-cooperative during bathing which results in the child requiring alternative bathing methods;

(ii) Dressing, which means the child does not assist with dressing by helping place arms in sleeves or legs into pants;

(iii) Eating, which means the child requires more than three hours per

day for feeding or eating; or

(iv) Mobility, which means the child requires a stander, requires someone to support his or her weight in a standing position, or is unable to take steps holding on to furniture.

(b) At least one skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, at least two days per week.

(5) A child from age twenty-four months through age thirty-five months requires each of the following:

(a) Assistance with at least two of the following age-appropriate ADLs as described in the ODM 10126 or the ODM 10128:

(i) Bathing, which means the child needs adaptive equipment or is non-cooperative during bathing which results in the child requiring alternative bathing methods;

(ii) Dressing, which means the child does not assist with dressing by helping place his or her arms in sleeves or does not assist by helping place his or her legs into pants;

(iii) Eating, which means the child requires more than three hours per day for feeding or eating; or

(iv) Mobility, which means the child requires a stander, requires someone to support his or her weight in a standing position, does not walk inside the house, needs assistance to walk inside the house, needs assistance with transfers, or needs assistance with positioning.

(b) At least one skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, at least two days per week.

(6) A child from age thirty-six months through age forty-seven months requires each of the following:

(a) Assistance with at least two of the following age-appropriate ADLs as described in the ODM 10126 or the ODM 10128:

(i) Bathing, which means the child needs adaptive equipment or is non-cooperative during bathing;

(ii) Grooming, which means the child is non-cooperative during grooming;

(iii) Dressing, which means the child does not assist with dressing by helping place his or her arms in sleeves, does not assist by helping place his or her legs into pants, or is unable to dress himself or herself independently;

(iv) Eating, which means the child requires more than three hours per day for feeding or eating;

(v) Toileting, which means the child has no awareness of being wet or soiled or does not use a toilet when placed there by a caregiver; or

(vi) Mobility, which means the child does not walk inside the house, needs assistance to walk inside the house, needs assistance with transfers, needs assistance with positioning, or uses a mechanical lift.

(b) At least one skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, at least two days per week.

(7) A child from age four years through age five years requires each of the following:

(a) Assistance with at least two of the following age-appropriate ADLs as described in the ODM 10126 or the ODM 10128:

(i) Bathing, which means the child needs adaptive equipment, needs to be lifted in and out of the bathtub, or is non-cooperative during bathing;

(ii) Grooming, which means the child is non-cooperative during grooming or is unable to wash hands without assistance;

(iii) Dressing, which means the child needs assistance with basic dressing tasks such as pulling on pants, shirt, and coat or is unable to dress himself or herself independently;

(iv) Eating, which means the child needs to be fed or requires more than three hours per day for feeding or eating;

(v) Toileting, which means the child is incontinent of bowel and/or bladder during the day or needs assistance other than wiping; or

(vi) Mobility, which means the child does not walk inside the house, needs assistance to walk inside the house, needs assistance with transfers, needs assistance with positioning, or uses a mechanical lift.

(b) At least one skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, at least two days per week.

(8) A child from age six years through age eight years requires each of the following:

(a) Assistance with at least two of the following age-appropriate ADLs as described in the ODM 10126 or the ODM 10128:

(i) Bathing, which means the child needs assistance with bathing tasks, needs adaptive equipment, needs to be lifted in and out of the bathtub, or is non-cooperative during bathing;

(ii) Grooming, which means the child needs assistance with grooming tasks, is non-cooperative during grooming, or is unable to wash hands or face without assistance;

(iii) Dressing, which means the child needs assistance with dressing;

(iv) Eating, which means the child needs to be fed;

(v) Toileting, which means the child needs assistance with toileting, is incontinent of bowel and/or bladder during the day, or is incontinent of bowel during the night; or

(vi) Mobility, which means the child does not walk inside the house, needs assistance to walk inside the house, needs assistance with transfers, needs assistance with positioning, or uses a mechanical lift.

(b) At least one skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, at least two days per week.

(9) A child from age nine years through age eleven years requires each of the following:

(a) Assistance with at least two of the following age-appropriate ADLs as described in the ODM 10126 or the ODM 10128:

(i) Bathing, which means the child needs assistance with bathing tasks, needs adaptive equipment, needs to be lifted in and out of the bathtub, or is non-cooperative during bathing;

(ii) Grooming, which means the child needs assistance with grooming tasks or is non-cooperative during grooming;

(iii) Dressing, which means the child needs assistance with dressing;

(iv) Eating, which means the child needs to be fed;

(v) Toileting, which means the child needs assistance with toileting or is incontinent of bowel or bladder; or

(vi) Mobility, which means the child does not walk inside the house, needs assistance to walk inside the house, needs assistance with transfers, needs assistance with positioning, or uses a mechanical lift.

(b) At least one skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, at least two days per week.

(10) A child from age twelve years through age thirteen years requires each of the following:

(a) Assistance with at least two of the following age-appropriate ADLs as described in the ODM 10126 or the ODM 10128:

(i) Bathing, which means the child needs assistance with bathing tasks, needs adaptive equipment, needs to be lifted in and out of the bathtub or shower, or is non-cooperative during bathing;

(ii) Grooming, which means the child needs assistance with grooming tasks or is non-cooperative during grooming;

(iii) Dressing, which means the child needs assistance with dressing;

(iv) Eating, which means the child needs to be fed;

(v) Toileting, which means the child needs assistance with toileting or is incontinent of bowel or bladder; or

(vi) Mobility, which means the child does not walk inside the house, needs assistance to walk inside the house, needs assistance with transfers, needs assistance with positioning, or uses a mechanical lift.

(b) At least one skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, at least two days per week.

(11) For a child from age fourteen years through age twenty years:

(a) The child needs assistance with at least two age-appropriate ADLs as

described in the ODM 10126 or the ODM 10128 and in paragraph (C)(11)(c) of this rule and at least one skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, at least two days per week; or

(b) The child needs assistance with at least two age-appropriate ADLs as described in the ODM 10126 or the ODM 10128 and in paragraph (C)(11)(c) of this rule and assistance with at least three age-appropriate instrumental activities of daily living (IADL) as described in the ODM 10126 or the ODM 10128 and in paragraph (C)(11)(d) of this rule.

(c) Age-appropriate ADLs:

(i) Bathing, which means the child needs assistance with bathing tasks, needs adaptive equipment, needs to be lifted in and out of the bathtub or shower, or is non-cooperative during bathing;

(ii) Grooming, which means the child needs assistance with grooming tasks or is non-cooperative during grooming;

(iii) Dressing, which means the child needs assistance with dressing;

(iv) Eating, which means the child needs to be fed;

(v) Toileting, which means the child needs assistance with toileting or is incontinent of bowel or bladder; or

(vi) Mobility, which means the child does not walk inside the house, needs assistance to walk inside the house, needs assistance with transfers, needs assistance with positioning, or uses a mechanical lift.

(d) Age-appropriate IADLs:

(i) Community access, which means the child needs assistance in getting and using transportation that is not provided by the caregiver or needs someone to arrange and help use transportation that is not provided by the caregiver;

(ii) House cleaning, which means the child needs assistance to clean or tidy;

(iii) Meal preparation, which means the child needs assistance making simple meals for himself or herself;

(iv) Money management, which means the child needs assistance purchasing with cash or elecronic systems, determining amount of

change, needs assistance in keeping money secure and accessing it, or needs someone to manage money;

(v) Personal laundry, which means the child needs assistance with washing and drying personal clothing and household items by machine or by hand, or needs someone to wash and dry personal clothing and household items by machine or by hand;

(vi) Shopping, which means the child needs assistance obtaining or purchasing necessary items or needs someone to obtain or purchase necessary items; or

(vii) Telephoning, which means the child needs assistance in making and answering telephone calls, using technology to communicate, or needs someone to make and answer telephone calls or use technology to communicate. Needing assistance using technology to communicate does not include speech-generating devices.

(D) A child will not be considered to have an intermediate level of care as described in paragraph (C) of this rule when a child has a developmental disability as defined in section 5126.01 of the Revised Code, or meets the developmental disabilities level of care criteria as described in rule 5123:2-8-01 of the Administrative Code.

(E) A child will be considered to have a skilled level of care when the child is first considered to have an intermediate level of care, in accordance with paragraph (C) of this rule and the child:

(1) Requires a minimum of one of the following:

(a) One skilled nursing service, as defined in paragraph (B)(31) of rule 5160-3-05 of the Administrative Code, within the day on no less than seven days per week; or

(b) One skilled rehabilitation service, as defined in paragraph (B)(32) of rule 5160-3-05 of the Administrative Code, within the day on no less than five days per week; and

(2) Has an unstable medical condition as defined in paragraph (B)(35) of rule 5160-3-05 of the Administrative Code.

(F) When a child has a skilled level of care as described in paragraph (E) of this rule, the child or the child's representative, hereafter referred to as the child, may request placement in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) that provides services to individuals who have a skilled level of care. When a child with a skilled level of care requests placement in an ICF-IID, the following apply:

(1) The child may be determined to have a developmental disabilities level of care; and

(2) The ICF-IID must provide written certification that the services provided in the facility are appropriate to meet the needs of a child who meets the criteria for a skilled level of care.

(G) When a child is enrolled on a nursing facility-based medicaid waiver program and is being re-assessed for continued enrollment in accordance with rule 5160-46-02 of the Administrative Code, the child may continue to be enrolled on the medicaid waiver program notwithstanding paragraph (D) of this rule, when all waiver eligibility criteria are met and the following conditions are met:

(1) The child was considered to have a skilled level of care when initially enrolled on the medicaid waiver program; and

(2) At re-assessment the child is considered to have an intermediate level of care as described in paragraph (C) of this rule.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5165.04

5160-3-10 **Nursing facility-based level of care assessment and determination process for children.**

(A) This rule describes the processes and timeframes for a child's level of care assessment and determination for a nursing facility-based level of care program, as defined in paragraph (B)(27) of rule 5160-3-05 of the Administrative Code.

(1) The processes described in this rule shall not be used for a determination of a developmental disabilities level of care.

(2) The processes described in this rule shall not be used for a level of care determination for a child on a medicaid managed care plan who is seeking a nursing facility admission.

(3) A nursing facility-based level of care is necessary for:

(a) A nursing facility to submit claims for services included in the nursing facility per diem rate, in accordance with rule 5160-3-39.1 of the Administrative Code.

(b) A child to be enrolled on a nursing facility-based medicaid waiver program.

(B) Level of care assessment for a child seeking medicaid fee-for-service payment for a nursing facility stay.

(1) An ODM 10128 "Child Level of Care Questionnaire" (11/2017) must be completed and submitted to the PASSPORT administrative agency (PAA) in order for the PAA to make a level of care determination. An ODM 10128 is considered complete when a qualified assessor, as defined in paragraph (B)(30) of rule 5160-3-05 of the Administrative Code, completes all required data fields on the ODM 10128 and submits it to the PAA, along with any necessary supporting documentation.

(2) The nursing facility shall ensure that the preadmission screening and resident review (PASRR) requirements have been met in accordance with rules 5160-3-15, 5160-3-15.1 and 5160-3-15.2 of the Administrative Code.

(a) In order for the Ohio department of medicaid (ODM) to authorize payment to a nursing facility, the child must have received a non-adverse PASRR determination and subsequent nursing facility-based level of care determination.

(i) ODM cannot authorize payment to the nursing facility before the effective date of the PASRR determination.

(ii) The level of care effective date cannot precede the effective date of the PASRR determination date.

(b) If a nursing facility receives medicaid payment from ODM for a child who does not have a nursing facility-based level of care, the nursing facility is subject to the claim adjustment for overpayment process described in rule 5160-1-19 of the Administrative Code.

(c) The PAA shall issue documentation of the PASRR outcome(s) to the submitter of the PASRR request.

(3) Supporting documentation to be submitted with the ODM 10128 may include, but is not limited to:

(a) Minimum data set (MDS) details;

(b) Discharge summary;

(c) Medical history and physical; and

(d) PASRR forms or other PASRR documentation.

(4) When the PAA receives an incomplete ODM 10128 or insufficient supporting documentation, the PAA shall:

(a) Notify the submitter that a level of care determination cannot be issued due to an incomplete ODM 10128 or insufficient supporting documentation and specify the necessary information the submitter must provide.

(b) Notify the submitter that the level of care will be denied if the PAA does not receive the necessary information within fourteen calendar days.

(i) When the submitter provides the necessary information within the fourteen calendar day timeframe, the PAA shall proceed with the level of care determination process

(ii) When the submitter does not provide the necessary information within the fourteen calendar day timeframe, the PAA shall deny the level of care.

(C) Desk review level of care determination.

(1) The PAA shall complete a desk review level of care determination, as defined in paragraph (B)(14) of rule 5160-3-05 of the Administrative Code, within one business day from the date of receipt of the most current version of the ODM

10128 when a child is seeking admission or re-admission to a nursing facility from an acute care hospital or hospital emergency room.

(2) The PAA shall complete a desk review level of care determination within five calendar days from the date of receipt of the ODM 10128 when:

(a) A child is seeking admission to a nursing facility and is requesting medicaid fee-for-service payment for the nursing facility stay.

(b) A child who resides in a nursing facility is requesting to change from a non-medicaid payor to medicaid fee-for-service payment for the continued nursing facility stay.

(c) A child who resides in a nursing facility is requesting to change from medicaid managed care to medicaid fee-for-service payment for the continued nursing facility stay.

(D) The PAA shall complete a face-to-face level of care assessment, as defined in paragraph (B)(15) of rule 5160-3-05 of the Administrative Code, within ten calendar days from the date of receipt of the ODM 10128 when:

(1) An adult, medicaid authorized representative, or other representative of the child requests a face-to-face level of care assessment.

(2) A child resides in the community and the PAA verifies that the child does not have a current nursing facility-based level of care determination.

(3) A desk review level of care determination results in an adverse level of care determination, as defined in paragraph (B)(5) of rule 5160-3-05 of the Administrative Code. A registered nurse shall conduct a face-to-face level of care assessment to verify the level of care outcome.

(4) The PAA determines that there is insufficient of inconsistent information provided during the desk review level of care determination process.

(E) Delayed face-to-face visit.

(1) The PAA shall complete a delayed face-to-face visit, as defined in paragraph (B)(13) of rule 5160-3-05 of the Administrative Code, within ninety calendar days after the PAA conducts a desk review level of care determination.

(2) The following are exceptions to the delayed face-to-face visit:

(a) A child as described in paragraph (C)(2)(c) of this rule.

(b) An adult, medicaid authorized representative, or other representative of the child declines a delayed face-to-face visit.

(c) A child who has had a long-term care consultation in accordance with Chapter 173-43 of the Administrative Code since the child's nursing facility admission.

(d) A child who has had an in-person resident review in accordance with Chapter 5160-3 of the Administrative Code since the child's nursing facility admission.

(e) A child 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 a medicaid home and community-based waiver.

(F) Level of care validation.

The PAA shall complete a level of care validation, as defined in paragraph (B)(21) of rule 5160-3-05 of the Administrative Code, within one business day from the date of receipt of the ODM 10128 for

(1) A child who is enrolled on a nursing facility-based medicaid waiver program and is seeking admission to a nursing facility.

(2) A child who is a nursing facility resident and is seeking readmission to the same nursing facility after a hospitalization.

(3) A child with a nursing facility-based level of care is transferring from one nursing facility to another nursing facility.

(G) Level of care determination for a child seeking enrollment on a nursing facility-based medicaid waiver program.

(1) In accordance with rule 5160-46-02 of the Administrative Code, a nursing facility-based level of care is one criterion required for enrollment on a nursing facility-based medicaid waiver program.

(2) A qualified assessor shall conduct a face-to-face level of care assessment using the ODM 10126 "Child Comprehensive Assessment Tool (CCAT)" (11/2017).

(3) When the ODM 10126 is submitted with all required fields completed, ODM or its designee shall issue a level of care determination.

(4) When a licensed social worker or licensed independent social worker performs the face-to-face level of care assessment resulting in an adverse level of care determination, a registered nurse shall conduct a subsequent face-to-face level of care assessment to verify the level of care outcome.

(H) Issuing notice for level of care determinations.

(1) ODM shall notify the child and his or her medicaid authorized representative as applicable, of the level of care determination.

(2) When the PAA makes a level of care determination based upon a level of care assessment submitted in accordance with paragraph (B) of this rule, the PAA shall issue documentation of the level of care determination outcome(s) to the submitter of the ODM 10128.

(3) In accordance with Chapter 5160:1-2 of the Administrative Code, the county department of job and family services shall determine medicaid eligibility.

(4) In accordance with division 5101:6 of the Administrative Code, ODM shall issue proper notice and hearing rights.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5165.04

5160-3-14 **Nursing facility-based level of care assessment and determination process for adults.**

(A) This rule describes the processes and timeframes for an adult's level of care assessment and determination for a nursing facility-based level of care program, as defined in paragraph (B)(27) of rule 5160-3-05 of the Administrative Code.

(1) The processes described in this rule shall not be used for a determination of a developmental disabilities level of care.

(2) The processes described in this rule shall not be used for a level of care determination for an adult on a medicaid managed care plan who is seeking a nursing facility admission.

(3) A nursing facility-based level of care is necessary for:

(a) A nursing facility to submit claims for services included in the nursing facility per diem rate, in accordance with rule 5160-3-39.1 of the Administrative Code.

(b) An adult to be enrolled on a nursing facility-based medicaid waiver program.

(B) Level of care assessment for an adult seeking medicaid fee-for-service payment for a nursing facility stay.

(1) An ODM 10127 "Adult Level of Care Questionnaire" (11/2017) must be completed and submitted to the PASSPORT administrative agency (PAA) in order for the PAA to make a level of care determination. An ODM 10127 is considered complete when a qualified assessor, as defined in paragraph (B)(30) of rule 5160-3-05 of the Administrative Code, completes all required data fields on the ODM 10127 and submits it to the PAA, along with any necessary supporting documentation.

(2) The nursing facility shall ensure that the preadmission screening and resident review (PASRR) requirements have been met in accordance with rules 5160-3-15, 5160-3-15.1 and 5160-3-15.2 of the Administrative Code.

(a) In order for the Ohio department of medicaid (ODM) to authorize payment to a nursing facility, the adult must have received a non-adverse PASRR determination and subsequent nursing facility-based level of care determination.

(i) ODM cannot authorize payment to the nursing facility before the effective date of the PASRR determination.

(ii) The level of care effective date cannot precede the effective date of the PASRR determination date.

(b) If a nursing facility receives medicaid payment from ODM for an adult who does not have a nursing facility-based level of care, the nursing facility is subject to the claim adjustment for overpayment process described in rule 5160-1-19 of the Administrative Code.

(c) The PAA shall issue documentation of the PASRR outcome(s) to the submitter of the PASRR request.

(3) Supporting documentation to be submitted with the ODM 10127 may include, but is not limited to:

(a) Minimum data set (MDS) details;

(b) Discharge summary;

(c) Medical history and physical; and

(d) PASRR forms or other PASRR documentation.

(4) When the PAA receives an incomplete ODM 10127 or insufficient supporting documentation, the PAA shall:

(a) Notify the submitter that a level of care determination cannot be issued due to an incomplete ODM 10127 or insufficient supporting documentation and specify the necessary information the submitter must provide.

(b) Notify the submitter that the level of care will be denied if the PAA does not receive the necessary information within fourteen calendar days.

(i) When the submitter provides the necessary information within the fourteen calendar day timeframe, the PAA shall proceed with the level of care determination process.

(ii) When the submitter does not provide the necessary information within the fourteen calendar day timeframe, the PAA shall deny the level of care.

(C) Desk review level of care determination.

(1) The PAA shall complete a desk review level of care determination, as defined in paragraph (B)(14) of rule 5160-3-05 of the Administrative Code, within one business day from the date of receipt of the ODM 10127 when an adult is

seeking admission or re-admission to a nursing facility from an acute care hospital or hospital emergency room.

(2) The PAA shall complete a desk review level of care determination within five calendar days from the date of receipt of the ODM 10127 when:

(a) An adult is seeking admission to a nursing facility and is requesting medicaid fee-for-service payment for the nursing facility stay.

(b) An adult who resides in a nursing facility is requesting to change from a non-medicaid payor to medicaid fee-for-service payment for the continued nursing facility stay

(c) An adult who resides in a nursing facility is requesting to change from medicaid managed care to medicaid fee-for-service payment for the continued nursing facility stay.

(D) Face-to-face level of care assessment.

(1) The PAA shall complete a face-to-face level of care assessment, as defined in paragraph (B)(15) of rule 5160-3-05 of the Administrative Code, within two business days from the date of a request when:

(a) An adult is receiving adult protective services, as defined in rule 5101:2-20-01 of the Administrative Code.

(b) An adult appears to meet level of care criteria solely on the basis of a need for twenty-four hour support in order to prevent harm due to a cognitive impairment, in accordance with paragraph (B)(3) of rule 5160-3-08 of the Administrative Code.

(2) The PAA shall complete a face-to-face level of care assessment within ten calendar days from the date of the request when:

(a) An adult, medicaid authorized representative, or other representative of the adult requests a face-to-face level of care assessment.

(b) An adult resides in the community and the PAA verifies that the adult does not have a current nursing facility-based level of care determination.

(c) A desk review level of care determination results in an adverse level of care determination, as defined in paragraph (B)(5) of rule 5160-3-05 of the Administrative Code. A registered nurse shall conduct a face-to-face level of care assessment to verify the level of care outcome.

(d) The PAA determines that there is insufficient of inconsistent information provided during the desk review level of care determination process.

(E) Delayed face-to-face visit.

(1) The PAA shall complete a delayed face-to-face visit, as defined in paragraph (B)(13) of rule 5160-3-05 of the Administrative Code, within ninety calendar days after the PAA conducts a desk review level of care determination.

(2) The following are exceptions to the delayed face-to-face visit:

(a) An adult as described in paragraph (C)(2)(c) of this rule.

(b) An adult who declines a delayed face-to-face visit.

(c) An adult who has had a long-term care consultation in accordance with Chapter 173-43 of the Administrative Code since the adult's nursing facility admission.

(d) An adult who has had an in-person resident review in accordance with rule 5160-3-15.2 of the Administrative Code since the adult's nursing facility admission.

(e) An adult 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 a medicaid home and community-based waiver.

(F) Level of care validation.

The PAA shall complete a level of care validation, as defined in paragraph (B)(21) of rule 5160-3-05 of the Administrative Code, within one business day from the date of receipt of the ODM 10127 for:

(1) An adult who is enrolled on a nursing facility-based medicaid waiver program and is seeking admission to a nursing facility.

(2) An adult who is a nursing facility resident and is seeking readmission to the same nursing facility after a hospitalization.

(3) An adult with a nursing facility-based level of care is transferring from one nursing facility to another nursing facility.

(G) Level of care determination for an adult seeking enrollment on a nursing facility-based medicaid waiver program.

(1) In accordance with rules 5160-46-02, 5160-58-02.2, 5160-31-03, and 5160-33-03 of the Administrative Code, a nursing facility-based level of care is one criterion required for enrollment on a nursing facility-based medicaid waiver program.

(2) A qualified assessor shall conduct a face-to-face level of care assessment using the ODM 10125 "Adult Comprehensive Assessment Tool (ACAT)" (11/2017).

(3) When the ODM 10125 is submitted with all required fields completed, ODM or its designee shall issue a level of care determination.

(4) When a licensed social worker or licensed independent social worker performs the face-to-face level of care assessment resulting in an adverse level of care determination, a registered nurse shall conduct a subsequent face-to-face level of care assessment to verify the level of care outcome.

(H) Issuing notice for level of care determinations.

(1) ODM shall notify the adult, and/or his or her medicaid authorized representative, as applicable, of the level of care determination.

(2) When the PAA makes a level of care determination based upon a level of care assessment submitted in accordance with paragraph (B) of this rule, the PAA shall issue documentation of the level of care determination outcome(s) to the submitter of the ODM 10127.

(3) In accordance with Chapter 5160:1-2 of the Administrative Code, the county department of job and family services shall determine medicaid eligibility.

(4) In accordance with division 5101:6 of the Administrative Code, ODM shall issue proper notice and hearing rights.

Replaces: 5160-3-14

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5165.04
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, 3/19/12