TO BE RESCINDED

5123:2-7-10 **Intermediate care facilities - outlier services for behavioral redirection and medical monitoring.**

(A) Purpose

(1) The purpose of this rule is to identify a subpopulation of those persons determined to require an intermediate care facility level of care whose care needs are not adequately measured by the individual assessment form or by the resident assessment classification and case mix payment system described in rule 5123:2-7-20 of the Administrative Code.

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

(1) "Behavioral phenotype" means the observable or measurable expression of a gene or genes and the heightened probability that a person with a given syndrome will exhibit behavioral or developmental sequelae relative to others without the syndrome.

(2) "Intermediate care facility for behavioral redirection and medical monitoring" means an intermediate care facility approved by the department to deliver outlier services for behavioral redirection and medical monitoring that holds an effective intermediate care facility for behavioral redirection and medical monitoring provider agreement with the Ohio office of medical assistance.

(3) "Individual plan" means a written description of the services to be provided to an individual, developed by an interdisciplinary team that represents the professions, disciplines, or service areas that are relevant to identifying the individual's needs, as described by the comprehensive functional assessments.

(4) "Level of care review" means the evaluation of an individual's physical, mental, and social/emotional status to determine the level of care required to meet the individual's service needs and includes activities necessary to safeguard against unnecessary utilization. Level of care determinations are based upon the criteria regarding the amount and type of services needed by an individual that are set forth in rules in Chapter 5101:3-3 of the Administrative Code. The level of care process is also the mechanism by which the medicaid vendor payment is initiated for non-outlier facilities. For outlier facilities, individuals require written preadmission or continued stay prior authorization approval from the department before vendor payment may be initiated or continued for a time-specific duration.

(5) "Designated outlier coordinator" means a designated department staff member who coordinates the general operations of the intermediate care facility outlier program. This coordinator works with providers of outlier services, the individuals and their representatives requesting and receiving outlier services, other service agencies, and other department staff. This coordinator's duties include, but are not limited to, the following:

(a) Assisting with the initial approval and ongoing monitoring of outlier provider facilities; and

(b) Coordinating the processing of preadmission and continued stay prior authorization requests for individuals; and

(c) Representing the department as a team member on the individual's interdisciplinary team; and

(d) Reviewing assessments, individual plans, day programming plans, staffing plans, and other documents.

(6) "Outlier services" means those clusters of services that have been determined by the department to require reimbursement rates established pursuant to section 5111.258 of the Revised Code when delivered by qualified providers to individuals who have been prior authorized for the receipt of a category of service identified as an outlier service by the department and/or set forth as such in Chapter 5123:2-7 of the Administrative Code.

(7) "Physician" means a doctor of medicine or osteopathy who is licensed to practice medicine.

(8) "Plan of correction" means a corrective action plan prepared by an intermediate care facility in response to deficiencies cited by the state survey agency. The plan shall conform to regulations and guidelines, and shall include information that describes how the deficiency will be corrected, when it will be corrected, how other residents that may be affected by the deficiency will be identified, and how the facility will assure that compliance will be maintained upon correction.

(9) "Prior authorization assessment for intermediate care facility behavioral redirection and medical monitoring services" means an evaluation to determine if an individual meets the criteria to be served by an intermediate care facility for behavioral redirection and medical monitoring as outlined in paragraphs (C)(3) to (C)(10) of this rule, and shall take place only after the individual is

determined to meet the financial eligibility and level of care requirements set forth in paragraphs (C)(1) and (C)(2) of this rule.

(10) "Prior authorization approval for intermediate care facility behavioral redirection and medical monitoring services" means approval obtained by the provider of intermediate care facility behavioral redirection and medical monitoring services from the department on behalf of a specific individual for specific time-limited initial or continued stay periods at an that holds an effective intermediate care facility for behavioral redirection and medical monitoring provider agreement. Prior authorization for intermediate care facility behavioral redirection and medical monitoring services shall be required for the provider to be authorized by the department to receive reimbursement for services rendered to the individual, because payment rates for these services are determined through a contracted rate process in accordance with rule 5101:3-3-17 of the Administrative Code. Reimbursement may be denied for any service not rendered in accordance with rules in Chapters 5101:3-3 and 5123:2-7 of the Administrative Code.

(a) Initial prior authorization for intermediate care facility behavioral redirection and medical monitoring services.

Unless the individual is seeking a change of payer, the prior authorization of payment for intermediate care facility behavioral redirection and medical monitoring services shall occur prior to admission to the intermediate care facility for behavioral redirection and medical monitoring.

(b) Continued stay prior authorization for intermediate care facility behavioral redirection and medical monitoring services.

In the case of requests for continued stay, the prior authorization of payment for intermediate care facility behavioral redirection and medical monitoring services shall occur no later than the final day of the previously authorized intermediate care facility for behavioral redirection and medical monitoring stay.

(11) "Progressive serious medical condition" means an illness, injury, impairment, or physical or mental condition, or a combination of mental and physical conditions, that continues over an extended period of time and involves a regimen of continuing treatment and/or periodic visits/monitoring by a physician, or by a nurse or physician's assistant under direct supervision of a physician. A progressive serious medical condition involves the characteristic

signs and symptoms of the condition becoming more prominent by manifesting more frequently or increasing in severity as part of the course of the condition.

(12) "Secondary medical condition" means an additional physical or mental health condition that occurs more frequently among persons having a specific primary progressive serious medical condition.

(C) Individual eligibility criteria

To receive prior authorization approval for intermediate care facility behavioral redirection and medical monitoring services, an individual shall meet all the following criteria:

(1) Financial eligibility

The individual shall have been determined by the county department of job and family services to meet the medicaid financial eligibility standards for institutional care; and

(2) Level of care determination

The individual must have obtained a level of care determination from the department within the last thirty days, or, at the time of prior authorization assessment for intermediate care facility behavioral redirection and medical monitoring services, be determined by the department to meet the criteria for a level of care as set forth in rule 5101:3-3-07 of the Administrative Code; and

(3) Presence of progressive developmental disability

The individual shall have either a developmental disability other than an intellectual disability, or have a diagnosis of intellectual disability and have been determined to function at the mild or moderate intellectual level in accordance with standard measurements as recorded in the most current revision of the manual of terminology and classification published by the American association on intellectual disabilities; and

(4) Presence of primary progressive serious medical condition

The individual shall have a primary diagnosis of a progressive serious medical condition other than a mental or physical impairment solely caused by mental illness as defined in division (A) of section 5122.01 of the Revised Code, and other than an intellectual disability, that is generally acknowledged to be associated with:

(a) Behaviors posing a substantial risk of injury to self or others that cannot be eradicated by psychiatric, pharmacologic, neurologic, or behavioral intervention, or combination of interventions; and

(b) Behaviors requiring a restrictive environment to maintain health and safety; and

(5) Presence of secondary medical condition

The individual shall have at least one medical condition other than mental illness or intellectual disability that is a secondary manifestation of the primary progressive serious medical condition listed in paragraph (C)(4) of this rule; and that, without intervention, would threaten the person's medical stability; and

(6) Episode of injury to self or others and continuing risk of injury to self or others

(a) Within the twelve months preceding the initial prior authorization assessment for intermediate care facility behavioral redirection and medical monitoring services, the individual shall have exhibited behavior that is generally acknowledged to be associated with one of the medical conditions described in paragraph (C)(4) or (C)(5) of this rule that resulted in substantial injury to self or others; and

(b) Within the twelve months prior to any continued stay prior authorization assessment for intermediate care facility behavioral redirection and medical monitoring services, the individual shall have exhibited behavior that is generally acknowledged to be associated with one of the medical conditions described in paragraph (C)(4) or (C)(5) of this rule that poses substantial risk of injury to self or others; and

(7) Presence of aberrant motivational behavioral profile

Within the past twelve months, the individual shall have exhibited a consistent pattern of behaviors or frequent episodes that displays the following behavioral profile:

(a) Lacks impulse control; and

(b) Exhibits purposeful, but dysfunctional, goal-directed behavior to obtain or avoid something; and

(c) Makes manipulative threats of harm to self, others, or property to obtain this goal; and

(d) Has the physical capability to carry out the threats; and

(e) Has a history of carrying out the threats and/or currently attempts to carry out the threats; and

(8) Constant monitoring and continual behavioral intervention

For individuals eligible to receive intermediate care facility behavioral redirection and medical monitoring services, reduction in health and safety risks are expected to result from external and continuously required intervention, not from any expected internal gains in insight or impulse control by the individual or elimination of risk through medical treatment of the medical conditions.

(a) The individual shall exhibit behaviors generally acknowledged to be associated with the medical conditions described in paragraph (C)(4) or (C)(5) of this rule that are not expected to be eliminated through the implementation of psychiatric, neurologic, or pharmacologic interventions or combination of interventions, and thus present a continuing need for temporary control through behavioral intervention strategies such as behavioral redirection.

(b) The individual shall require constant staff attention during waking hours for redirection and intervention, and awake staff supervision twenty-four hours a day, seven days a week; and

(9) A substantially restrictive environment

The individual shall have at least one behavioral manifestation generally acknowledged to be associated with the primary medical condition listed in paragraph (C)(4) of this rule, and that requires a substantially restrictive environment to maintain health and safety by eliminating opportunities for the behavior to occur; and

(10) Less restrictive settings ruled out

The individual shall not be able to have these behavioral and medical needs met in any setting less restrictive than an intermediate care facility for behavioral redirection and medical monitoring.

(D) Provider eligibility criteria

Prior to enrollment as an intermediate care facility behavioral redirection and medical monitoring service provider, and at regular intervals to be determined subsequent to that enrollment, the department shall determine whether the intermediate care facility

behavioral redirection and medical monitoring service provider qualifications are fulfilled through review of documentation of appropriate policies and procedures, on-site visits, and other mechanisms determined to be appropriate by the department. In order to obtain an intermediate care facility behavioral redirection and medical monitoring provider agreement and qualify for enhanced payment for provision of intermediate care facility behavioral redirection and medical monitoring services to prior authorized individuals, a provider shall meet all of the following criteria:

(1) Certified intermediate care facility and consent to oversight

The provider shall be an Ohio medicaid certified intermediate care facility, and shall agree to cooperate with the department's oversight of intermediate care facility behavioral redirection and medical monitoring services; and

(2) Intermediate care facility provider agreement

The provider shall meet the requirements set forth in rule 5123:2-7-02 of the Administrative Code in order to obtain a provider agreement; and

(3) Dedicated facility or discrete unit of facility

Intermediate care facility behavioral redirection and medical monitoring services shall be provided in either a discrete, distinctly identified unit of the intermediate care facility dedicated to the provision of outlier services for persons requiring intermediate care facility behavioral redirection and medical monitoring services, or in a freestanding intermediate care facility.

(a) If the service is delivered in a distinctly identified unit of a larger intermediate care facility, the provider's state licensure process and its medicaid certification process may continue to recognize only one facility, but the Ohio office of medical assistance shall issue separate provider agreements to the outlier and non-outlier units.

(b) Unoccupied certified beds may be moved between the outlier and non-outlier units in accordance with the following:

(i) The department must receive a written request from the provider at least five business days before the selected date of the bed change. All requests shall be in writing and shall be mailed to "Ohio Department of Developmental Disabilities, Division of Medicaid Development and Administration, 30 East Broad Street, 13th Floor, Columbus, Ohio 43215-3414" or faxed to (614) 466-0652. The department shall issue a written response either approving or denying the request; and

(ii) Approvals may be granted for unoccupied bed moves only once per calendar quarter. More than one bed movement during a calendar quarter may be authorized at the sole discretion of the department; and

(iii) No intermediate care facility shall discharge a resident earlier than is indicated in the resident's treatment plan as a result of a request to move beds from the outlier unit to the non-outlier unit; and

(iv) The intermediate care facility shall meet all requirements set forth in paragraphs (D)(7) and (D)(8) of this rule for beds moved into the outlier unit from the non-outlier unit; and

(4) Licensure survey findings

(a) Within the thirty-six months prior to acceptance by the department as a provider of intermediate care facility behavioral redirection and medical monitoring services, the provider shall:

(i) Have been in full compliance with residential facility licensure standards; or

(ii) Have an approved plan of correction and have not demonstrated a pattern of repeat deficiencies.

(b) New facilities shall not be approved as providers of intermediate care facility behavioral redirection and medical monitoring services until any required licensure plans of correction are implemented; and

(5) Certification survey findings

(a) Within the thirty-six months prior to acceptance as a provider of intermediate care facility behavioral redirection and medical monitoring services, the provider shall:

(i) Have fully met all the standards for medicaid intermediate care facility certification; or

(ii) Have met the medicaid program requirements of a facility for which the state survey agency found deficiencies, have an approved plan of correction from the state survey agency, and have not demonstrated a pattern of repeat deficiencies.

(b) Facilities may not be approved as providers of intermediate care facility behavioral redirection and medical monitoring services until any required certification plans of correction are implemented; and

(6) Physical environment

(a) Single person bedrooms.

Each resident shall have a private bedroom.

(b) Environmental alterations.

Residents who qualify for prior authorization of intermediate care facility behavioral redirection and medical monitoring services are aggressive, assaultive, and/or destructive, and pose significant health or security risks.

(i) Based on the expected care needs of those residents, including residents whose records document that programs incorporating the use of less restrictive environments have been tried systematically and demonstrated to be ineffective, the provider shall make significant environmental alterations that are expected to reduce or eliminate the destructive outcome to people or the environment, or to reduce the need for continual replacement of damaged property.

(ii) Examples of such resident-specific adaptations or modifications may include, but are not limited to, fenced yards, alarm systems, reduced access to kitchens and food supplies, or furnishings that are more difficult to destroy.

(c) Structural modifications.

The provider shall demonstrate the ability to rapidly respond to presented needs for structural changes related to the residents' behaviors; and

(7) Facility staffing

(a) Availability of direct care staff.

(i) Providers shall schedule direct care staff to ensure that adequately trained staff are present and on duty seven days a week, twenty-four hours a day, every day of the year. Staffing shall be sufficient to ensure that urgent, emergent, and routine resident needs are identified appropriately and in a timely manner, and are met

through the implementation of intervention strategies reflected in the resident's individual plan.

(ii) Absences of staff for breaks and meals shall not compromise this requirement.

(b) Management/qualified intellectual disability professional experience.

Staff employed to manage intermediate care facility behavioral redirection and medical monitoring services, including services delivered by a qualified intellectual disability professional, shall have evidence of at least two year's work experience with individuals who have severe behavioral issues.

(c) Staff training.

Staff training programs shall address the specific behavioral and medical domains a staff member must master for a thorough understanding and demonstration of competency in order to meet the intensive needs of residents requiring intermediate care facility behavioral redirection and medical monitoring services. Initial and continuing direct care staff training shall include all of the following:

(i) Orientation to the facility or distinct part unit's status as a provider of intermediate care facility behavioral redirection and medical monitoring services, including the individual eligibility criteria outlined in paragraph (C) of this rule, and the provider eligibility criteria outlined in this paragraph; and

(ii) Information about the disorders/syndromes, behavioral phenotypes, and stages of disease progression affecting the current residents of the intermediate care facility behavioral redirection and medical monitoring provider; and

(iii) Accepted best practices and innovative approaches to meet these resident needs in both behavioral and medical domains; and

(8) Service collaboration and day programming

(a) Prior to approval as a provider of intermediate care facility behavioral redirection and medical monitoring services, the provider shall demonstrate the ability to collaborate with county boards of developmental disabilities and with others to provide service for individuals described in paragraph (C) of this rule.

(b) Prior to any individual's admission to an intermediate care facility for behavioral redirection and medical monitoring, the provider shall arrange for a suitable school or day program for the individual and shall submit the plan for such program to the designated outlier coordinator or other department designee; and

(9) Preliminary evaluation

Prior to an individual's admission, the provider shall develop and submit to the designated outlier coordinator or other department designee accurate assessments or reassessments by an interdisciplinary team that address the individual's health, social, psychological, educational, vocational, and chemical dependency needs; and

(10) Transitional plan

(a) Due to the complex and intensive needs of individuals being admitted to an intermediate care for facility behavioral redirection and medical monitoring, the provider shall perform sufficient planning prior to admission in order to ensure that the facility is able to meet an individual's health, safety, and behavioral needs from the day of admission.

(b) The transitional plan shall address major concerns and shall be submitted for review to the designated outlier coordinator or other department designee prior to the individual's admission; and

(11) Initial assessment

Within thirty days after admission, the provider shall develop and submit to the designated outlier coordinator or other department designee accurate assessments or reassessments by an interdisciplinary team that address the individual's health, social, psychological, educational, vocational, and chemical dependency needs in order to supplement the preliminary evaluation described in paragraph (D)(9) of this rule, which was conducted prior to admission; and

(12) Individual plan, team meeting, and quarterly report

(a) Within thirty days of an individual's admission, the facility shall develop and submit to the designated outlier coordinator or other department designee a comprehensive, individual plan. The plan shall be reviewed by the appropriate program staff at least quarterly and revised as necessary.

(b) The facility shall notify the designated outlier coordinator or other department designee at least one week in advance of each full-

team meeting, and provide the designated outlier coordinator or other department designee with minutes of the meeting upon request.

(c) The facility shall prepare and provide to the designated outlier coordinator or other department designee a quarterly report in a format approved by the department that summarizes the resident's individual plan, progress, changes in treatment, current status relative to discharge goals, and any updates to the discharge plan, including referrals made and anticipated time frames. A current copy of the resident's individual plan shall be available to the designated outlier coordinator or other department designee upon request; and.

(13) Discharge plan

(a) Within thirty days after admission, the facility shall develop and submit for approval to the designated outlier coordinator or other department designee a written discharge plan developed by the interdisciplinary team in conjunction with the individual and others concerned with the individual's welfare.

(b) The discharge plan shall include all of the following:

(i) Description of targeted behavioral and medical/health status indicators that would signify the resident could be safely discharged; and

(ii) Recommendations for any counseling and/or training of the individual and family members or interested persons to prepare them for post-discharge care; and

(iii) Evaluation of the likely need for appropriate post-discharge services, the availability of those services, the providers of those services, the payment source for each service, and dates on which notification of the individual's needs and anticipated time frames was or would be made to the providers of those services; and

(14) Reassessment of discharge plan

When periodic reassessment of the discharge plan indicates that an individual's discharge needs have changed, the provider shall submit the results of the reassessments and the revised discharge plan to the designated outlier coordinator or other department designee within five working days following the revision; and

(15) Continued stay denials

If prior authorization is denied during an assessment that was requested for an individual already residing in the intermediate care facility for behavioral redirection and medical monitoring unit, the intermediate care facility shall do both of the following:

(a) Move the individual to the first available intermediate care facility bed that is not in the intermediate care facility for behavioral redirection and medical monitoring unit for as long as intermediate care facility services are needed; and

(b) Until such time as a more appropriate placement can be made, accept payment for the provision of services at the non-outlier intermediate care facility reimbursement rate; and

(16) Contracted rate

(a) Based on materials submitted by the intermediate care facility and the methodology set forth in this rule, the department shall contract with the intermediate care facility to set initial and subsequent rates for intermediate care facility behavioral redirection and medical monitoring services.

(b) With the exception of any specific items that are direct-billed in accordance with rule 5123:2-7-11 of the Administrative Code, the provider shall agree to accept as payment in full the per diem rate established for intermediate care facility behavioral redirection and medical monitoring services in accordance with this rule, and to make no additional charge to the individual, to any member of the individual's family, or to any other source for covered intermediate care facility behavioral redirection and medical monitoring services.

(E) Prior authorization for services

Payment for intermediate care facility behavioral redirection and medical monitoring services covered by the medicaid program shall be available only upon prior authorization by the department for each individual in accordance with the procedures set forth in this paragraph. These prior authorization procedures are in addition to the level of care review process as set forth in rule 5123:2-7-06 of the Administrative Code.

(1) Submission of initial request

(a) All requests shall be in writing and shall be mailed to "Ohio Department of Developmental Disabilities, Division of Medicaid Development and

Administration, 30 East Broad Street, 13th Floor, Columbus, Ohio 43215-3414" or faxed to (614) 466-0652.

(b) Requests shall be sent to the designated outlier coordinator or other department designee.

(c) A request is considered submitted when it is received by the designated outlier coordinator or other department designee.

(2) Initial request requirements

It is the responsibility of the provider to ensure that all required information is provided to the department as requested. Prior authorization will not be given until all of the initial application requirements set forth in this rule have been met. An initial request for prior authorization of intermediate care facility behavioral redirection and medical monitoring services is considered complete when all of the following requirements have been met:

(a) The Ohio office of medical assistance form 03142, "Prior Authorization" (revised March 2008), has been appropriately completed and submitted; and

(b) The Ohio office of medical assistance form 03697, "Level of Care Assessment" (revised April 2003), or an alternative form specified by the department that accurately reflects the individual's current mental and physical condition and is certified by a physician has been appropriately completed and submitted; and

(c) In accordance with the level of care review process for intermediate care facilities set forth in rule 5123:2-7-06 of the Administrative Code, a level of care determination has been issued in accordance with rule 5101:3-3-07 of the Administrative Code; and a determination regarding the feasibility of community-based care has been made; and

(d) The intermediate care facility for behavioral redirection and medical monitoring has submitted to the designated outlier coordinator the prior authorization request form and supporting documentation exhibiting evidence that the applicant meets criteria listed in paragraphs (C)(3) to (C)(12) of this rule. The provider shall retain a duplicate copy of all submitted documentation. Supporting documentation may include, but is not limited to, the preliminary evaluation, assessments, and individual plan required prior to admission as set forth in paragraph (D) of this rule.

(3) Initial stay assessment

The department's determination will be based on the completed initial stay request and any additional information or documentation necessary to make the determination of eligibility for intermediate care facility behavioral redirection and medical monitoring services, which may include a face-to-face visit by at least one department representative with the individual and, if applicable, the individual's representative and, to the extent possible, the individual's formal and informal care givers, to review and discuss the individual's care needs and preferences.

(4) Prior authorization determination

Based upon a comparison of the individual's condition, service needs, and the requested placement site, with the eligibility criteria set forth in paragraph (C) of this rule, the department shall conduct a review of the application, assessment report, and supporting documentation about the individual's condition and service needs to determine whether the individual is eligible for intermediate care facility behavioral redirection and medical monitoring services.

(5) Notice of determination

When the prior authorization request has been processed by the department indicating approval or denial of the request for authorization of reimbursement, notices shall be sent by mail or fax that include all of the determinations made and the individual's state hearing rights, in accordance with Chapter 5101:6-2 of the Administrative Code, to the individual, the individual's legal guardian and/or representative (if any), and the provider. The provider may perform any service(s). However, reimbursement shall be limited to services approved as indicated in the approval letter.

(a) Denial

When a request for prior authorization of reimbursement for intermediate care facility behavioral redirection and medical monitoring services is denied, the department shall issue a notice of medical determination and a right to a state hearing. A copy of this denial notice shall be sent to the the county department of job and family services to be filed in the individual's case record. The notice shall also include an explanation of the reason for the denial.

(b) Approval

When a request for prior authorization of reimbursement for intermediate care facility behavioral redirection and medical monitoring services has

been approved, the department shall issue an approval letter that includes an assigned prior authorization number, the number of days for which the intermediate care facility for behavioral redirection and medical monitoring placement is authorized, and the date on which payment is authorized to begin. It also will include the name, location, and phone number of the department staff member who is assigned to monitor the individual's progress in the facility, participate in the individual's interdisciplinary team, and monitor implementation of the individual's discharge plan.

The department shall send a copy of the approval letter to the county department of job and family services to be filed in the individual's case record.

(i) Authorization for initial stay

Individuals who are determined to have met the eligibility criteria set forth in paragraph (C) of this rule may be approved for an initial stay of up to a maximum of six months, or up to one hundred eighty-four days. The number of months or days that is prior authorized for each eligible individual shall be based upon the submitted application materials, consultation with the individual's attending physician, and/or any additional consultations or materials required by the assessor to make a reasonable estimation regarding the individual's probable length of stay in the intermediate care facility for behavioral redirection and medical monitoring unit.

(ii) Authorization for continued stays

Continued stay determinations shall be based on reports from the facility submitted to the designated outlier coordinator regarding critical events and the status of the individual's condition and discharge planning options, face-to-face assessments conducted by the department, and other collaborative information determined by the department. When the department determines that the individual continues to meet the eligibility criteria set forth in paragraph (C) of this rule, continued stays may be approved for maximum increments of six months, up to one hundred eighty-four days.

(6) Discharge

(a) An individual is expected to be discharged to the setting specified in the individual's discharge plan at the end of the prior authorized initial or continued stay, and progress toward that end shall be monitored by the department or its designee throughout the individual's stay in the intermediate care facility for behavioral redirection and medical monitoring unit.

(b) Intermediate care facility behavioral redirection and medical monitoring services may be extended beyond the previously approved length of stay if the provider submits a written request to the department proving that it is not possible to implement the individual's discharge plan. Such requests shall be submitted at least one week prior to the last day of the previously authorized stay, unless there is a significant change of circumstances within the week preceding the expected discharge date that prevents implementation of the discharge plan.

(F) Provider agreement addendum

(1) After the department has approved an intermediate care facility operator as a qualified provider of intermediate care facility behavioral redirection and medical monitoring services, the Ohio office of medical assistance form 03642, "Provider Agreement for Behavioral Redirection and Medical Monitoring Outlier Services" (revised July 2007), shall be completed.

(2) The form 03642 shall be completed as part of each subsequent annual provider agreement renewal with the Ohio office of medical assistance, unless the provider chooses to withdraw as a provider of intermediate care facility behavioral redirection and medical monitoring outlier services or is determined by the department to no longer meet the qualifications set forth in paragraph (D) of this rule.

(G) Payment authorization

The payment authorization date shall be one of the following, but shall not be earlier than the effective date of the individual's level of care determination:

(1) The date of admission to the intermediate care facility for behavioral redirection and medical monitoring unit if it is within thirty days of the physician's signature on the Ohio office of medical assistance form 03697, "Level of Care Assessment" (revised April 2003), or an alternative form specified by the department; or

(2) The date of intermediate care facility for behavioral redirection and medical monitoring prior authorization approval, if the individual was already a resident of an intermediate care facility behavioral redirection and medical monitoring but was using another payer source; or

(3) A date other than that specified in paragraph (G)(1) or (G)(2) of this rule. This alternative date may be authorized only upon receipt of a letter by the designated outlier coordinator or other department designee that contains a credible explanation for the delay from the originator of the request for prior authorization of intermediate care facility behavioral redirection and medical monitoring services. If the request is to backdate the level of care and intermediate care facility for behavioral redirection and medical monitoring eligibility determination more than thirty days from the physician's signature, the physician shall verify the continuing accuracy of the information and need for inpatient care either by adding a statement to that effect on the form 03697 or alternative approved form, or by attaching a separate letter of explanation.

(H) Required information

In addition to information that must be submitted pursuant to rule 5123:2-7-12 of the Administrative Code, an outlier provider must submit the following:

(1) In the initial year that an intermediate care facility is approved as an outlier provider, the provider must submit, no later than ninety days after the effective date of the outlier provider agreement, each of the following:

(a) The projected cost report budget for the initial year of operation; and

(b) The current calendar year capital expenditure plan, including a detailed asset listing; and

(c) The current calendar year plan for basic staffing patterns, using a format to be approved by the department, that includes the staff schedule by shift, number of staff in each position, staff position descriptions, base wage rates, and a brief explanation of contingencies that may require adjustments to these basic staffing patterns.

(2) The following information must be submitted no later than ninety days after the end of the initial three months of operation as an outlier provider:

(a) A cost report for the period of the initial three months of service; and

(b) Current individual plans for residents to be served in the period for which a rate is being established.

(3) In each calendar year subsequent to the year of the initial contracted rate, the following information must be submitted by the thirty-first of March:

(a) Current individual plans for residents to be served in the period for which a rate is being established; and

(b) The actual year end cost report shall be submitted within the deadline specified in rule 5123:2-7-12 of the Administrative Code. The current calendar year cost report budget shall be submitted by the thirty-first of March of the current calendar year, in conjunction with the previous calendar year's actual cost report; and

(c) For-profit providers shall submit a balance sheet, income statement, and statement of cash flows for the outlier facility relating to the previous calendar year's actual cost report submitted in accordance with paragraph (I)(3)(b) of this rule; and

(d) Not-for-profit providers shall submit a statement of financial position, statement of activities, and statement of cash flows for the outlier facility relating to the previous calendar year's actual cost report submitted in accordance with paragraph (I)(3)(b) of this rule; and

(e) The current calendar year capital expenditure plan, including the detailed asset listing; and

(f) The current calendar year plan for basic staffing patterns, using a format to be approved by the department, that includes the staff schedule by shift, number of staff in each position, staff position descriptions, base wage rates, and a brief explanation of contingencies that may require adjustments to these basic staffing patterns; and

(g) Approved board minutes from the legal entity holding the provider agreement and all other related legal entities for the calendar year covered by the actual cost report submitted in accordance with paragraph (I)(3)(b) of this rule.

(I) Per diem rates

Medicaid per diem rates for outlier providers shall be based upon reasonable and allowable costs using the following method:

(1) There shall be four components of the per diem rate: direct care, indirect care, capital, and other protected (including the franchise permit fee rate).

(a) The direct care per diem shall be determined in accordance with section 5111.23 of the Revised Code. The rate may be increased if deemed necessary by the department based on analysis of historical direct care costs if the provider had previously been a medicaid provider, a comparison of direct care costs and staffing ratios of facilities caring for individuals with similar needs, a comparison of payment rates paid by private insurers and/or other states, and an analysis of the impact on historical costs if there are plans to change the resident mix.

(b) The indirect care per diem shall be determined in accordance with section 5111.241 of the Revised Code. The rate may be increased due to increased expenses deemed necessary by the department for treatment of individuals requiring outlier services.

(c) The capital per diem shall be determined in accordance with section 5111.251 of the Revised Code. Adjustments may be made for special high cost equipment or other capital expenditures deemed by the department to be necessary for treatment of individuals requiring outlier services.

(d) The other protected per diem shall be determined in accordance with section 5111.235 of the Revised Code.

(2) The total prospective rate for intermediate care facilities or discrete units of intermediate care facilities providing outlier services, shall be established by combining the allowable direct care, indirect care, capital, and other protected per diems determined in accordance with paragraphs (I)(1)(a) to (I)(1)(d) of this rule.

(J) Initial and subsequent contracted rates

Intermediate care facilities approved by the department as outlier providers shall receive rates established in accordance with this rule for individuals that have been prior authorized by the department on the first day of the month in which prior authorized outlier services were provided, but no earlier than the first day of the month in which the approved application for an outlier provider agreement was received by the Ohio office of medical assistance.

(1) The department shall establish the initial contracted rate no later than ninety days after the department receives all the required information. The initial contracted rate will be implemented retroactively to the initial date services were provided pursuant to the outlier provider agreement.

(2) In each year subsequent to the year of the initial contracted rate, the contracted rate will be effective for the fiscal year beginning on the first of July and ending on the thirtieth day of June of the following calendar year.

Effective:

Five Year Review (FYR) Dates: 4/23/2018

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5111.02, 5111.226, 5123.04
Rule Amplifies:	5111.02, 5111.226, 5123.04
Prior Effective Dates:	01/10/2013