

*Long Term Care and LOC Review*  
*Ohio Administrative Codes*

<u>5101:3-3-08</u>	<i>Criteria for Nursing Facility –based Level of care</i>
<u>5101:3-3-15</u>	<i>Process &amp; time frame for a Level of Care determination for Nursing Facility-based Level of care programs</i>
<u>5101:3-26-03</u>	<i>Managed Health Care Programs-Covered Services</i>
<u>5101:3-26-02</u>	<i>Managed Health Care Programs-Eligibility, Membership; Automatic Renewal Membership</i>
<u>5101:3-26-02.1</u>	<i>Termination of membership</i>

- I. Refer to 5101:03-3-08--Criteria for Nursing Facility-based level of Care
- Section B
  - Section C
  - Section D
- II. Refer to 5101:3-3-15 Process & Timeframes for a level of care for nursing facility-based level of care programs
- Look at Section A, 3)b
  - Look at Section B, 2 & 4
  - Look at Section C
- III. Refer to 5101:3-26-03 Managed Health care programs: Covered Services
- Section H-- Exclusions, Limitations, Clarifications
- 1) Automatic termination can occur:  
*When MCP members are placed in Nursing facilities, the plan is responsible for payment for the NF services as described in rule 5101:3-3-02.3 (Eligible facilities), and payment for all covered services until the last day of the month following the month of the member's NF admission, for a period not to exceed sixty-two calendar days. The plan members remaining in a NF after this period will be disenrolled in accordance with Section C--g (i) & (ii) of rule 5101:3-3-02.1 (Termination of Membership) EX. Admitted to NF on April 2;termination, May 31.*
- 2) Automatic termination can occur if  
*A member is placed in the nursing facility prior to the membership effective date and the member remains in the NF on the membership effective date. Following the plan notification to ODJFS, the membership termination is effective the last day of*

*the month preceding placement in the NF. Ex. Placed in NF April 2, so termination date is March 30.*

- 3) Automatic termination can occur if After the membership effective date, and the member remains in the NF past the last day of the second calendar month following the month of NF admission. (proper documentation must be submitted to ODJFS)  
*Ex. Admitted April 2 → terminated May 31.*

\*Archive\* 5101:3-26-03

**Managed Health Care Programs: Covered Services**

**MCTL 32**

***Effective Date: February 1, 2010***

- (A) Except as provided in this rule, managed care plans (MCPs) must ensure that members have access to all medically-necessary services covered by medicaid. The MCP must ensure that:
- (1) Services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished;
  - (2) The amount, duration, or scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;
  - (3) Coverage decisions are based on the practice guidelines specified in paragraph (B) of rule 5101:3-26-05.1 of the Administrative Code; and
  - (4) If a member is unable to obtain medically-necessary services offered by medicaid from a MCP panel provider, the MCP must adequately and timely cover the services out of panel, until the MCP is able to provide the services from a panel provider.
- (B) MCPs may place appropriate limits on a service;
- (1) On the basis of medical necessity; or
  - (2) For the purposes of utilization control, provided the services furnished can be reasonably expected to achieve their purpose as specified in paragraph (A)(1) of this rule.
- (C) MCPs must cover annual physical examinations for adults.
- (D) At the request of the member, MCPs must provide for a second opinion from a qualified health care professional within the panel. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.
- (E) MCPs must assure that emergency care services as defined in rule 5101:3-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week. At a minimum, such services must be provided and reimbursed in accordance with the following:
- (1) MCPs may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have resulted in the outcomes specified in paragraph (W) of rule 5101:3-26-01 of the Administrative Code.
  - (2) MCPs cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
  - (3) MCPs must cover all emergency services without requiring prior authorization.
  - (4) MCPs must cover medicaid-covered services related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the MCP including but not limited to the member's PCP or the MCP's twenty-four-hour toll-free call-in-system.
  - (5) MCPs cannot deny payment of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the

visit.

- (6) For the purposes of this paragraph, "non-contracting provider of emergency services" means any person, institution, or entity who does not contract with the MCP but provides emergency services to an MCP member, regardless of whether or not that provider has a medicaid provider agreement with ODJFS pursuant to Title XIX of the Social Security Act. An MCP must cover emergency services as defined in paragraph (X) of rule 5101:3-26-01 of the Administrative Code when the services are delivered by a non-contracting provider of emergency services and claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in paragraph (W) of rule 5101:3-26-01 of the Administrative Code. Such services must be reimbursed by the MCP at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the MCP is required to reimburse at this rate only until the member can be transferred to a provider designated by the MCP.
  - (7) MCPs must adhere to the judgment of the attending provider when requesting a member's transfer to another facility or discharge. MCPs may establish arrangements with hospitals whereby the MCP may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat and transfer the member.
  - (8) A member who has had an emergency medical condition may not be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.
- (F) MCPs must establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services as described in paragraph (E)(6) of this rule. Such information must be made available to non-contracting providers, including non-contracting providers of emergency services, on request. MCPs may not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.
- (G) MCPs must assure that post-stabilization care services as defined in rule 5101:3-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week.
- (1) The MCP must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line must be available twenty-four hours a day. MCPs must document that the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The MCP must maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time that the MCP communicated the decision in writing to the provider.
  - (2) At a minimum, post-stabilization care services must be provided and reimbursed in accordance with the following:
    - (a) MCPs must cover services obtained within or outside the MCP's panel that are pre-approved in writing to the requesting provider by a plan provider or other MCP representative.

- (b) MCPs must cover services obtained within or outside the MCP's panel that are not pre-approved by a plan provider or other MCP representative but are administered to maintain the member's stabilized condition within one hour of a request to the MCP for preapproval of further post-stabilization care services.
- (c) MCPs must cover services obtained within or outside the MCP's panel that are not pre-approved by a plan provider or other MCP representative but are administered to maintain, improve or resolve the member's stabilized condition if:
  - (i) The MCP fails to respond within one hour to a provider request for authorization to provide such services.
  - (ii) The MCP cannot be contacted.
  - (iii) The MCP's representative and treating provider cannot reach an agreement concerning the member's care and a plan provider is not available for consultation. In this situation, the MCP must give the treating provider the opportunity to consult with a plan provider and the treating provider may continue with care until a plan provider is reached or one of the criteria specified in paragraph (G)(3) of this rule is met.
- (3) The MCP's financial responsibility for post stabilization care services it has not pre-approved ends when:
  - (a) A plan provider with privileges at the treating hospital assumes responsibility for the member's care;
  - (b) A plan provider assumes responsibility for the member's care through transfer;
  - (c) A MCP representative and the treating provider reach an agreement concerning the member's care; or
  - (d) The member is discharged.
- (H) Exclusions, limitations and clarifications.
  - (1) When an MCP member is placed in a nursing facility (NF), MCPs are responsible for payment for NF services as described in rule 5101:3-3-02.3 of the Administrative Code, and payment for all covered services until the last day of the month following the month of the member's NF admission, for a period not to exceed sixty-two calendar days. MCP members remaining in a NF after this period will be disenrolled in accordance with paragraph (C) of rule 5101:3-26-02.1 of the Administrative Code.
  - (2) MCPs are not responsible for payment of services provided to a member that has been enrolled in a home and community-based waiver program administered by ODJFS, the Ohio department of aging (ODA), or the Ohio department of mental retardation and developmental disabilities (ODMR/DD). MCP members enrolled in a waiver program will be disenrolled in accordance with paragraph (C)(2)(h) of rule 5101:3-26-02.1 of the Administrative Code.
  - (3) MCPs are not responsible for payment of habilitation services as described in 42 U.S.C. 1396n(c)(5) (~~2002~~ December 3, 2004).
  - (4) MCP members are permitted to self-refer to all community mental health centers and the Ohio department of alcohol and drug addiction services

- (ODADAS)-certified medicaid providers. MCPs must ensure access to medicaid-covered behavioral health services for members who are unable to timely access services or unwilling to access services through community providers.
- (5) MCP members are permitted to self-refer to family planning Title X services provided by any qualified family planning provider (QFPP). The MCP is responsible for payment of claims for family planning Title X services delivered by QFPPs not contracting with the MCP at the lesser of one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate or billed charges, in effect for the date of service.
- (6) MCPs must permit members to self-refer to any women's health specialist within the MCP's panel for covered care necessary to provide women's routine and preventative health care services. This is in addition to the member's designated PCP if that PCP is not a women's health specialist.
- (7) MCPs must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).
- (8) Where available, MCPs must ensure access to covered services provided by a certified nurse practitioner.
- (9) ODJFS may approve an MCP's members to be referred to certain MCP non-contracting hospitals, as specified in rule 5101:3-26-11 of the Administrative Code, for medicaid-covered non-emergency hospital services. When ODJFS permits such authorization, ODJFS will notify the MCP and the MCP non-contracting hospital of the terms and conditions, including the duration, of the approval and the MCP must reimburse the MCP non-contracting hospital at one hundred per cent of the current Ohio medicaid program fee-for-service reimbursement rate in effect for the date of service for all medicaid-covered non-emergency hospital services delivered by the MCP non-contracting hospital. ODJFS will base its determination of when an MCP's members can be referred to MCP non-contracting hospitals pursuant to the following:
- (a) The MCP's submission of a written request to ODJFS for the approval to refer members to a hospital that has declined to contract with the MCP. The request must document the MCP's contracting efforts and why the MCP believes it will be necessary for members to be referred to this particular hospital; and
  - (b) ODJFS consultation with the MCP non-contracting hospital to determine the basis for the hospital's decision to decline to contract with the MCP, including but not limited to whether the MCP's contracting efforts were unreasonable and/or that contracting with the MCP would have adversely impacted the hospital's business.
- (10) Paragraph (H)(9) of this rule is not applicable when an MCP and an MCP non-contracting hospital have mutually agreed to that hospital providing non-emergency hospital services to an MCP's members. MCPs must ensure that such arrangements comply with paragraph (A)(9) of rule 5101:3-26-05 of the Administrative Code.
- (11) MCPs are not responsible for payment of services provided through medicaid school program (MSP) providers pursuant to Chapter 5101:3-35 of the Administrative Code. MCPs must ensure access to medicaid-covered services for members who are unable to timely access services or unwilling to access services through MSP providers.

(12) MCPs are not responsible for the payment or provision of prescribed drugs and supplies covered under the medicaid fee-for-service pharmacy benefit. MCP members will receive their pharmacy benefit through the medicaid fee-for-service program, pursuant to Chapter 5101:3-9 of the Administrative Code.

~~(11)~~(13) MCPs must provide all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with the periodicity schedule identified in Chapter 5101:3-14 of the Administrative Code, to eligible individuals and assure that services are delivered and monitored as follows:

(a) Healthchek exams must include those components specified in Chapter 5101:3-14 of the Administrative Code. All components of exams must be documented and included in the

medical record of each healthchek eligible member and made available for the ODJFS annual external quality review.

(b) The MCP or its contracting provider must notify members of the appropriate healthchek exam intervals as specified in Chapter 5101:3-14 of the Administrative Code.

(c) Healthchek exams are to be completed within ninety days of the initial effective date of membership for those children found to have a possible ongoing condition likely to require care management services.

(l) Out-of-country coverage

MCPs are not required to cover services provided to members outside the United States.

Effective: 02/01/2010

R.C. 119.032 review dates: 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 01/22/2010

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.16, 5111.162, 5111.17

Rule Amplifies: 5111.01, 5111.02, 5111.021, 5111.16, 5111.162, 5111.163, 5111.17, 5111.172, section 309.10 of Am. Sub. HB 1 of the 128th General Assembly

Prior Effective Dates: 4/1/85, 5/2/85, 10/1/87, 2/15/89 (Emer), 5/8/89, 11/1/89 (Emer), 5/1/92, 5/1/93, 11/1/94, 7/1/96, 7/1/97 (Emer), 9/27/97, 5/14/99, 12/10/99, 7/1/00, 7/1/01, 7/1/02, 7/1/03, 1/1/06, 6/1/06, 1/1/07, 7/1/07, 1/1/08, 9/15/08

5101:3-26-02

**\*Archive\* 5101:3-26-02      Managed Health Care Programs: Eligibility, Membership, and Automatic Renewal of Membership**

**MCTL 31****Effective Date: July 1, 2009**

- (A) For the purpose of this rule, "authorized representative" means an individual eighteen years of age or older who stands in the place of the consumer. The authorized representative may act on behalf of individuals inside or outside of the household in which the authorized representative lives. For the purpose of this rule, the authorized representative may be the primary information person of the household, another member of the same assistance group, a custodial parent, or a person designated by custodial parent.
- (B) Eligibility.
- (1) For the purpose of this rule, an eligible individual is a medicaid consumer who is either subject to mandatory MCP membership, or has the option to select MCP membership, and is ~~The eligible categories of assistance for MCP membership are as follows:~~
- (a) ~~Covered families and children (CFC) category of assistance as described in rule 5101:1-40-01 of the Administrative Code, with the exception of individuals in the groups specified in paragraphs (B)(2) to (B)(4) of this rule.~~ Found eligible for covered families and children (CFC) medicaid in accordance with Chapter 5101:1-40 of the Administrative Code, and paragraphs (B)(2) to (B)(4) of this rule do not apply; and
  - (b) ~~Aged, blind, and disabled (ABD) category of assistance as described in division (A)(2) of section 5111.01 of the Revised Code, with the exception of individuals specified in paragraphs (B)(2), (B)(4) and (B)(5) of this rule.~~ Found eligible for aged, blind, or disabled (ABD) medicaid in accordance with Chapter 5101:1-39 of the Administrative Code, and paragraphs (B)(2), (B)(4), and (B)(5) of this rule do not apply.
- (2) Individuals who are dually eligible under both the medicaid and medicare programs are excluded from medicaid MCP membership.
- (3) The following individuals are not required to enroll in an MCP:
- (a) Children under nineteen years of age and eligible for supplemental security income (SSI);
  - (b) Children under nineteen years of age and receiving Title IV-E federal foster care maintenance through an agreement between the local children services board and the foster care provider;
  - (c) Children under nineteen years of age and receiving Title IV-E adoption assistance through an agreement between the local children services board and the adoptive parent;
  - (d) Children under nineteen years of age and in foster care or other out-of-home placement; and
  - (e) Children under nineteen years of age and receiving services through the Ohio department of health's bureau for children with medical handicaps (BCMh) or any other family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title



V of the Social Security Act, and is defined by the state in terms of either program participation or special health care needs; ~~and.~~

- (4) Indians who are members of federally recognized tribes are not required to enroll in an MCP, except as permitted under 42 C.F.R. 438.50(d)(2).
  - (5) ~~Individuals~~ Eligible individuals for who belong to the ABD category of assistance described in paragraph (B)(1)(b) of this rule are excluded from MCP membership if they are:
    - (a) Under twenty-one years of age;
    - (b) Institutionalized;
    - (c) Eligible for medicaid by spending down their income or resources to a level that meets the medicaid program's financial eligibility requirements; or
    - (d) Individuals receiving medicaid services through a medicaid waiver component, as defined in section 5111.85 of the Revised Code.
  - (6) Individuals are eligible for MCP membership in the manner prescribed in this rule if ODJFS has a provider agreement with an MCP(s) in the eligible individual's service area.
  - (7) Nothing in this rule shall be construed to limit or in any way jeopardize an eligible individual's basic medicaid eligibility or eligibility for other non-medicaid benefits to which he or she may be entitled.
- (C) ~~Selection of MCP membership enrollment.~~
- (1) A managed care enrollment center (MCEC) shall assist the eligible individual or authorized representative of any eligible assistance group requesting help in selecting an MCP or other healthcare option.
  - (2) The ODJFS, MCEC, or other ODJFS-approved entity must accept and process initial MCP membership selection transactions on behalf of eligible individuals in accordance with paragraph (C)(3) of this rule.
  - (3) The following applies to ~~membership selection~~ MCP enrollment:
    - (a) MCP membership must occur without regard to an eligible individual's race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services. The MCP will not use any discriminatory policy or practice in accordance with 42 C.F.R. 438.6(d)(4).
    - (b) MCP membership for the CFC category of assistance as described in paragraph (B)(1)(a) of this rule must occur at the assistance group level. Except for individuals described in paragraphs (B)(3) and (B)(4) of this rule, all eligible individuals in the CFC assistance group must be enrolled in the same MCP.
    - (c) MCP membership for ABD as described in paragraph (B)(1)(b) of this rule must occur at the individual level.
    - ~~(e) Eligible individuals or the authorized representative requesting MCP membership may change their choice up to the ninth working day from the end of the month in which the choice is made. Eligible individuals or the authorized representative must be informed of this provision when requesting MCP membership.~~
    - ~~(d) Except as specified in paragraph (C)(3)(g) of this rule, newborn children~~

- ~~whose mothers are MCP members at the time of birth are deemed eligible for medicaid and treated as an MCP member effective on the date of birth:~~
- ~~(i) The MCP must utilize the CDJFS designated written format to inform the CDJFS of a birth to a member.~~
  - ~~(ii) Within five working days of a birth, or immediately upon learning of the birth, the MCP must provide written notification to the appropriate CDJFS, forward a copy of such notice to the ODJFS, and notify the mother in writing of the need to apply to the CDJFS as soon as possible to have the newborn added to the assistance group to ensure ongoing MCP membership.~~
  - ~~(iii) If the MCP has not received confirmation by ODJFS of a newborn's MCP membership within ninety days of the date of birth, the MCP must send an additional written notification to the CDJFS, ODJFS, and the mother. If at the end of one hundred twenty days from the date of birth no confirmation has been received, the MCP must again send written notification to the CDJFS, ODJFS, and the mother.~~
  - ~~(iv) Notwithstanding the addition of the newborn to the assistance group by the CDJFS, the MCP must provide covered services to the newborn through the last day of the month in which the newborn reaches one hundred twenty days of age unless the provisions of paragraph (C) or (D) of rule 5101:3-26-02.1 of the Administrative Code apply.~~
- ~~(e) In the case of newborns added by the CDJFS to the assistance group of a mother who is an MCP member ODJFS will provide retrospective premium back to the first day of the month of the child's birth provided that:~~
- ~~(i) The MCP has notified the CDJFS, ODJFS and the mother as described in paragraphs (C)(3)(d)(i) to (C)(3)(d)(iii) of this rule; and~~
  - ~~(ii) ODJFS has not paid claims under fee-for-service for the newborn. In the event that fee-for-service claims have been paid, the newborn will be covered under medicaid fee-for-service for the month(s) in question.~~
- ~~(f) In the case of newborns as described in paragraph (C)(3)(d)(iv) of this rule, ODJFS will provide premium payments to the MCP up to the end of the month in which the newborn reaches one hundred twenty days of age.~~
- ~~(g) Newborns whose mothers are MCP members due to their eligibility in the aged, blind, and disabled category of assistance as described in paragraph (B)(1)(b) of this rule, are not eligible for MCP membership from their date of birth.~~
- ~~(h)(d) Newborns or other eligible Eligible individuals for CFC, including newborns, who are automatically added and authorized to the assistance group after the assistance group's initial MCP membership effective date will be enrolled in the same MCP as the rest of the assistance group.~~
- ~~(h)(e) The MCP must accept eligible individuals who request MCP membership, and honor without restriction, the PCP(s) selected when~~

available, except as otherwise provided in this rule.

~~(f)~~ In the event that an MCP member loses medicaid eligibility and is automatically terminated from the MCP but within a period of sixty days or less regains medicaid eligibility, membership in the same MCP shall automatically be renewed.

~~(f)~~(f) The MCEC ~~will~~ shall document via the CCR all information provided by the eligible individual or the authorized representative of each eligible assistance group requesting

MCP membership. The MCEC shall document via the CCR that ~~verbal~~ oral authorization of MCP membership was given and the date of the authorization.

~~(g)~~(g) The MCEC shall complete MCP membership enrollment requests and assignments as described in paragraph (C)(5)(c) of this rule, and received by the MCEC. The MCEC shall place enrollment information on the CCR and forward the CCR ~~will be processed utilizing only information contained on the CCR. Following processing by the MCEC a copy of the CCR will be forwarded to the MCP.~~

(h) In the event that an MCP member loses medicaid eligibility and is automatically terminated from the MCP, but regains medicaid eligibility within a period of sixty days or less, his or her membership in the same MCP shall automatically be renewed.

~~(m)~~(i) ODJFS ~~will~~ shall confirm the eligible individual's MCP membership to the MCP via an ODJFS-produced roster of new members, continuing members, and terminating members on or before the fifth day prior to the end of the calendar month preceding commencement of coverage.

~~(n)~~(j) The MCP ~~will~~ shall not be required to provide coverage until MCP membership is confirmed via an ODJFS-produced roster except as provided in paragraph ~~(C)(3)(d)~~ (C)(6) of this rule or upon mutual agreement between ODJFS and the MCP.

(4) ODJFS may designate that MCP membership is voluntary in any service area.

(5) In addition to the provisions of paragraphs (C)(1) to (C)(3) and (C)(6) of this rule, the following applies to membership in service areas designated as mandatory by ODJFS.

(a) Except as specified in paragraphs (B)(2) to (B)(5) of this rule, MCP membership is required for eligible individuals who are residents of service areas designated as mandatory by ODJFS.

(b) When a service area is initially designated by ODJFS as mandatory for ~~one of the categories of assistance~~ eligible individuals specified in paragraph (B)(1) of this rule, ODJFS shall confirm the eligibility of each eligible individual in the designated category of assistance is confirmed by ODJFS as prescribed in paragraph ~~(C)(3)(m)~~ (C)(3)(i) of this rule. Upon the confirmation of eligibility:

(i) Eligible individuals residing in the service area who are currently MCP members are deemed participants in the mandatory program; and

(ii) All other eligible individuals residing in the mandatory service area may request MCP membership at any time but must select an

MCP following receipt of a notification of mandatory selection (NMS) issued by ODJFS.

- (c) MCP membership selection procedures for the mandatory program:
- (i) An eligible assistance group ~~which~~ that does not make a choice following issuance of an NMS by ODJFS and one additional notice will be assigned to an MCP by ODJFS, the MCEC, or other ODJFS-approved entity.
  - (ii) ODJFS or the MCEC ~~will~~ shall assign the assistance group to an MCP based on prior medicaid fee-for-service and/or MCP membership history, whenever available, or at the discretion of ODJFS.
  - (iii) In the event that an eligible assistance group does not identify to the MCEC those individuals who are not required to enroll in an MCP because they meet the criteria as specified in ~~paragraph~~ paragraphs (B)(3) and (B)(4) of this rule, such individuals shall be enrolled in the same MCP as the rest of the assistance group until such time as the assistance group notifies the MCEC.

(6) Newborn notification and membership.

- (a) The MCP must notify the CDJFS and ODJFS of the birth of any newborn that qualifies for MCP enrollment as specified in paragraph (C)(6)(b) of this rule and advise the mother of the importance of contacting her CDJFS caseworker.
- (b) Newborns are eligible for MCP membership from their date of birth if:
  - (i) The newborn's mother is eligible for CFC in accordance with paragraph (B)(1)(a) of this rule and enrolled in an MCP on the date of birth; and
  - (ii) The newborn is eligible for CFC in accordance with rule 5101:1-40-02.2 of the Administrative Code and paragraphs (B)(2) to (B)(4) of this rule do not apply.
- (c) Depending on the addition of the newborn to the mother's case and the authorization of eligibility by the CDJFS, MCP membership for the newborn will be in accordance with this rule or limited to the date of birth through the last day of the month in which the newborn reaches ninety days of age unless the provisions of paragraphs (C) or (D) of rule 5101:3-26-02.1 of the Administrative Code apply. Premium payment for newborns is as follows:
  - (i) If the CDJFS adds and authorizes the newborn to the mother's case prior to the last day of the month in which the newborn reaches ninety days of age, MCP membership will continue in accordance with this rule. ODJFS shall provide retrospective premium back to the month of the child's birth if ODJFS has not paid claims under fee-for-service for the newborn. In the event that fee-for-service claims have been paid, the newborn will be covered under medicaid fee-for-service for the month(s) for which fee-for-service claims were paid.
  - (ii) If the CDJFS does not add and authorize the newborn to the mother's case prior to the last day of the month in which the

newborn reaches ninety days of age, MCP membership will end after the last day of the month in which the newborn reaches ninety days of age. ODJFS shall provide premium from the date of birth through the last day of the month in which the newborn reaches ninety days of age only after the CDJFS has added the newborn to the mother's case and authorized his or her eligibility and ODJFS has not paid claims under fee-for-service for the newborn. In the event that fee-for-service claims have been paid, the newborn will be covered under medicaid fee-for-service for the month(s) for which fee-for-service claims were paid.

(iii) If the MCP continued to treat the newborn as a member beyond the last day of the month in which the newborn reached ninety days of age, ODJFS may determine that additional retrospective premiums may be paid for the months between the last day of the month in which the newborn reached ninety days of age and the months prior to the addition and authorization of the newborn for which there were no fee-for-service claims paid.

(7) Newborns whose mothers are MCP members due to their eligibility for ABD medicaid, as described in paragraph (B)(1)(b) of this rule, are not eligible for MCP membership from their date of birth.

(D) Commencement of coverage.

(1) Coverage of MCP members will be effective at the beginning of the first day of the calendar month following the confirmation of the eligible individual's effective date of MCP membership

via an ODJFS-produced roster to the MCP, except as identified in paragraph ~~(C)(3)(d)~~ (C)(6) of this rule.

~~(2) In no event shall an MCP notify a pending member about coverage until MCP membership is confirmed by ODJFS as specified in paragraph (C)(3)(m) of this rule.~~

~~(3)~~(2) An MCP may request deferment of coverage for a new member admitted to an inpatient facility prior to the effective date of managed care coverage who remains an inpatient on the effective date of coverage in accordance with the following:

(a) The new member must be enrolling in the MCP from medicaid fee-for-service. In the event the member is transferring membership from one MCP to another, the provisions of paragraphs (D)(3) and (D)(4) and ~~(D)(5)~~ of this rule apply.

(b) The MCP must submit deferment requests to ODJFS in writing with required documentation, as specified in paragraph ~~(D)(3)(d)~~(D)(2)(d) of this rule, no later than six months from the assistance group member's original effective date with the MCP or the last automatic MCP renewal date, if applicable.

(c) MCPs coverage and responsibility for payment of medicaid-covered services to a new MCP member may be deferred following MCP notification of the new member's inpatient admission to ODJFS as specified in paragraph ~~(D)(3)(b)~~(D)(2)(b) of this rule and subject to approval by ODJFS.

(d) Documentation includes but is not limited to a copy of the inpatient

admission form or other proof of inpatient admission and discharge, as approved by ODJFS, along with the MCP's written request for deferral of the new member's effective date of MCP membership.

- (e) In the event that a previous MCP member subject to automatic renewal of MCP membership as specified in paragraph ~~(C)(3)(i)~~(C)(2)(j) of this rule is admitted to an inpatient facility after ~~their~~ his or her MCP membership is terminated, and remains an inpatient on the effective date of automatic renewal of MCP membership, the provisions of paragraphs ~~(D)(3)(a)~~(D)(2)(a) to ~~(D)(3)(e)~~(D)(2)(c) and paragraphs ~~(D)(3)(f)~~(D)(2)(f) to ~~(D)(3)(i)~~(D)(2)(i) of this rule apply.
  - (f) In the event a new assistance group member, other than a newborn, is admitted to an inpatient facility prior to, and remains an inpatient on, the effective date of MCP membership, the provisions of paragraphs ~~(D)(3)~~(a)(D)(2)(a) to ~~(D)(3)(e)~~(D)(2)(c) and paragraphs ~~(D)(3)(f)~~(D)(2)(f) to ~~(D)(3)(i)~~(D)(2)(i) of this rule apply.
  - (g) The MCP is responsible for the provision of all medicaid-covered services for all other MCP members of the same assistance group as specified in paragraph (D)(1) of this rule.
  - (h) The MCP's liability for all medicaid-covered services for the deferred MCP member begins the first day of the month following the deferred MCP member's date of discharge from the hospital.
  - (i) Premium payments for the MCP will be adjusted to reconcile the period of MCP membership deferral.
- ~~(4)(3)~~ The coverage responsibilities listed in paragraph ~~(D)(5)~~(D)(4) of this rule shall apply to a member who meets the following criteria:
- (a) The member's current MCP membership is changed or terminated for any reason, including, but not limited to, any of the reasons set forth in rule 5101:3-26-02.1 of the Administrative Code, except for the reason specified in paragraph (C)(2)(a) of rule 5101:3-26-02.1 of the Administrative Code; and
  - (b) The member is admitted to an inpatient facility prior to the effective date of the MCP change or termination; and
  - (c) The member remains an inpatient in an inpatient facility after the date that membership in the current MCP ends.
- ~~(5)(4)~~ The following coverage responsibilities shall apply to a member who meets the criteria listed in paragraph ~~(D)(4)~~(D)(3) of this rule:
- (a) The disenrolling MCP shall remain responsible for providing all medically necessary medicaid covered services through the last day of the month in which the membership is changed or terminated, and shall remain responsible for all inpatient facility charges through the date of discharge. For retroactive disenrollments authorized by ODJFS, where the date of inpatient admission is prior to the last day of MCP coverage, the disenrolling MCP is responsible for inpatient facility charges through the date of discharge.
  - (b) The disenrolling MCP shall receive capitation through the end of the month in which membership is changed or terminated regardless of the length of the inpatient stay. Additional capitation payments will not be

made by ODJFS regardless of the length of the inpatient stay.

- (c) If the member will be enrolling in a new MCP, the disenrolling MCP shall notify the enrolling MCP of the inpatient status of the member following verification of the change or termination by the MCEC via the consumer contact record and the disenrollment by ODJFS via the monthly member roster.
- (d) The disenrolling MCP shall notify the inpatient facility of the change or termination in MCP enrollment including the name of the enrolling MCP, if applicable, following verification of the disenrollment by ODJFS via the monthly membership roster, but advise the inpatient facility that the disenrolling MCP shall remain responsible for the inpatient facility charges through the date of discharge.
- (e) If the member will be enrolling in a new MCP, the enrolling MCP shall assume responsibility for all medically necessary ~~Medicaid~~ medicaid covered services including professional and ancillary services related to the inpatient stay beginning with the effective date of membership in the MCP, except for the inpatient facility charges.
- (f) If the member will be enrolling in a new MCP, the enrolling MCP shall receive capitation beginning with the effective date of MCP membership.
- (g) If the member will be enrolling in a new MCP, then upon notification of the inpatient status of the new member as specified in paragraph ~~(D)(5)~~ ~~(e)(D)(4)(c)~~ of this rule, the enrolling MCP shall contact the inpatient facility to verify responsibility for all services following discharge for the member, and to assure that discharge plans are arranged through the MCP's panel. The enrolling MCP shall also verify the MCP's responsibility for all professional and ancillary charges related to the inpatient stay beginning with the effective date of MCP membership.
- (h) If the member will be enrolling in a new MCP, and if the enrolling MCP fails to contact the inpatient facility prior to discharge, the enrolling MCP must honor discharge arrangements until such time that the MCP can transition the member to the MCP's participating providers.

Effective: 07/01/2009

R.C. 119.032 review dates: 04/14/2009 and 07/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 06/19/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.16, 5111.17

Rule Amplifies: 5111.01, 5111.02, 5111.16, 5111.17

Prior Effective Dates: 4/1/85, 2/15/89 (Emer), 5/18/89, 5/1/92, 5/1/93, 11/1/94, 7/1/96, 7/1/97 (Emer), 9/27/97, 12/10/99, 7/1/00, 7/1/01, 7/1/02, 7/1/03, 7/1/04, 10/31/05, 6/1/06, 1/1/07, 7/1/07, 1/1/08, 8/26/08 (Emer), 10/9/08

*\*Archive\** 5101:3-26-02.1      **Managed Health Care Programs: Termination of Membership**

**MCTL 32**

***Effective Date: February 1, 2010***

- (A) For the purpose of this rule, "authorized representative" means an individual eighteen years of age or older who stands in the place of the consumer. The authorized representative may act on behalf of individuals inside or outside of the household in which the authorized representative lives. For the purpose of this rule, the authorized representative may be the primary information person of the household, another member of the same assistance group, a custodial parent, or a person designated by a custodial parent.
- (B) Termination of MCP membership occurs through one of the following:
- (1) Automatic termination occurs due to a change in MCP member medicaid eligibility, residence, or other circumstance, as set forth in paragraph (C) of this rule.
  - (2) Member-initiated termination occurs as set forth in paragraph (D) of this rule.
  - (3) MCP-initiated termination occurs as set forth in paragraph (E) of this rule.
- (C) The following applies to all automatic terminations of MCP membership in voluntary and mandatory service areas:
- (1) Automatic termination occurs at the individual level.
  - (2) Automatic termination occurs for one of the following reasons:
    - (a) The member becomes ineligible for medicaid.
    - (b) The member's permanent place of residence is moved outside the MCP membership service area.
    - (c) The member dies, in which case the period of MCP membership ends on the date of death.
    - (d) An MCP member is placed in a residential facility for the treatment of behavioral or developmental health issues and ODJFS determines following investigation, that ongoing receipt of health care through the MCP may not be in the best interest of the member or meet the rules of MCP enrollment. Upon ODJFS approval, termination is effective the last day of the month preceding placement.
    - (e) A member is incarcerated for either more than fifteen working days or is incarcerated and has accessed non-emergent medical care. When this occurs and following MCP, CDJFS, or other public agency notification to ODJFS, termination is effective the last day of the month prior to incarceration.
    - (f) A member is found by ODJFS to meet the criteria for an ICF-MR level of care and is then placed in an ICF-MR facility. When this occurs and following MCP notification to ODJFS, membership termination is effective the last day of the month preceding placement in the ICF-MR facility.
    - (g) A member is placed in a nursing facility (NF):
      - (i) Prior to the membership effective date and the member remains



- in the NF on the membership effective date. Following MCP notification to ODJFS, the membership termination is effective the last day of the month preceding placement in the NF. When this occurs, the MCP must submit required documentation which includes, but is not limited to, a copy of the approved level of care (LOC) obtained pursuant to division 5101:3 of the Administrative Code and a copy of the NF admission form or other proof of NF admission.
- (ii) After the membership effective date, and the member remains in the NF past the last day of the second calendar month following the month of NF admission. Following MCP notification to ODJFS, membership termination is effective the last day of the second calendar month following the month of NF admission. When this occurs, the MCP must submit required documentation which includes, but is not limited to, a copy of the approved level of care (LOC) obtained pursuant to division 5101:3 of the Administrative Code and a copy of the NF admission form or other proof of NF admission.
- (h) A member is enrolled in a home and community-based waiver program administered by ODJFS, ODA, or ODMR-DD. When this occurs, termination is effective no later than the last day of the month preceding enrollment in the home and community-based waiver program.
- (i) A minor MCP member's custody has been legally transferred from the legal parent or guardian to another entity. When this occurs, following appropriate notification to ODJFS, membership termination is effective the last day of the month preceding the transfer.
- (j) A member becomes ineligible in an MCP medicaid-eligible category.
- (k) A member's eligibility changes from either the ABD category of assistance as described in paragraph (B)(1)(b) of rule 5101:3-26-02 of the Administrative Code to the CFC category of assistance as described in paragraph (B)(1)(a) of rule 5101:3-26-02 of the Administrative Code or from the CFC category of assistance as described in paragraph (B)(1)(a) of rule 5101:3-26-02 of the Administrative Code to the ABD category of assistance as described in paragraph (B)(1)(b) of rule 5101:3-26-02 of the Administrative Code.
- (l) A member has third party coverage and ODJFS determines, following MCP, member, or other public agency notification to ODJFS and based on the type of coverage and the existence of conflicts between provider panels and access requirements, that continuing MCP membership may not be in the best interest of the member. When this occurs the effective date of termination shall be determined by ODJFS but in no event shall the termination date be later than the last day of the month in which ODJFS approves the termination.
- (m) The provider agreement between ODJFS and the MCP is terminated or ODJFS takes action as specified in paragraphs (G) and (H) of rule 5101:3-26-10 of the Administrative Code.
- (3) Automatic terminations of MCP membership do not require completion of a CCR.
- (4) Except as specified in paragraphs (C)(2)(c) to (C)(2)(i) of this rule, automatic

membership termination will be effective at the end of the last day of the month in which the change in eligibility, residence, or other circumstance occurred.

- (5) If ODJFS fails to notify the MCP of a member's termination from an MCP, ODJFS shall continue to pay the MCP the monthly premium rate with respect to such member, subject to the provisions of rule 5101:3-26-09 of the Administrative Code. The MCP shall remain liable for the provision of covered services as set forth in rule 5101:3-26-03 of the Administrative Code, until such time as ODJFS provides the MCP with documentation of the member's termination.
  - (6) ODJFS shall recover from the MCP any premium paid for retroactive membership termination occurring as a result of paragraphs (C)(2)(c) to (C)(2)(i) of this rule.
  - (7) In the event that an MCP member loses medicaid eligibility during an annual open enrollment period resulting in the temporary inability to change managed care plans, the member may request to change managed care plans within thirty days following automatic renewal of MCP membership.
- (D) The following applies to MCP member-initiated change requests or terminations:
- (1) MCP member-initiated change requests or terminations must occur at the assistance group level except as provided in paragraph (B)(1)(b) of rule 5101:3-26-02 of the Administrative Code and paragraphs (D)(2)(d) and (D)(9)(e) of this rule. All individuals within an assistance group must be terminated at the same time.
  - (2) MCP member-initiated change requests in mandatory service areas or MCP member-initiated terminations in voluntary service areas may occur:
    - (a) From the date of enrollment through the initial three months of MCP membership; or
    - (b) During an open enrollment month for the member's service area as described in paragraph (D)(8) of this rule; or
    - (c) If the just cause request meets one of the reasons for just cause as specified in paragraph (D)(9)(a) of this rule; or
    - (d) Upon notification to the MCEC if the member meets the criteria as specified in paragraphs (B)(2) to (B)(4) of rule 5101:3-26-02 of the Administrative Code, MCP membership is terminated in mandatory and voluntary counties.
  - (3) When requesting MCP member-initiated change requests in mandatory service areas, members must select membership in another participating MCP except as specified in paragraph (D)(2)(d) of this rule.
  - (4) When requesting MCP member-initiated terminations in voluntary service areas, members will be returned to medicaid fee-for-service or may select membership in another participating MCP, if available.
  - (5) The MCEC shall document via the consumer contact record (CCR) all information provided by the member or authorized representative of each eligible assistance group requesting termination. The MCEC shall document via the CCR that oral authorization was given and the date of the authorization.
  - (6) MCP member-initiated terminations in voluntary service areas, and MCP member-initiated change requests in mandatory service areas, will be effective the last day of the calendar month or the succeeding calendar month, subject to

state cut-off.

- (7) MCPs must:
- (a) Provide information on MCP membership change or termination options, including reasons for just cause requests as described in paragraph (D)(9)(a) of this rule, to eligible individuals and members as required in rules 5101:3-26-08 and 5101:3-26-08.2 of the Administrative Code.
  - (b) Continue to recognize the MCP identification card and not request its return from the member until the MCP receives documentation from ODJFS that the change or termination is effective. ODJFS shall continue to pay the MCP the monthly premium until the change or termination is effective.
- (8) Open enrollment months will be designated for each voluntary and mandatory service area by ODJFS or its designee at least annually. ODJFS shall notify each assistance group by mail at least sixty days prior to the designated open enrollment month of the opportunity to change or terminate MCP membership and where to obtain further information. During open enrollment months, consumers not in their initial three months of membership as described in paragraph (D)(2)(a) of this rule or meeting the criteria described in paragraphs (D)(2)(c) and (D)(2)(d) of this rule will be limited to only a one month time period to change MCPs.
- (9) MCP members or authorized representatives may request to change or terminate MCP membership for just cause when the members' or authorized representatives' contacts to the MCPs are unsuccessful in identifying providers of services that would alleviate the members' need to make a just cause request.
- (a) Changing MCPs in mandatory service areas or terminating MCP membership in voluntary service areas for just cause includes the following:
    - (i) The member moves out of the MCP's service area and a non-emergency service must be provided out of the service area before the effective date of the member's automatic termination as described in paragraph (C)(2)(b) of this rule;
    - (ii) The MCP does not, for moral or religious objections, cover the service the member seeks;
    - (iii) The member needs related services to be performed at the same time; not all related services are available within the MCP network, and the member's PCP or another provider determines that receiving services separately would subject the member to unnecessary risk;
    - (iv) Poor quality of care and the services are not available from another provider within the MCP's network;
    - (v) Lack of access to medically necessary medicaid-covered services or lack of access to the type of providers experienced in dealing with the member's health care needs;
    - (vi) The PCP selected by a member leaves the MCP's panel and was the only available and accessible PCP speaking the primary language of the member, and another PCP speaking the

language is available and accessible in another MCP in the member's service area; and

(vii) A situation in which, as determined by ODJFS, continued membership in the MCP would be harmful to the interests of the member.

- (b) Requests for just cause must be made directly to ODJFS or other ODJFS-approved entity orally or in writing.
- (c) ODJFS shall review all requests for just cause within seven working days of receipt. ODJFS may request documentation as necessary from both the member and the MCP. ODJFS shall make a decision within ten working days of receipt of all necessary documentation. ODJFS may establish retroactive termination dates and/or recover premium payments as determined necessary and appropriate. Regardless of the procedures followed, the effective date of an approved just cause request must be no later than the first day of the second month following the month in which the member

requests change or termination. If ODJFS fails to make the determination within this timeframe, the just cause request is considered approved.

- (d) If the just cause request is not approved, ODJFS shall notify the member or the authorized representative of the member's right to a state hearing.
- (e) Requests for just cause may be processed at the individual level or the assistance group level as ODJFS determines necessary and appropriate.
- (f) In the case of members who lose medicaid eligibility prior to ODJFS action to change or terminate membership for just cause, ODJFS shall assure that the member's MCP membership is not automatically renewed if eligibility for medicaid is reauthorized.

- (10) All MCP member-initiated changes or terminations must be voluntary. No member may be encouraged by an MCP to change or terminate due to an adverse change in the member's health status or need for health services, age, gender, sexual orientation, disability, national origin, race, color, religion, veteran's status, or ancestry. No policy or practice that has the effect of discrimination on the basis of race, color, or national origin shall be used.

(E) The following applies to all MCP-initiated membership terminations:

- (1) In the following instances, the MCP may submit a request to ODJFS for the termination of a member:
- (a) Fraudulent behavior by the member; or
- (b) Uncooperative or disruptive behavior by the member or someone acting on the member's behalf to the extent that such behavior seriously impairs the MCP's ability to provide services to either the member or other MCP members.
- (2) All proposed MCP-initiated terminations of members must contain ODJFS-specified documentation.
- (3) The MCP may not request termination due to a change in the member's health status or need for health services, age, gender, sexual orientation, disability, national origin, race, color, religion, veteran's status, or ancestry.

- (4) There are no state hearing rights for a member(s) terminated from an MCP pursuant to paragraph (E)(1) of this rule.
- (5) The MCP must provide medicaid-covered services to a terminated member(s) through the last day of the month in which the MCP membership is terminated, notwithstanding the date of ODJFS approval of the termination request. Inpatient facility services must be provided in accordance with paragraphs (D) ~~(4)~~(3) and (D) ~~(5)~~(4) of rule 5101:3-26-02 of the Administrative Code.
- (6) For MCP-initiated termination of MCP membership:
  - (a) Termination must occur at the assistance group level with all members returning to the fee-for-service medicaid program, if eligible.
  - (b) If ODJFS approves the MCP's request for termination, ODJFS shall:
    - (i) Notify the member(s) or authorized representative, in writing, of the impending MCP-initiated termination of all members within the assistance group; and
    - (ii) Notify in writing the member(s) or authorized representative, the MCP, or other ODJFS-approved entity and the MCEC, when applicable, of the decision to terminate all members within the assistance group, and initiate the process for returning the individuals to the fee-for-service medicaid program.
- (F) The MCP must provide medicaid-covered services to a terminated member(s) through the last day of the month in which the MCP membership is terminated, with the exception of inpatient facility services that must be provided in accordance with paragraphs (D) ~~(4)~~(3) and (D) ~~(5)~~(4) of rule 5101:3-26-02 of the Administrative Code.

Effective: 02/01/2010

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

Certification: CERTIFIED ELECTRONICALLY

Date: 01/22/2010

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.16, 5111.17

Rule Amplifies: 5111.01, 5111.02, 5111.16, 5111.17

Prior Effective Dates: 4/1/85, 2/15/89 (Emer), 5/8/89, 5/18/89, 10/9/89, 11/1/89 (Emer), 2/1/90, 2/15/90, 5/1/92, 5/1/93, 11/1/94, 7/1/96, 7/1/97 (Emer), 9/27/97, 12/10/99, 7/1/00, 11/6/00, 7/1/01, 7/1/02, 7/1/03, 7/1/04, 10/31/05, 6/1/06, 7/1/07, 1/1/08, 8/26/08 (Emer), 10/9/08, 7/1/09

5101:3-3-08

**Criteria for nursing facility-based level of care.**

(A) This rule describes the criteria for an individual to meet the nursing facility (NF)-based level of care. The NF-based level of care includes the intermediate and skilled levels of care. An individual is determined to meet the NF-based level of care when the individual meets the criteria as described in paragraphs (B) to (D) of this rule.

(B) The criteria for the intermediate level of care is met when:

(1) The individual's needs for long-term services and supports (LTSS), as defined in rule 5101:3-3-05 of the Administrative Code, exceed the criteria for the protective level of care, as described in paragraph (B)(3) of rule 5101:3-3-06 of the Administrative Code.

(2) The individual's LTSS needs are less than the criteria for the skilled level of care, as described in paragraph (D)(4) of this rule.

(3) The individual's LTSS needs do not meet the criteria for the ICF-MR-based level of care, as defined in rule 5101:3-3-05 of the Administrative Code.

(4) The individual has a need for a minimum of one of the following:

(a) Assistance, as defined in rule 5101:3-3-05 of the Administrative Code, with the completion of a minimum of two activities of daily living (ADL), as defined in rule 5101:3-3-05 of the Administrative Code and as described in paragraph (C) of this rule;

(b) Assistance with the completion of a minimum of one ADL as described in paragraph (C) of this rule, and assistance with medication administration, as defined in rule 5101:3-3-05 of the Administrative Code;

(c) A minimum of one skilled nursing service or skilled rehabilitation service, as defined in rule 5101:3-3-05 of the Administrative Code; or

(d) Twenty-four hour support, as defined in rule 5101:3-3-05 of the Administrative Code, 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.

(C) For the purposes of meeting the criteria described in paragraph (B)(4) of this rule, an individual has a need in an ADL when:

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

5101:3-3-08

- (a) Bed mobility;
  - (b) Locomotion; or
  - (c) Transfer.
- (2) The individual requires assistance with bathing.
- (3) The individual requires assistance with grooming in all of the following three components:
- (a) Oral hygiene;
  - (b) Hair care; and
  - (c) Nail care.
- (4) The individual requires assistance with toileting in at least one of the following four components:
- (a) Using a commode, bedpan, or urinal;
  - (b) Changing incontinence supplies or feminine hygiene products;
  - (c) Cleansing self; or
  - (d) Managing an ostomy or catheter.
- (5) The individual 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.
- (6) The individual requires assistance with eating.
- (D) The criteria for the skilled level of care is met when:
- (1) The individual's LTSS needs exceed the criteria for the protective level of care, as described in paragraph (B)(3) of rule 5101:3-3-06 of the Administrative Code.
  - (2) The individual's LTSS needs exceed the criteria for the intermediate level of care as described in paragraph (B)(4) of this rule.
  - (3) The individual's LTSS needs exceed the criteria for the ICF-MR-based level of

care.

(4) The individual requires a minimum of one of the following:

(a) One skilled nursing service within the day on no less than seven days per week; or

(b) One skilled rehabilitation service within the day on no less than five days per week.

(5) The individual has an unstable medical condition, as defined in rule 5101:3-3-05 of the Administrative Code.

(E) When an individual meets the criteria for a skilled level of care, as described in paragraph (D) of this rule, the individual may request placement in an intermediate care facility for persons with mental retardation (ICF-MR) that provides services to individuals who have a skilled level of care. When an individual with a skilled level of care requests placement in an ICF-MR, the following requirements apply:

(1) The individual may be determined to meet the criteria for the ICF-MR-based level of care; and

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



Replaces: Part of 5101:3-3-05, 5101:3-3-06

Effective:

R.C. 119.032 review dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02, 5111.204
Prior Effective Dates:	7/1/80, 11/10/83, 10/1/93 (Emer.), 12/31/93, 7/1/08

5101:3-3-15 **Process and timeframes for a level of care determination for nursing facility-based level of care programs.**

(A) This rule describes the processes and timeframes for a level of care determination, as defined in rule 5101:3-3-05 of the Administrative Code, for a nursing facility (NF)-based level of care program, as defined in rule 5101:3-3-05 of the Administrative Code.

(1) The processes described in this rule shall not be used for a determination for an ICF-MR-based level of care, as defined in rule 5101:3-3-05 of the Administrative Code.

(2) A level of care determination may occur face-to-face or by a desk review, as defined in rule 5101:3-3-05 of the Administrative Code, and is one component of medicaid eligibility in order to:

(a) Authorize medicaid payment to a NF; or

(b) Approve medicaid payment of a NF-based home and community-based services (HCBS) waiver or other NF-based level of care program.

(3) An individual who is seeking a NF admission is subject to both a preadmission screening and resident review (PASRR) process, as described in rules 5101:3-3-14, 5101:3-3-15.1, 5101:3-3-15.2, 5122-21-03, and 5123:2-14-01 of the Administrative Code, and a level of care determination process.

(a) The preadmission screening process must be completed before a level of care determination or a level of care validation can be issued.

(b) In order for the Ohio department of job and family services (ODJFS) to authorize payment to a NF, the individual must have received a non-adverse PASRR determination and subsequent NF-based level of care determination.

(i) ODJFS may authorize payment to the NF effective on the date of the PASRR determination.

(ii) The level of care effective date cannot precede the date that the PASRR requirements were met.

(iii) If a NF receives medicaid payment from ODJFS for an individual who does not have a NF-based level of care, the NF is subject to the claim adjustment for overpayments process described in rule 5101:3-1-19 of the Administrative Code.

(B) Level of care request.

(1) In order for ODJFS or its designee (hereafter referred to as ODJFS) to make a

level of care determination, ODJFS must receive a complete level of care request. A level of care request is considered complete when all necessary data elements are included and completed on the JFS 03697, "Level of Care Assessment" (rev. 4/2003) or alternative form, as defined in rule 5101:3-3-05 of the Administrative Code, and any necessary supporting documentation is submitted with the JFS 03697 or alternative form, as described in paragraphs (B)(2) to (B)(4) of this rule.

(2) Necessary data elements on the JFS 03697 or alternative form:

- (a) Individual's legal name;
- (b) Individual's medicaid case number, or a pending medicaid case number;
- (c) Date of original admission to the facility, if applicable;
- (d) Individual's current address, including county of residence;
- (e) Individual's current diagnoses;
- (f) Date of onset for each diagnosis, if available;
- (g) Individual's medications, treatments, and required medical services;
- (h) A description of the individual's activities of daily living and instrumental activities of daily living;
- (i) A description of the individual's current mental and behavioral status; and
- (j) Type of service setting requested.

(3) Physician certification on the JFS 03697 or alternative form.

- (a) A physician certification means a signature from a physician, as defined in rule 5101:3-3-05 of the Administrative Code, and date on the JFS 03697 or alternative form.
- (b) A physician certification must be obtained within thirty calendar days of submission of the JFS 03697 or alternative form.
- (c) Exceptions to the physician certification:
  - (i) When an individual resides in the community and ODJFS determines that the individual's health and welfare is at risk and that it is not possible for the submitter of the JFS 03697 or alternative form to obtain a physician signature and date at the time of the submission of the JFS 03697 or alternative form, a

verbal physician certification is acceptable.

(ii) ODJFS must obtain a physician certification within thirty days of the verbal physician certification.

(4) Necessary supporting documentation with the JFS 03697 or alternative form when the individual is subject to a preadmission screening process:

(a) A copy of the JFS 03622, "Preadmission Screening/Resident Review (PAS/RR) Identification Screen" (rev. 11/2010) and JFS 07000, "Hospital Exemption from Preadmission Screening Notification" (rev. 11/2010), as applicable, in accordance with rules 5101:3-3-15.1 and 5101:3-3-15.2 of the Administrative Code; and

(b) Any preadmission screening results and assessment forms.

(C) Process when ODJFS receives a complete level of care request.

(1) When ODJFS determines that a level of care request is complete, ODJFS shall:

(a) Issue a level of care determination.

(b) Inform the individual, and/or the sponsor and the authorized representative, as applicable, about the individual's PASRR results.

(c) Notify the individual, and/or the sponsor and the authorized representative, as applicable, as defined in rule 5101:3-3-05 of the Administrative Code, of the level of care determination.

(d) When there is an adverse level of care determination, inform the individual, the sponsor, and the authorized representative, as applicable, about the individual's hearing rights in accordance with division 5101:6 of the Administrative Code.

(2) In accordance with rules 5101:1-38-01 and 5101:1-39-23 of the Administrative Code, the county department of job and family services (CDJFS) shall determine medicaid eligibility and issue proper notice and hearing rights to the individual.

(D) Process when ODJFS receives an incomplete level of care request.

(1) When ODJFS determines that a level of care request is not complete, ODJFS shall:

(a) Notify the submitter that a level of care determination cannot be issued due to an incomplete JFS 03697 or alternative form.

(b) Specify the necessary information the submitter must provide on or with the JFS 03697 or alternative form.

(c) Notify the submitter that the level of care request will be denied if the submitter does not submit the necessary information to ODJFS within fourteen calendar days.

(i) When the submitter provides a complete level of care request to ODJFS within the fourteen calendar day timeframe, ODJFS shall perform the steps described in paragraph (C) of this rule.

(ii) When the submitter does not provide a complete level of care request to ODJFS within the fourteen calendar day timeframe, ODJFS may deny the level of care request and document the denial in the individual's electronic record maintained by ODJFS.

(2) In accordance with rules 5101:1-38-01 and 5101:1-39-23 of the Administrative Code, the CDJFS shall determine medicaid eligibility and issue proper notice and hearing rights to the individual.

(E) Desk review level of care determination.

(1) A desk review level of care determination is required within one business day from the date of receipt of a complete level of care request when:

(a) ODJFS determines that an individual is seeking admission or re-admission to a NF from an acute care hospital or hospital emergency room.

(b) A CDJFS requests a level of care determination for an individual who is receiving adult protective services, as defined in rule 5101:2-20-01 of the Administrative Code, and the CDJFS submits a JFS 03697 or alternative form at the time of the level of care request.

(2) A desk review level of care determination is required within five calendar days from the date of receipt of a complete level of care request when:

(a) ODJFS determines that an individual who resides in a NF is requesting to change from a non-medicaid payor to medicaid payment for the individual's continued NF stay.

(b) ODJFS determines that an individual who resides in a NF is requesting to change from medicaid managed care to medicaid fee-for-service as payment for the individual's continued NF stay.

(c) ODJFS determines that an individual is transferring from one NF to another NF.

(F) Face-to-face level of care determination.

(1) A face-to-face level of care determination is required within ten calendar days from the date of receipt of a complete level of care request when:

(a) An individual or the authorized representative of an individual requests a face-to-face level of care determination.

(b) ODJFS makes an adverse level of care determination, as defined in rule 5101:3-3-05 of the Administrative Code, during a desk review level of care determination.

(c) ODJFS determines that the information needed to make a level of care determination through a desk review is inconsistent.

(d) An individual resides in the community and ODJFS verifies that the individual does not have a current NF-based level of care.

(e) ODJFS determines that an individual has a pending disenrollment from a NF-based HCBS waiver due to the individual no longer having a NF-based level of care.

(2) A face-to-face level of care determination is required within two business days from the date of a level of care request from a CDJFS for an individual who is receiving adult protective services when the CDJFS does not submit a JFS 03697 or alternative form at the time of the level of care request.

(G) Delayed face-to-face visit.

(1) A delayed face-to-face visit, as defined in rule 5101:3-3-05 of the Administrative Code, is required within ninety calendar days after ODJFS conducts a desk review level of care determination for an individual as described in paragraphs (E)(1)(a), (E)(1)(b), and (E)(2)(a) of this rule.

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

(a) An individual as described in paragraphs (E)(2)(b) and (E)(2)(c) of this rule.

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

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

(d) An individual who has had an in-person resident review, in accordance

with Chapter 5101:3-3 of the Administrative Code, since the individual's NF admission.

(e) An individual 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 an HCBS waiver.

(H) Level of care validation.

ODJFS may conduct a level of care validation, as defined in rule 5101:3-3-05 of the Administrative Code, in lieu of a face-to-face level of care determination within one business day from the date of a level of care request for:

(1) An individual who is enrolled on a NF-based HCBS waiver and is seeking admission to a NF.

(2) An individual who is a NF resident and is seeking readmission to the same NF after a hospitalization.

5101:3-3-15

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Replaces: 5101:3-3-15

Effective:

R.C. 119.032 review dates:

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Certification

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Date

Promulgated Under: 119.03  
Statutory Authority: 5111.02  
Rule Amplifies: 5111.01, 5111.02, 5111.204, 5111.205  
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



