Frequently Asked Questions
Managed Care and Nursing Facility-Based Levels of Care

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Individuals seeking Medicaid payment for a nursing facility (NF) stay must have a nursing facility-based level of care (LOC) to ensure Medicaid payment for those services. NF-based levels of care are described in Ohio Administrative Code (OAC) rules 5160-3-05 and 5160-3-08. This document is specific to individuals who are enrolled in managed care at the time of a nursing facility stay.

What are the nursing facility based levels of care?

- **Intermediate Level of Care (ILOC) –** when an individual's need for long-term services and supports exceeds the criteria for protective LOC and the individual has a need for at least one of the following:
  - Assistance with two activities of daily living (ADLs);
  - Assistance with one ADL and medication self-administration;
  - A need for one skilled nursing or skilled rehabilitation service; or
  - A need for 24-hour support in order to prevent harm due to a cognitive impairment.
- **Skilled Level of Care (SLOC)** – when an individual's need for long-term services and supports exceeds the criteria for ILOC or the Developmental Disabilities LOC. The individual must also have an unstable condition and a need for either one skilled nursing service (per day, seven days a week) or one skilled rehabilitation service (per day, no less than five days per week).
- Either of the above levels of care meet the standard for Medicaid payment to a nursing facility per OAC rule 5160-3-08.

What is the role of the discharge hospital and/or admitting nursing facility?

When a Medicaid managed care organization (MCO) or MyCare Ohio plan (MCOP) member is transitioning from a hospital into a NF, the hospital and/or admitting NF must ensure the member meets PASRR requirements and must request prior authorization (PA) or LOC approval from the MCO or MCOP for the NF stay. The NF should be in-network unless otherwise approved by the MCO or MCOP. (S*ee MMC and MCOP PA/LOC FAQ documents for additional managed care specific requirements)*

What is the role of the Area Agency on Aging (AAA)?

Unlike the fee-for-service (FFS) process, the AAAs do not have a state-defined role in the LOC determination process for NF admissions for individuals enrolled in an MCO or MCOP.

What documentation does the NF need to submit?

- For specific information related to each MCO and MCOP's authorization requirements for NF stays, see the separate PA/LOC FAQ documents on ODM's website: http://medicaid.ohio.gov/provider/ManagedCare/PolicyGuidance
- When an individual receives Medicaid services through an MCO or MCOP, the hospital transitioning a member into a NF or the admitting NF shall notify the MCO or MCOP and request approval for the NF stay. An MCO or MCOP must ensure the NF-based LOC criteria are met and provide authorization upon admission to a NF. In order for an MCO or MCOP to complete the LOC process, the following specific documentation may be requested:
  - PASRR compliance documentation[1]*;
  - Clinical information (diagnoses, medications, MDS Section G, etc.);
  - Other documentation per plan request

[1] The nursing facility is responsible for ensuring PASRR requirements are met in accordance with OAC rules 5130-3-15, 5160-3-15.1 and 5160-3-15.2.

How does the MCO or MCOP determine an individual's level of care?

- In order to determine LOC, the MCO or MCOP must receive a complete PA or LOC request per the plan-specific requirements. The request typically originates with the hospital or admitting NF. For managed care members, the MCO or MCOP must evaluate the member's need for the level of services provided by the NF.
- Providers may submit the Ohio Medicaid Managed Care/MyCare Ohio Nursing Facility Request form as an attachment when submitting a prior authorization request for a NF stay.
- When the MCO or MCOP receives a complete PA or LOC request, the documentation is reviewed in accordance with OAC 5160-3-05 and 5160-3-08. The PA or LOC determination is issued to the individual and/or their authorized representative, and the NF. If the individual has been determined to have either an Intermediate or Skilled LOC, the MCO or MCOP will pay for the NF stay (pending other eligibility requirements).
- The MCO or MCOP must provide documentation of the member's LOC determination to the NF. The MCO or MCOP must maintain a written record that the criteria were met, or if not met, the MCO or MCOP must maintain a record that a Notice of Action (NOA) was issued in accordance with OAC 5160-26-08.4 or 5160-58-08.4.

Who makes the final determination for a NF stay?

When an individual is receiving Medicaid services through managed care, the MCO or the MCOP makes the final determination regarding a NF stay, and issues proper notice and appeal rights to the individual and/or their authorized representative.

What rate do plans pay nursing facility providers?

MCOs and MCOPs are required to pay a nursing facility, at a minimum, at the rate specified in statute (Ohio Revised Code 5165.15). The calculation in ORC 5165.15 is used by ODM in the calculation of the capitation rates paid to managed care organizations. The rates outlined in ORC 5165.15 are applicable to both intermediate and skilled levels of care. There is not a difference in rates for intermediate versus skilled level of care.

What are the member's appeal rights when an adverse PA or LOC is issued?

The member will receive appeal rights from the MCO or MCOP at the time an adverse PA or LOC determination is issued. Per OAC rule 5160-26-08.4 and 5160-58-08.4, the member must exhaust the managed care appeal process before being granted state hearing rights. If the CDJFS determines no Medicaid eligibility for the NF stay, the member will receive state hearing rights.

What are the provider's appeal rights when an adverse PA or LOC is issued?

Per ORC 5160.34, MCOs and MCOPs are required to have a provider appeals process for prior authorization denials. Appeals that are considered "urgent" must be resolved within 48 hours and all other appeals must be resolved within 10 calendar days. The appeal process shall be between the provider and a clinical peer appointed by the plan.

When does a managed care member switch to fee-for-service (FFS) Medicaid?

This question and answer does not apply to MyCare Ohio members or individuals covered under Adult Extension. These individuals will continue to be enrolled in managed care for the duration of their NF stay.

- In accordance with OAC rule 5160-26-02.1, MCOs shall request disenrollment for members who are Covered Families and Children (CFC) or Aged, Blind or Disabled (ABD) recipients when the following criteria are met:
    - The MCO has authorized a NF stay for the month of admission and two complete consecutives calendar months;
    - The individual has remained in the NF for that entire time period;
    - The individual has a need for long-term care and NF discharge is not expected in the foreseeable future; and
    - The individual is not using hospice services during this time period.
- Members who meet the criteria for the developmental disabilities LOC and is admitted to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) will be disenrolled from managed care.

- The MCO shall request disenrollment from ODM using an established process outlined in the provider agreement. ODM may approve or deny the MCO's request after it is submitted and reviewed against the disenrollment criteria listed in OAC rule 5160-26-02.1.

How does a NF know when an individual is on managed care or FFS Medicaid?

- NFs can obtain the most current member information through the Medicaid Information Technology System (MITS) provider portal located online at: https://www.ohmits.com/prosecure/authtam/handler?TAM_OP=login&URL=%2FPortal%2FDesktopModules%2FiC_Authenticate%2FSignIn.aspx%3FReturnUrl%3D%252fPortal%252fdefault.aspx
- If available, NFs can review an individual's Medicaid card to determine if they are enrolled in managed care. Examples of *Medicaid* managed care cards are below. MyCare Ohio cards will have the MyCare logo on them.

What are the NF and MCO/MCOP communication responsibilities?

- In accordance with the provider agreements, MCOs and MCOPs are expected to manage transitions of care effectively and comprehensively between settings. This includes:
  - Identifying members who require assistance transitioning between settings;
  - Developing a method for evaluating risk of readmission in order to determine the intensity of follow up that is required for the member after the date of discharge;
  - Allowing for adequate advance notice before denying continuing NF stay request;
  - Designating plan staff who will communicate with the discharging NF and inform the NF of the plans' designated contacts;
  - Ensuring that timely notification and receipt of admission dates, discharge dates and clinical information is communicated between plan departments, care settings and with the primary care provider, as appropriate;
  - Participating in discharge planning activities with the NF, making arrangements for safe discharge placement and facilitating clinical hand-offs between the NF, the plan, and if applicable, any home and community-based care provider;
  - Obtaining a copy of the discharge/transition plan;
  - Arranging for services specified in the discharge/transition plan; and
  - Conducting timely follow up with the member and the member's primary provider to ensure post discharge services have been provided.
- NFs are expected to communicate member intake/discharge information and are expected to actively participate with the MCO or MCOP in the activities listed above.