Business Impact Analysis

Agency, Board, or Commission Name: The Ohio Department of Medicaid

Rule Contact Name and Contact Information:

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Regulation/Package Title (a general description of the rules' substantive content):

Nursing Facility Budget Bill Rules – HB110

Rule Number(s): 5160-3-58 (Rescind), 5160-3-50 (New), 5160-3-70 (New)

Date of Submission for CSI Review: 2/28/2022

Public Comment Period End Date: 3/7/2022

Rule Type/Number of Rules:

New/_2__ rules

No Change/____ rules (FYR? ___)

Amended/____ rules (FYR? ___)

Rescinded/__1__ rules (FYR? _No__)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing

regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

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

   Rule 5160-3-58, entitled "Nursing facilities (NFs): quality indicators and quality payment rate" sets forth provisions specifying the nursing facility quality indicators and the methodology for determining the per Medicaid day quality payment rate. This rule is being proposed for rescission due to legislative changes that were made with the implementation of Amended Substitute House Bill 110 of the 133rd General Assembly.

   Rule 5160-3-50, entitled "Nursing facilities (NFs): use of additional dollars as a result of rebasing of rates" is being proposed for adoption. This new rule addresses the use, reporting, and reimbursement of additional dollars received as a result of rebasing of rates. It includes a definition of "cost center report" as well as provisions regarding direct care spending, submission of cost center reports, extensions for the submission of cost center reports, late reporting penalties, change of operator, new providers, reviews of cost center reports by the Department of Medicaid, and reimbursement of funds to the Department.

Rule 5160-3-70, entitled "Nursing facilities (NFs): appeals for special focus facilities (SFFs) proposed for termination from the medicaid program" is being proposed for adoption. This new rule includes provisions regarding appeals under Chapter 119. of the Revised Code for nursing facilities that are proposed for termination from the Medicaid program due to failure to improve or to graduate from the Special Focus Facility program within certain periods of time, and provisions for the hearings for those appeals.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

4. **5160-3-58**

   Statutory Authority: 5165.02

   Amplifies: 5165.25

   5160-3-50

   Statutory Authority: 5165.02, 5165.36

   Amplifies: 5165.01, 5165.16, 5165.19, 5165.21, 5165.36

   5160-3-70

   Statutory Authority: 5165.02, 5165.771

   Amplifies: 5165.771

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

   No.

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

   5160-3-70

   This proposed rule contains provisions that address the state's appeals process for the nursing facility Special Focus Facility (SFF) Program when the Ohio Department of Medicaid proposes to terminate a facility's participation in the Medicaid program if the facility is placed on the SFF list and fails to make improvements or graduate from the SFF program within required timeframes. This rule contains provisions for an expedited appeals process for nursing facilities to dispute the length of time a facility is placed in a specific table on the SFF list. This change was made to provide an additional due process element in the state's SFF statute.

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

5160-3-58

Not applicable. This rule is being proposed for rescission.

5160-3-50

The public purpose of this rule is to implement provisions contained in the Ohio Revised Code regarding nursing facilities' use of any additional dollars they may receive as a result of the rebasing of nursing facility rates.

5160-3-70

The public purpose of this rule is to implement due process provisions found in the Revised Code regarding the federal Special Focus Facility program for nursing facilities.

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

5160-3-58

Not applicable. This rule is being proposed for rescission.

5160-3-50

The success of this rule will be measured by the proper use of additional rebasing funds as required by this rule.

5160-3-70

The success of this rule will be measured by the extent to which appeals are submitted according to the specifications of this rule by nursing facilities designated as Special Focus Facilities that are being proposed for termination from the Medicaid program, and by the extent to which hearings for those appeals are conducted according to the specifications of this rule.

9. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.
None of the proposed rules are being submitted pursuant to these specified sections of the Revised Code.

Development of the Regulation

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

   The primary stakeholders are Ohio's three nursing facility provider associations. The nursing facility provider associations in Ohio are:

   - Ohio Health Care Association (OHCA)
   - The Academy of Senior Health Sciences, Inc.
   - LeadingAge Ohio

   Ohio's nursing facility provider associations represent and advocate for small and large nursing facilities and nursing facilities with both individual and group ownership, publicly traded and government-owned properties, and for-profit and non-profit facilities. In addition to representing and advocating for nursing facilities, the associations are informational and educational resources to Ohio's nursing facilities, their suppliers, consultants, and the public at large.

   The nursing facility provider associations were involved in review of the draft rules when the Department of Medicaid emailed the draft rules and a summary of the rule changes to the associations on December 16, 2021.

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

    No input was provided by stakeholders on the proposed draft rules.

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

    Scientific data was not applicable to the development of these rules.

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

    No alternative regulations were considered. The Department of Medicaid considers Administrative Code rules the most appropriate type of regulation for the provisions contained in these rules.

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

    Performance-based regulations are not considered appropriate for these regulations.

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

The Department of Medicaid's staff reviewed the applicable ORC and OAC to ensure these rules do not duplicate any of the Department of Medicaid's rules or any other regulations in the ORC or OAC.

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

The final rules as adopted by the Ohio Department of Medicaid will be posted via the Department's website at http://medicaid.ohio.gov/RESOURCES/LegalandContracts/Rules.aspx. In addition, the Department will notify stakeholders during regular Provider Association meetings when the final rules become effective.

Adverse Impact to Business

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

a. Identify the scope of the impacted business community; and

These rules impact approximately 970 nursing facilities in Ohio that choose to participate in the Medicaid program. Provider participation in the Medicaid program is optional and at the provider's discretion.

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

Compliance with Medicaid program requirements is mandatory for providers who choose to participate in the program and may result in administrative costs as detailed below.

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

5160-3-58

b.) and c.)

There is no expected adverse impact to nursing facilities to meet the quality indicators described in this rule. It is standard practice for nursing homes to provide quality care so there would be no cost to meet the criteria in the rule.

In accordance with paragraph (E)(1) of this rule, a nursing facility will not receive a point for the pressure ulcer, antipsychotic medication, and unplanned weight loss quality indicators when the Department of Medicaid determines there is insufficient data to calculate a rate for these indicators. The adverse impact to a nursing facility would be the facility's portion of the total amount of the quality funds to be paid statewide to all nursing facilities that the facility would now not receive.

In accordance with paragraph (E)(2) of this rule, a nursing facility will not receive a quality point for the employee retention quality indicator when the facility fails to complete section eight of the Department of Medicaid's nursing facility annual cost report. The adverse impact to a nursing facility would be the facility's portion of the total amount of the quality funds to be paid statewide to all nursing facilities that the facility would now not receive.

However, all the above costs are existing costs. There are no new costs as this rule is being proposed for rescission.

5160-3-50

b.) and c.)

In accordance with paragraph (C) of this rule, nursing facilities are to submit their first cost center report to the Department of Medicaid not later than 90 days after the end of calendar year 2021. Subsequent cost center reports are to be submitted not later than 90 days after the end of the applicable calendar year. Cost center reports are to be submitted on an electronic form prescribed by the Department and are to include only direct care, ancillary and support, and tax costs, as well as inpatient days. The Department of Medicaid estimates it will take a nursing facility's accountant approximately 10 hours at the rate of approximately $32.00 per hour (total estimated cost: $320.00) to prepare and submit one cost center report.

In accordance with paragraph (D) of this rule, a nursing facility may submit a cost center report within 14 days after the original due date for good cause shown if written approval for an extension request is received from the Department of Medicaid prior to the original due date of the report. The Department of Medicaid estimates it will take a nursing facility's attorney approximately 1 hours at the rate of approximately $400.00 per hour (total estimated cost: $400.00) to prepare and submit one request for an extension to the Department of Medicaid.

In accordance with paragraph (E) of this rule, if a cost center report is not received by the Department of Medicaid by the original due date or by an approved extension due date, the provider may be assessed a late reporting penalty for each day a complete and adequate report is not received. The penalty is $100.00 per calendar day for each day after the original due date or the extension due date that a facility does not submit a report. The amount of the penalty would be calculated by multiplying $100.00 by the number of calendar days after the due date or extension due date that a facility does not submit the report.

In accordance with paragraph (I) of this rule, any amounts a nursing facility spends on cost centers other than as permitted by this rule, Section 333.240 of Am Sub HB110 of the 134th General Assembly, and ORC section 5165.36 must be reimbursed to the Department of Medicaid with interest. The amount to be reimbursed by a nursing facility would be calculated by multiplying the amount improperly spent by the facility by the rate of interest to be used.

5160-3-70

b.) and c.)

In accordance with paragraph (A)(3) of this rule, if a nursing facility chooses to appeal an order terminating the facility's participation in the Medicaid program due to failure to make improvements or graduate from Special Focus Facility program within certain periods of time, the facility must submit the appeal to the Ohio Department of Medicaid within 48 hours of receipt of the order. The Department of Medicaid estimates it will take a nursing facility's attorney approximately 1.5 hours at the rate of approximately $400.00 per hour (total estimated cost: $600.00) to prepare and submit one such appeal.

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

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Not applicable. This rule is being proposed for rescission.

5160-3-50

The adverse impact to nursing facilities associated with this rule is justified because this rule is intended to increase direct care staffing in nursing homes, thereby helping to ensure the provision high quality, person centered care and result in better resident outcomes.

5160-3-70

The adverse impact to nursing facilities associated with this rule is justified because this rule adds an additional due process element to the state's Special Focus Facility statute. This new appeals process allows a nursing facility that has been placed on the federal Special Focus Facility (SFF) list and has received notice of termination from the Medicaid program for failure to make improvements or graduate from the SFF program within a certain period of time to file an appeal to dispute the length of time the facility has been on the SFF list.

Regulatory Flexibility

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

No. The provisions in these rules are the same for all nursing facilities regardless of size.

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

ORC section 119.14 is not applicable to these regulations.

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

Providers in need of assistance may contact the Bureau of Long-Term Services and Supports at (614) 466-6742.

*** DRAFT - NOT YET FILED ***

TO BE RESCINDED

5160-3-58 Nursing facilities (NFs): quality indicators and quality payment rate.

(A) In accordance with section 5165.25 of the Revised Code, this rule describes the criteria for each of the quality indicators that nursing facilities need to meet to earn quality points, and the method by which the Ohio department of medicaid (ODM) determines the per medicaid day quality payment rate.

(B) Measurement period.

For purposes of this rule, "measurement period" means the calendar year immediately preceding the calendar year in which the state fiscal year begins.

(C) Quality indicators.

A nursing facility may earn a maximum of one point for each of the following quality indicators during the measurement period. For the pressure ulcer quality indicator and the antipsychotic medication quality indicator, nursing facilities may earn a maximum of one point each for rates for short-stay residents and a maximum of one point each for rates for long-stay residents. Based on the number of quality indicator points earned, ODM will calculate a per medicaid day quality payment rate for each nursing facility. To earn a point for each of the indicators, the nursing facility needs to meet the following criteria:

(1) Pressure ulcers.

Score no more than the fortieth percentile for pressure ulcer rates. ODM obtains the pressure ulcer rates from the centers for medicare and medicaid services (CMS) website at https://data.medicare.gov using the CMS quality measure for short-stay residents with post-acute pressure ulcer/pressure injury changes in skin integrity , and the CMS quality measure for long-stay residents with pressure ulcers.

(2) Antipsychotic medications.

Score no more than the fortieth percentile, as established by ODM, for antipsychotic medication use rates.

(3) Unplanned weight loss.

Score no more than the fortieth percentile for long-stay nursing facility residents' unplanned weight loss rate. ODM obtains the unplanned weight loss rate from the CMS website using the CMS quality measure for long-stay residents who lose too much weight.

(4) Employee retention.

Attain an employee retention target rate of at least the seventy-fifth percentile. ODM calculates the percentile using the employee retention rates from section eight of all ODM nursing facility annual cost reports.

(5) Satisfaction survey.

(a) For even-numbered state fiscal years, attain a target rate of at least the fiftieth percentile of the overall score for all participating nursing facilities on the department of aging's most recently published resident satisfaction survey conducted pursuant to section 173.47 of the Revised Code.

(b) For odd-numbered state fiscal years, attain a target rate of at least the fiftieth percentile of the overall score for all participating nursing facilities on the department of aging's most recently published family satisfaction survey conducted pursuant to section 173.47 of the Revised Code.

(D) Religious nonmedical health care institutions (RNHCIs).

RNCHIs will receive one point for each of the quality indicators described in paragraphs (C)(1), (C)(2), and (C)(3) of this rule.

(E) Reasons for which no quality indicator points will be awarded.

(1) For the pressure ulcer, antipsychotic medication, and unplanned weight loss quality indicators described in paragraphs (C)(1) to (C)(3) of this rule, no points will be awarded when there is insufficient data to calculate a rate, as determined by ODM.

(2) For the employee retention rate quality indicator described in paragraph (C)(4) of this rule, no point will be awarded when a nursing facility fails to complete section eight of the ODM nursing facility annual cost report.

(F) Calculation of the per medicaid day quality payment rate.

(1) Determine the number of inpatient medicaid days reported by each nursing facility on the ODM nursing facility annual cost report for the calendar year preceding the fiscal year in which the quality payment will be paid.

(2) Determine the total number of inpatient medicaid days reported by all nursing facilities on the ODM nursing facility annual cost report for the calendar year preceding the fiscal year in which the quality payment will be paid.

(3) Determine the number of quality points earned by each nursing facility during the applicable measurement period.

(4) For each nursing facility, multiply the number of inpatient medicaid days as determined in paragraph (F)(1) of this rule for the nursing facility by the number of quality points earned by the nursing facility as determined in paragraph (F)(3) of this rule. This product is the point days earned by each nursing facility.

(5) Determine the total number of point days for all nursing facilities.

(6) Multiply one dollar and seventy-nine cents by the total number of medicaid days determined in paragraph (F)(2) of this rule. This product is the total amount of quality funds to be paid to nursing facilities by ODM in the applicable fiscal year.

(7) Divide the total amount of quality funds to be paid as calculated in paragraph (F)(6) of this rule by the total number of point days for all nursing facilities as determined in paragraph (F)(5) of this rule.

(8) Multiply the amount calculated in accordance with paragraph (F)(7) of this rule by the quality points earned by each nursing facility as determined in paragraph (F)(3) of this rule. This product is the per medicaid day quality payment for each nursing facility.

(G) Appeals.

The calculation of the quality payment rate is not subject to appeal under Chapter 119. of the Revised Code.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5165.02
Rule Amplifies:	5165.25
Prior Effective Dates:	07/01/2016, 09/22/2018, 10/10/2020

*** DRAFT - NOT YET FILED ***

5160-3-50 Nursing facilities (NFs): use of additional dollars as a result of rebasing of rates.

(A) Definitions.

For purposes of this rule:

(1) "Ancillary and support costs," "cost center," "direct care costs," "rebasing" and "tax costs" have the same meaning as in section 5165.01 of the Revised Code.

(2) "Cost center report" means a report submitted to the Ohio department of medicaid (ODM) by a nursing facility provider that identifies the amount spent on each cost center included in rebasing.

(B) Direct care spending.

(1) In accordance with section 5165.36 of the Revised Code, nursing facilities should increase direct care spending by at least seventy percent of any additional dollars received as a result of rebasing.

(2) For purposes of determining compliance with section 5165.36 of the Revised Code, the increased spending in direct care will be evaluated using calendar year 2019 medicaid nursing facility cost report data for direct care.

(C) Submission of cost center reports.

(1) In accordance with Section 333.240 of Amended Substitute House Bill 110 of the 134th General Assembly, for state fiscal years 2022 and 2023, cost center reports are to be submitted as follows:

(a) The first cost center report is to be submitted not later than ninety days after the end of calendar year 2021 and should cover the period of July 1, 2021 through December 31, 2021.

(b) Subsequent cost center reports should cover one calendar year each and should be submitted not later than ninety days after the end of the applicable calendar year.

(2) Reports should include only direct care, ancillary and support, and tax costs as well as inpatient days.

(3) Reports should be submitted on an electronic form prescribed by ODM.

(D) Extensions.

For good cause shown, cost center reports may be submitted within fourteen days after the original due date if written approval is received from ODM prior to the original due date of the report. Requests for extensions should be sent via email to

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LTCAudits@medicaid.ohio.gov and explain the circumstances resulting in the need for an extension.

(E) Late reporting penalties.

(1) If a report is not received by the original due date, or by an approved extension due date if applicable, the provider may be assessed a late reporting penalty for each day a complete and adequate report is not received

(2) The late reporting penalty period begins on the day after the original due date or on the day after the extension due date, whichever is applicable, and continues until the complete and adequate report is received by ODM.

(3) The late reporting penalty will be one hundred dollars per calendar day for each day after the original due date or the extension due date, whichever is applicable, that a nursing facility does not submit a cost center report.

(4) The late reporting penalty is assessed annually and will be a reduction in payments to providers that submit claims directly to ODM or by payment submitted to ODM outside the claims process for providers that do not submit claims directly to ODM. No penalty is imposed during a fourteen-day extension granted by ODM.

(F) Change of operator (CHOP).

In cases of a change of operator, the exiting operator's 2019 cost reports and the additional dollars received as a result of rebasing will be used for the purposes of determining the entering operator's compliance with section 5165.36 of the Revised Code and Section 333.240 of Amended Substitute House Bill 110 of the 134th General Assembly.

(G) New providers.

For state fiscal years 2022 and 2023, nursing facilities with an initial medicaid certification date on or after January 1, 2020 are excluded from the requirements set forth in paragraphs (B) and (C) of this rule.

(H) Reviews.

For purposes of determining compliance with this rule, Section 333.240 of Amended Substitute House Bill 110 of the 134th General Assembly, and section 5165.36 of the Revised Code, ODM may conduct reviews of cost center report data beginning with calendar year 2022 data.

(I) Reimbursement of funds to ODM.

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(1) Any amounts spent on cost centers other than as permitted by this rule, Section 333.240 of Amended Substitute House Bill 110 of the 134th General Assembly, and section 5165.36 of the Revised Code will be reimbursed to ODM with interest.

(a) The interest will be no greater than two times the current average bank prime rate determined at the mid-point of the reporting quarter.

(b) Interest will accrue from the mid-point of the reporting quarter until the date funds are recouped from medicaid payments or until payment is submitted to ODM outside the claims process for providers who do not submit claims directly to ODM.

(2) Reimbursement of funds pursuant to a review as set forth in paragraphs (H) and (I) of this rule is not subject to appeal under Chapter 119. of the Revised Code.

*** DRAFT - NOT YET FILED ***

5160-3-70 Nursing facilities (NFs): appeals for special focus facilities (SFFs) proposed for termination from the medicaid program.

(A) Appeal.

(1) A nursing facility may appeal under Chapter 119. of the Revised Code an order pursuant to section 5165.771 of the Revised Code terminating a nursing facility's participation in the medicaid program as provided in this rule.

(2) A nursing facility may only appeal the length of time the facility has been listed in a table as described in division (B) of section 5165.771 of the Revised Code.

(3) The appeal is to be submitted by the nursing facility to the Ohio department of medicaid (ODM) within forty-eight hours of the nursing facility's receipt of the termination order.

(B) Hearing.

(1) ODM will conduct a hearing within seven business days of the filing of the appeal by the nursing facility.

(2) For good cause shown, the hearing date may be extended.