CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Department of Medicaid

Regulation/Package Title: NF Rule Changes Pursuant to Five-Year Review

Rule Number(s): 5160-3-17 (amend), 5160-3-17.1 (rescind), 5160-3-17.3 (rescind)

Date: June 17, 2014

Rule Type:

- ☐ New
- X Amended
- X 5-Year Review
- X Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

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

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OAC 5160-3-17

This rule establishes the payment methodology to be used for the provision of outlier services in Ohio nursing facilities. It also sets forth the information an outlier provider is required to submit to the Department of Medicaid, including the timeframes for submitting the information. In addition, this rule contains provisions governing the timeframes during which the Department of Medicaid must establish the initial and subsequent contracted outlier rates, and the process for the establishment of effective dates for those rates.

This rule is being proposed for amendment to delete the franchise fee add-on as a component of the outlier per diem rate because the franchise fee add-on became obsolete when section 5111.243 of the Revised Code was repealed with the implementation of Am. Sub. HB 153 of the 129th General Assembly. Revised Code references are being updated due to the creation of the Ohio Department of Medicaid and the subsequent reorganization of many Revised Code provisions governing the Medicaid program. Administrative Code references also are being updated due to the creation of the Department of Medicaid and the subsequent renumbering of rules by the Legislative Services Commission. The Department's name is being updated from the Ohio Department of Job and Family Services to the Ohio Department of Medicaid, and the rule title is being modified in order to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.

OAC 5160-3-17.1

This rule establishes the criteria for individuals eligible for outlier services in nursing facilities for individuals with severe maladaptive behaviors due to traumatic brain injury (NF-TBI services). It also sets forth the conditions under which a nursing facility or a discrete unit within a nursing facility may be approved as an eligible provider of NF-TBI services and thereby receive payment for the provision of those services. In addition, this rule establishes the prior authorization process for admission and continued stay of individuals who seek Medicaid coverage for NF-TBI services, and includes details regarding the provider agreement addendum, payment authorization, and materials to be submitted by the provider for setting the initial and subsequent contracted per diem rate.

This rule is being proposed for rescission. The Department has determined it no longer needs to have a NF-TBI program because no Medicaid payments for the provision of NF-TBI services have been made since July 1, 2008, and no nursing facility providers have expressed interest to the Department in furnishing NF-TBI services since that time.

OAC 5160-3-17.3

This rule establishes the criteria for individuals eligible for out-of-state NF-TBI services. It also sets forth the conditions under which a nursing facility or a discrete unit within a nursing facility may be approved as an eligible provider of out-of-state NF-TBI services and thereby receive payment for the provision of those services. In addition, this rule establishes the prior authorization process for admission and continued stay of individuals who seek Medicaid coverage for out-of-state NF-TBI services, and includes details regarding the provider agreement addendum, payment authorization, and materials to be submitted by the provider for setting the initial and subsequent contracted per diem rate.

This rule is being proposed for rescission. The Department has determined it no longer needs to have an out-of-state NF-TBI program because no Medicaid payments for the provision of out-of-state NF-TBI services have been made since August 20, 2000.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Ohio Revised Code section 5165.02

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

   No, these regulations do not implement any federal requirements

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

   Not applicable.

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

   OAC 5160-3-17

   The outlier rate methodology set forth in this rule calculates rates for nursing facilities that choose to serve individuals who have diagnoses or special care needs that require more direct care resources than are measured by the assessment tool used for nursing facility residents in Ohio. In addition, this rule implements portions of division (D) of section 5165.153 of the Revised Code, which specifically authorizes Medicaid to adopt rules to establish a methodology for determining the per diem payment rate for nursing facility outlier services provided by a nursing facility outlier provider.

OAC 5160-3-17.1

Not applicable. This rule is being proposed for rescission

OAC 5160-3-17.3

Not applicable. This rule is being proposed for rescission

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

OAC 5160-3-17

When ORC section 5111.243 in H.B. 153 of the 129th General Assembly eliminated the franchise fee add-on as a component of standard nursing facility rates, the quality payment component of the rate was increased pursuant to ORC section 309.30.70 to comprise a larger portion of the total rate and link more of the Medicaid payment to quality measures. This change in the standard nursing facility rate methodology resulted in a corresponding change in the outlier nursing facility rate methodology.

The Department measures the success of this regulation in terms of moving payment policy towards rewarding nursing facilities for achieving quality incentive measures that are designed to stimulate practices that support quality care for residents in five general areas: nursing home performance, choice, staffing, clinical practice, and environment. Success may also be measured by an increase in the number of facilities that receive the maximum quality incentive payment available.

OAC 5160-3-17.1

Not applicable. This rule is being proposed for rescission.

OAC 5160-3-17.3

Not applicable. This rule is being proposed for rescission.

Development of the Regulation

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

The nursing facility provider associations in Ohio are:

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

The nursing facility provider associations were involved in review of the draft rules during a meeting with the Department of Medicaid on March 19, 2014.

In addition, the Department published a federal notice on the Register of Ohio in May, 2014 that provided stakeholders the opportunity to submit written comments to the Department regarding reimbursement changes resulting from the proposed amendment of OAC 5160-3-17 and the proposed rescission of OAC 5160-3-17.1 and 5160-3-17.3.

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

   No substantive input was provided by stakeholders. Any comments received as a result of the federal notice will be carefully reviewed before the rules are filed with the Joint Committee on Agency Rule Review (JCARR). Any suggestions made by stakeholders will be sent to the CSI Ohio office, along with the Department's responses and a description of any changes made as a result of stakeholder suggestions.

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

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

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

    OAC 5160-3-17

    No alternative regulations were considered. ORC section 5165.153 specifically authorizes Medicaid to adopt rules to establish a methodology for determining the per diem payment rate that will be paid for nursing facility outlier services provided by a designated nursing facility outlier provider.

    OAC 5160-3-17.1

    This rule is being proposed for rescission, and no alternative regulation is considered necessary to replace it.

OAC 5160-3-17.3

This rule is being proposed for rescission, and no alternative regulation is considered necessary to replace it.

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

OAC 5160-3-17

A performance-based regulation was not considered appropriate. A uniform outlier payment methodology is necessary for the Department to reimburse providers in a consistent and equitable manner for the provision of outlier services in nursing facilities.

OAC 5160-3-17.1

Not applicable. This rule is being proposed for rescission.

OAC 5160-3-17.3

Not applicable. This rule is being proposed for rescission.

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

These rules have been reviewed by the Department of Medicaid's staff, including legal and legislative staff, to ensure there is no duplication within ODM rules or any others in the OAC.

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

OAC 5160-3-17

Although no providers currently have rates set according to this rule, the Department will apply the modified outlier rate methodology to set rates when providers choose to furnish outlier services.

OAC 5160-3-17.1

Not applicable. This rule is being proposed for rescission.

OAC 5160-3-17.3

Not applicable. This rule is being proposed for rescission.

Adverse Impact to Business

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

a. Identify the scope of the impacted business community;
These rules impact approximately 950 nursing facilities in Ohio that choose to participate in the Medicaid program.

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

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.

OAC 5160-3-17

b. When the franchise fee add-on was eliminated as a component of the Medicaid nursing facility per diem rate in the SFY 2012-2013 biennium budget, the direct care and quality payment components of the rate, which are calculated according to ORC sections 5165.19 and 5165.25, were increased in order to link more of the Medicaid payment to quality measures. Correspondingly, this rule amendment eliminates the franchise fee add-on as a component of the outlier rate, and the direct care and quality payment components, also calculated according to ORC sections 5165.19 and 5165.25, comprise a larger portion of the total outlier rate. Although there are currently no nursing facility outlier providers who have rates that are set according to this rule, a provider who chooses to furnish outlier services at some future time might receive a lower total outlier rate if they are unable to meet the accountability measures necessary to receive the full quality incentive payment as set forth in ORC section 5165.25. Providers might also experience an adverse impact in terms of time and effort they might need to expend in order to achieve a specific accountability measure, or to achieve a mix of accountability measures necessary to receive the full quality payment.

Additionally, this rule requires a provider who chooses to provide outlier services to submit the following information to the Department of Medicaid:

A. In the initial year that a provider is approved as an outlier provider: projected annual cost report budget; current calendar year capital expenditure plan and detailed asset listing; and current calendar year staffing plan.
B. After the initial three months of operation as an outlier provider: a cost report for the initial three months of outlier service; and current individual service plans for the residents to be served in the period for which a rate is being established.
C. In each calendar year after the year of the initial contracted outlier rate: current individual service plans for the residents to be served in the period for which a rate is being established; actual year end cost report and current calendar year cost report budget; for-profit providers must submit a balance sheet, income statement, and statement of cash flows relating to the previous year's actual cost report; not-for-profit providers must submit a statement of financial position, statement of activities, and statement of cash flows relating to the previous calendar year's actual cost report; current calendar year capital expenditure plan and detailed asset listing; current calendar year staffing plan; and approved board minutes from the legal entity holding the provider agreement and all other related legal entities.

d. The Department estimates the cost to a nursing facility to submit the documentation required above to the Department of Medicaid to be between $52.50 and $72.50. Note that none of the documents need to be created specifically to satisfy the requirements. The nursing facility would already have all of the required documents in their files, and would only need to retrieve, scan, and email them to the Department of Medicaid.

OAC 5160-3-17.1

b. and c. Although there are currently no providers of NF-TBI services, any nursing facility provider wishing to begin provision of NF-TBI services and receive Medicaid payment for the provision of such services would not be able to do so after this rule is rescinded since the NF-TBI eligibility requirements for both providers and recipients, as well as the requirements for payment for NF-TBI services, are not specified anywhere other than in this rule. However, general authority continues to exist in ORC section 5165.153 as a mechanism for meeting future outlier needs.

OAC 5160-3-17.3

b. and c. Although there are currently no providers of out-of-state NF-TBI services, any nursing facility provider wishing to begin provision of out-of-state NF-TBI services and receive Ohio Medicaid payment for the provision of such services would

not be able to do so after this rule is rescinded since the out-of-state NF-TBI eligibility requirements for both providers and recipients, as well as the requirements for payment for out-of-state NF-TBI services, are not specified anywhere other than in this rule. However, general authority continues to exist in OAC rule 5160-1-11 as a mechanism for meeting future out-of-state coverage needs, and in ORC section 5165.153 as a mechanism for meeting future outlier needs.

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

OAC 5160-3-17

The Department believes the adverse impact that might result from applying the modified outlier rate methodology would be justified because the modified methodology rewards providers for achieving quality measures that support high quality care for Ohio nursing home residents in the five general areas of performance, choice, staffing, clinical practice, and environment.

OAC 5160-3-17.1

Not applicable. This rule is being proposed for rescission

OAC 5160-3-17.3

Not applicable. This rule is being proposed for rescission

Regulatory Flexibility

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

OAC 5160-3-17

No. The outlier payment methodology and other provisions in this rule are the same for all providers.

OAC 5160-3-17.1

Not applicable. This rule is being proposed for rescission.

OAC 5160-3-17.3

Not applicable. This rule is being proposed for rescission

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

    ORC section 119.14 is not applicable to these regulations as they do not impose any fines or penalties.

18. **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 Care Services and Supports at (614) 466-6742.