CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Department of Medicaid

Regulation/Package Title: Five-Year Review – IMD Rule

Rule Number(s): 5160-3-06.1 (amend)

Date: May 27, 2014

Rule Type:

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- Rescinded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

   This rule sets forth the process by which the Ohio Department of Medicaid identifies nursing facilities that are at risk of becoming institutions for mental diseases (IMDs), the preventative measures to be taken by the Department when at risk facilities are identified, and the course of action to be taken by the Department if a nursing facility is determined to be an IMD.

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This rule is being proposed for amendment. In paragraph (A), the age for individuals for whom federal financial participation (FFP) is available for inpatient psychiatric hospital services is being changed from "under age 22" to "under age 21 and in certain circumstances under age 22" in order to better align the rule with provisions in Section 1905(a)(16) of the Social Security Act. This rule is also being amended in order to update the reference to the International Classification of Diseases (ICD) publication as part of the Department of Medicaid's implementation of ICD-10 medical coding, which was mandated by federal regulations issued in 2009 by the U.S. Department of Health and Human Services for all entities covered by the Health Insurance Portability and Accountability Act (HIPAA). 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, the name of the Ohio Department of Mental Health and Addiction Services is being updated from the Ohio Department of Mental Health, and the name of the Joint Commission is being updated from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

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.

   These regulations implement provisions in Section 1905(a) of the Social Security Act which stipulate that federal financial participation (FFP) is not available for any medical assistance for individuals who are in an institution for mental disease (IMD) unless the payments are for inpatient hospital services or nursing facility services for individuals 65 years of age or older in an IMD, or for inpatient psychiatric hospital services for individuals under age 21 and in certain circumstances under age 22.

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

   Although federal financial participation (FFP) is not available for individuals under age 65 who reside in a nursing facility if that facility is found to be an IMD, this rule exceeds federal regulations by requiring termination of Medicaid payments for those individuals in those circumstances. Ohio's requirement for termination of Medicaid payment implements ORC section 5162.06 (A)(2), which provides that no component of the Medicaid program shall be implemented without FFP.

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)?**

   The public purpose of this regulation is to ensure that the State of Ohio receives federal matching Medicaid funds for all Medicaid-eligible nursing facility residents under the age of 65.

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

   The success of this regulation may be measured in terms of retention of federal matching Medicaid funds.

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 rule when the Department of Medicaid emailed the draft rule and a summary of rule changes to the associations on May 13, 2014.

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

   No comments were received from the nursing facility provider associations.

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?**

    No alternative regulations were considered. This rule amplifies provisions in Section 1905(a) of the Social Security Act.

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.***

    A performance-based regulation was not considered appropriate and is not authorized by statute.

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.**

    Letters will be sent to providers and all County Departments of Job and Family Services explaining the changes that have been made to this rule, and the rationale for those changes. Additionally, the final rule as adopted by the Department of Medicaid will be made available to stakeholders and the general public on the Department's website.

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.

    b. If a nursing facility is determined to be an IMD, Medicaid payment is terminated for all Medicaid-eligible individuals residing in that facility who are under age 65. If

a facility chooses to appeal a determination that it is an IMD, it must do so within ten working days from the date the notice of the determination was mailed. If a facility does not choose to exercise its appeal rights within that ten day period, it must wait at least six months after the date of the initial determination if it chooses to request a redetermination survey. In addition, nursing facility providers who undergo IMD reviews might experience an adverse impact in terms of time and effort expended in order to facilitate the IMD review or, if an adverse determination has been made, to exercise their appeal rights or to request and undergo a redetermination survey.

c. Historically, Ohio has not determined any NF to be an IMD, and the Department of Medicaid does not anticipate that changing as a result of the proposed rule changes. The adverse impact in terms of dollars would be difficult to estimate because each nursing facility, including any determined to be an IMD, has a unique per diem payment rate. In addition, the Department cannot predict the following factors:

- Whether a facility deemed to be an IMD might choose to exercise its appeal rights, and the outcome of any such appeal.
- Whether a facility deemed to be an IMD might choose to request a redetermination survey, and the outcome of any such survey.
- The length of time for which Medicaid payments are terminated in cases where termination of payment is implemented.
- The costs in terms of time and effort expended by providers to facilitate IMD reviews, appeal a decision, or request a redetermination, because business practices vary from provider to provider.

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

The Department believes the termination of Medicaid payments for all individuals residing in a nursing facility who are under age 65 if that facility is determined to be an IMD is justified in order for Ohio to comply with provisions in both Section 1905(a) of the Social Security Act and in section 5162.06 of the Revised Code regarding federal financial participation.

Regulatory Flexibility

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

No. The provisions in this rule are the same for all nursing facility providers.

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 these regulations do not impose any fines or penalties for paperwork violations as defined in ORC section 119.14.

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.