CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Department of Medicaid

Regulation/Package Title: Nursing Facility Rule Amendments Pursuant to 5-Year Review

Rule Number(s): 5160-3-03.2 (rescind/new), 5160-3-16.5 (amend), 5160-3-24 (amend), 5160-3-39.1 (rescind/new),

Date: October 24, 2014

Rule Type:

- X 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- X Rescinded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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5160-3-03.2

This rule sets forth the provisions for the resident protection fund, including the methods and procedures for collection of fines that are subsequently deposited into the resident protection fund, and the purposes for which the money in the fund may be used. The changes being made to this rule include the following:

- 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.
- The definition of fines is being revised to include assessments other than civil monetary penalties (CMPs).
- The definition of and references to the resident protection fund coordinator are being removed because the position does not exist. The phrase has been replaced with "ODM."
- The provisions regarding the methods and procedures for collection of fines are being combined and revised to reflect that CMS is responsible for imposing and collecting the CMP fines and, if CMS is unable to do so, CMS will notify ODM, who will attempt to collect. It further clarifies that ODH is responsible for issuing fines to Medicaid-only providers for noncompliance with certification requirements, and for notifying ODM, who will attempt to collect.
- In paragraph (C), language is being revised pursuant to changes in federal requirements regarding the purposes for which the resident protection fund may be used, and language is being added regarding the requirement for CMS approval for the use of CMP funds deposited in the resident protection fund.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).
- Paragraph references are being updated as necessary.

5160-3-16.5

This rule sets forth the provisions for the management and use of nursing facility personal needs allowance (PNA) accounts and other resident funds. The changes being made to this rule include the following:

- 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.
- In the opening paragraph, the revision date of the reference to the Code of Federal Regulations is being updated.

- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly 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 (ODJFS) or the ODJFS office of Ohio Health Plans (OHP) to the Ohio Department of Medicaid (ODM).
- An Ohio Revised Code citation is being updated because Am. Sub. HB 59 of the 130th General Assembly created the Ohio Department of Medicaid, and subsequently relocated and reorganized many Revised Code provisions governing the Medicaid program.
- Form references are being updated and grammatical errors are being corrected.

5160-3-24

This rule sets forth the provisions for nursing facilities' requests for rate reconsiderations in cases of possible calculation errors. The changes being made to this rule include the following:

- 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.
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).
- Language regarding the timeframe for filing a rate reconsideration request is being changed from "no more than thirty days after the later of the initial payment of the rate or the receipt of the rate-setting calculation" to "no more than thirty days after the later of the initial payment of the rate for which reconsideration is being requested or the date on the rate setting package notification."
- The address where a rate reconsideration request must be sent is being updated.

5160-3-39.1

This rule sets forth the provisions for claim submission for nursing facilities. This rule is being proposed for adoption to replace rule 5160-3-39.1, which is being proposed for rescission. The differences between this rule and the rule it is replacing are:

- 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.

- The rule is being restructured to better delineate the requirements for submitting claims for services included and not included in the NF per diem rate, and to enhance readability and comprehension.
- Language is being added that requires nursing facility claims for services not included in the nursing facility per diem rate to be submitted in accordance with rule 5160-1-19 of the Administrative Code.
- Language is being clarified regarding use of electronic data interchange (EDI) and the Health Care Claim Institutional (837I) electronic format.
- Language is being added and modified to require electronic claim submission in EDI or the Medicaid Information Technology Systems (MITS) web portal and to require the use of the UB04 national uniform billing data specifications.
- Language is being added requiring use of the coding standards set forth in the healthcare common procedure coding system, the current procedure terminology codebook, and the international classification of diseases codebook.
- Language is being added that requires trading partners who submit EDI claim transactions to follow the requirements set forth in paragraph (H) of rule 5160-1-19 of the Administrative Code.
- Language is being updated to reference the ODM 837I Companion Guide for compliance requirements for claim submissions.
- Language is being updated to clarify that a single claim shall include days of service provided, including qualifying leave days, for a single individual within a single calendar month and shall not cross calendar months.
- Language is being modified to clarify provisions regarding lump sum payments when the County Department of Job and Family Services (CDJFS) and a Medicaid recipient in a NF determine that a lump sum shall be assigned to the NF as payment for past per diem services received by the recipient.
- Language is being modified to clarify that the date of receipt of an original claim submission shall be determined by the date the claim is received in the web portal or the date the claim is received via electronic data interchange (EDI).
- Language is being modified to clarify that when a provider identifies an underpaid claim, the provider shall submit an adjustment within 180 days of the date the underpaid claim was paid, and when a provider identifies an overpaid claim, an adjustment shall be submitted within 60 days of discovery of the overpayment. The language further clarifies that checks in lieu of claim adjustments shall not be accepted.

- Language is being modified to clarify that, if ODM identifies the need for a provider to adjust a claim, ODM shall notify the provider to make the adjustment within 60 days of notification. If the provider fails to make the adjustment, ODM shall either make the adjustment or void the claim. If an adjustment cannot be made due to lack of outgoing payments, ODM shall issue an invoice and the provider shall remit payment or seek reconsideration within 60 days. Any remaining balance shall be certified to the Ohio Attorney General for collection.
- Language is being added to clarify that claims with prior payment by Medicare or another insurance plan shall be submitted within 180 days from the date Medicare or the insurance plan paid the claim to the nursing facility.
- Language regarding delayed claim submissions has been moved to new paragraph (B)(10), "Exceptions to timely filing requirements."
- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).
- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- Language applicable to dates of service prior to July 1, 2005 and between July 1, 2005 and November 30, 2005 has been removed.
- Interest provisions have been removed.

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

   Ohio Revised Code sections 5162.02 and 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.

   5160-3-03.2

   Paragraph (C) of this rule implements federal regulations specified in 42 CFR 488.433 and 488.442. These federal regulations require civil monetary penalties (CMPs) collected by the State to be used for activities that protect or improve the quality of care or quality of life for residents of facilities in which deficiencies are found. These uses include:

   (1) Support and protection of residents of a facility that closes voluntarily or involuntarily.

(2) Time-limited expenses incurred in the process of relocating residents to home and community-based settings or another facility when a facility is closed voluntarily or involuntarily or downsized.
(3) Projects that support resident and family councils and other consumer involvement in assuring quality care in facilities.
(4) Facility improvement initiatives.
(5) Development and maintenance of temporary management or receivership capability.
(6) Reimbursement of residents for the loss of personal funds managed by the facility as a result of actions by the facility, or the loss of personal property as a result of actions by individuals used by the facility to provide services to residents.

5160-3-16.5

This rule implements federal regulations specified in 42 CFR 483.10(c)(1) through (c)(8). These federal regulations contain provisions regarding resident funds, including:

- Protection of resident funds
- Management of personal funds
- Deposit of funds
- Accounting and records
- Notice of certain balances
- Conveyance upon death
- Assurance of financial security
- Limitations on charges to personal funds

5160-3-39.1

This rule requires providers to submit claims in compliance with national standards for electronic health care transactions and code sets that were adopted under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 for protecting the confidentiality, integrity, and availability of electronic protected health information. Compliance with national standards that were adopted under HIPAA was required by April 20, 2005 for most affected health care entities.

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

5160-3-16.5

The Department believes the provisions in this rule that exceed federal requirements are necessary to ensure that residents have access to their personal funds on deposit with the provider, and that those funds are properly managed. Provisions in this rule that exceed federal requirements include the following:

- A provider must explain to the resident or the resident's representative that PNA funds are for the resident to use as he or she chooses.
- Upon request, a provider must furnish receipts to a resident or the resident's representative for purchases made with the resident's PNA funds.
- Within 30 days after the end of each quarter, a provider must provide a written quarterly statement to each resident or resident's representative of the financial transactions made by the provider on the resident's behalf. (The federal regulations contain this provision, but specify no timeframe.)
- Requires the local County Department of Job and Family Services (CDJFS) to monitor PNA accounts.

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)?**

5160-3-03.2

The public purpose of this rule is to implement state and federal regulations regarding the collection and use of civil monetary penalty (CMP) fines. In addition to the federal regulations specified in 42 CFR 488.442 and 488.433, this rule implements ORC section 5162.66.

5160-3-16.5

The public purpose of this rule is to implement federal resident rights regulations regarding resident funds. It is also to ensure that nursing facility residents have access to their personal funds and that those funds are properly managed.

5160-3-24

The public purpose of this rule is to implement ORC section 5165.38, which authorizes the adoption of rules to establish a process under which nursing facility providers may seek reconsideration of Medicaid payment rates calculated under ORC Chapter 5165.

5160-3-39.1

The public purpose of this rule is to implement the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requirements for protecting the confidentiality, integrity, and availability of electronic personal health information.

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

5160-3-03.2

The success of this rule will be measured by the extent to which 1) fines are correctly collected and deposited into the resident protection fund, and 2) CMP funds are used for the purposes for which they are intended.

5160-3-16.5

The success of this rule will be measured by the extent to which 1) residents have access to their personal funds, and 2) residents' personal funds are well managed by providers.

5160-3-24

The success of this rule will be measured by the extent to which 1) all rate reconsideration requests contain the required information, 2) both ODM and the provider comply with the rate reconsideration process within the specified timeframes, and 3) any rate adjustments that may be warranted are implemented according to this rule.

5160-3-39.1

The success of this rule will be measured by the extent to which nursing facility claims are submitted timely and according to the standards specified in this rule.

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 when the Department of Medicaid emailed the draft rules and summaries of the rule changes to the associations on September 2, 2014.

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

The Ohio Health Care Association provided input regarding the uses for federally imposed CMP funds specified in rule 5160-3-03.2, the use of licensed beds rather than certified beds in rule 5160-3-41 for the purposes of assigning nursing facilities to peer groups, and the insertion of language in rule 5160-3-42.3 that requires the use of salvage value to adjust capital asset values when calculating depreciation.

As a result of stakeholder input, language in draft rule 5160-3-03.2 was modified to reflect changes in federal regulations that were enacted by the Affordable Care Act.

No other changes were made to the proposed rules as a result of stakeholder input.

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. The Department considers Administrative Code rules the most appropriate type of regulation for the provisions contained in these rules.

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.***

    Performance-based regulations were not considered appropriate and are 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 to providers and all County Departments of Job and Family Services explaining the changes that have been made to these rules, and the rationale for those changes, will be posted to ODM's website. Additionally, the final rules as adopted by the Department of Medicaid will be made available to all 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;
Provider participation in the Medicaid program is optional and at the provider's discretion. 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
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.

5160-3-03.2

b.) Nursing facility providers must notify the Department of Medicaid in writing which payment option they select for the payment of fines imposed by the Centers for Medicare and Medicaid Services (CMS) and the Ohio Department of Health (ODH). If a nursing facility provider fails to adhere to the terms of the payment agreement, or fails to select a payment option within ten days of notification, the Department of Medicaid shall immediately begin collection through Medicaid payment offset if the nursing facility is a Medicaid-participating facility.

c.) The Department estimates it will take a nursing facility provider, per instance, approximately one hour of staff time at the rate of approximately $12.50 per hour (total estimated cost: $12.50) to select a payment option with which to pay fines imposed by ODH or CMS, and to advise the Department of Medicaid in writing. If a provider fails to adhere to the terms of a payment agreement or fails to select a payment option within ten days, the Department must implement collection by Medicaid payment offset if the nursing facility is a Medicaid-participating facility. The Department is not able to estimate the amount of such payments because the number of fines imposed, and the

amounts of the fines, will necessarily vary. However, these costs are existing costs of compliance. There are no new costs of compliance as a result of this rule filing.

5160-3-16.5

b.) Upon authorization by a resident, a nursing facility provider must hold, safeguard, manage, and account for personal funds deposited with the provider. Management of a resident's personal needs allowance (PNA) account includes: maintenance of ledger accounts showing deposit and credit of funds, as well as credit of any interest earned; provision to the resident of access to petty cash; provision of receipts for all transactions; provision of quarterly statements; notification to a resident when the amount in the resident's PNA account reaches $200 less than the resource limit; notification to the County Department of Job and Family Services when a resident's PNA account balance exceeds the resource limit; and release of funds upon discharge, or conveyance of funds upon death.

In addition, if a nursing facility provider cancels the required surety bond that protects all resident funds managed by the provider, the provider must notify the Department of Medicaid by certified mail 30 days prior to the effective date of the cancellation.

c.) The Department estimates a nursing facility provider will spend approximately 15 - 20 minutes per month at an estimated rate of $12.50 per hour (total estimated cost per month: $3.13 - $4.13) to manage a resident's PNA account.

The Department estimates it will cost a nursing facility provider a total of approximately $9.61 to notify the Department of Medicaid by certified mail prior to the cancellation of the surety bond. The total approximate cost is based on an estimated 15 minutes of staff time at an estimated rate of $12.50 per hour, plus $6.48, which is the cost to post and send a letter by certified mail via the U.S. Postal Service. However, these costs are existing costs of compliance. There are no new costs of compliance as a result of this rule filing.

5160-3-24

b.) A nursing facility provider's request for a rate reconsideration must be submitted in writing to the Department of Medicaid, and must include a detailed explanation of the possible error, the proposed corrected calculation, and references to any relevant section of the Revised Code or paragraphs of the Administrative Code.

Additionally, the change in language regarding timeframes for the submission of a rate reconsideration request from "no more than thirty days after the later of the initial payment of the rate **or the receipt of the rate-setting calculation**" to "no more than

thirty days after the later of the initial payment of the rate for which reconsideration is being requested **or the date on the rate setting package notification**" may shorten the period of time during which providers must submit a reconsideration request.

c.) The Department estimates it will take a nursing facility provider approximately 2 - 4 hours of staff time at an estimated rate of $12.50 per hour (total estimated cost: $25.00 - $50.00) to prepare a written request for a rate reconsideration and send it to the Department of Medicaid.

The adverse impact regarding timeframes for the submission of a rate reconsideration request cannot be quantified in terms of dollars or hours. Any adverse impact that providers may experience would be measured by the extent to which it becomes more difficult to submit a request within the required timeframes.

However, these costs are existing costs of compliance. There are no new costs of compliance as a result of this rule filing.

5160-3-39.1

b.) This rule requires nursing facility providers to report information to the Department of Medicaid as part of the claims submission process. It also requires providers to submit claims, and the data elements within those claims, using nationally standardized formats and code sets that have been established for institutional claims.

This rule also imposes timely filing requirements on providers.

c.) The Department estimates it will take a nursing facility provider approximately 5 minutes of staff time at the rate of approximately $12.50 per hour (total estimated cost: $1.04) to submit a claim.

The adverse impact regarding timely filing requirements cannot be quantified in terms of dollars or hours to comply. However, claims not received by ODM within the required timeframes as specified in this rule will be denied. For example, claims received beyond 365 days from the actual date the service was provided will be denied, and re-submitted claims received beyond 730 days from the actual date of service will be denied.

However, these costs are existing costs of compliance. There are no new costs of compliance as a result of this rule filing.

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

5160-3-03.2

The adverse impact to providers associated with this rule is justified because this rule implements ORC section 5162.66. In addition, provisions in this rule ensure that the Department of Medicaid is able to collect fines that have been imposed on facilities in an effective manner through Medicaid payment offset.

5160-3-16.5

The adverse impact to providers associated with this rule is justified because this rule implements federal regulations specified in 42 CFR 483.10(c)(1) through (c)(8).

5160-3-24

The adverse impact to providers associated with the provision requiring the inclusion of detailed information when requesting a rate reconsideration is justified because detailed information helps facilitate prompt and efficient resolution of providers' rate requests with the Department of Medicaid.

The adverse impact associated with the change in timeframes for the submission of a rate reconsideration request is justified because both ODM and providers will now have a clear submission deadline.

5140-3-39.1

The adverse impact to providers associated with this rule is justified because the report of information is inherent in the process of submitting claims for reimbursement. Additionally, the adoption of national standards for electronic health care transactions and code sets was mandated in 1996 by the Health Insurance Portability and Accountability Act (HIPAA).

Regulatory Flexibility

16. **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 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.