CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Department of Medicaid

Regulation/Package Title: Nursing Facility IMD and Leave Day Rules

Rule Number(s): 5160-3-06.1 (Amend), 5160-3-16.4 (Amend)

Date: April 4, 2017

Rule Type:

New ☑ 5-Year Review

☑ Amended Rescinded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.

5160-3-06.1

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

- In order to comply with federal regulations contained in 42 C.F.R. 438.6(e), language is being modified in paragraph (A) to allow Medicaid payment as permitted in 42 C.F.R. 438.6(e) for individuals in an IMD who are age 21 and over, and in certain circumstances age 22 and over, and under age 65.
- Also to comply with federal regulations contained in 42 C.F.R. 438.6(e), language in paragraph (D)(3)(a) is being modified to allow Medicaid payment as permitted in 42 C.F.R. 438.6(e) for individuals residing in a nursing facility that has been determined to be an IMD.
- In paragraphs (D) and (E), language is being updated so that a nursing facility determined to be an IMD has 30 days rather than 10 working days from the date the determination notice was mailed to exercise its reconsideration rights pursuant to OAC 5160-70-02. Also in paragraphs (D) and (E), the word "appeal" is being updated to "reconsideration" to be consistent with terminology used in OAC 5160-70-02.
- In paragraphs (B)(4)(c) and (E)(2), typographical errors are being corrected.

5160-3-16.4

This rule sets forth the provisions for Medicaid bed-hold days for nursing facilities. The changes to the rule are:

- The rule title is being modified to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- In paragraph (A)(1), reference to OAC rule 5101:3-1-06 (now 5160-1-06) is being deleted because that rule was rescinded effective May 1, 2015. Also in paragraph (A)(1), "intermediate care facility for the mentally retarded (ICF-MR)" is being changed to "intermediate care facility for individuals with intellectual disabilities (ICF-IID)" because the terminology has been updated.
- In paragraph (A)(2) the definition of hospitalization is being modified in order to account for situations in which residents are in the hospital on observation status rather than being formally admitted.
- In paragraphs (A)(5) and (A)(8), the definitions of NF Admission and NF Occupied Day are being modified in conjunction with language changes in paragraphs (C)(1) and (C)(4) so that a nursing facility may be paid for the day a resident returns from leave days even if the resident is in the NF for fewer than 8 hours on the day of return.
- In paragraphs (A)(8) and (I)(2), out-of-date references to the Administrative Code are being replaced with references to the Revised Code.
- In paragraph (J)(2)(b)(ii), for purposes of clarification, language is being modified so that a level of care evaluation is not necessary when a Medicaid eligible resident who receives Medicare Part A benefits in a nursing facility is transferred to the hospital and the nursing facility bills the hospital bed-hold days to Medicaid.

- In paragraph (J)(4), language is being added to clarify that Medicaid eligible residents includes low resource utilization residents for whom Medicaid payment is made in accordance with ORC section 5165.152.
- Paragraph (J)(5) is being deleted because there is nothing unique about leave day benefits for QMB eligible individuals who reside in nursing facilities.
- In order to comply with federal regulations contained in 42 C.F.R. 438.6(e), language in paragraph (K)(2) is being modified so that payment may be made for bed-hold days during the period NF residents age 21 and over, and in some circumstances age 22 and over, and under age 65, are hospitalized in an IMD, as permitted in 42 C.F.R. 438.6(e).
- Also in paragraph (K)(2), language regarding Medicaid eligibility is being deleted because it is not needed in this rule.
- In paragraph (K)(3), the citations for the Administrative Code Chapters that contain eligibility criteria for the HCBS waiver program are being deleted because they are not necessary for this rule.
- Paragraph (K)(4) is being deleted because it contains provisions excluding residents enrolled in a managed care program.
- The order of paragraphs (L)(1)(a) and (L)(1)(b) are being reversed to enhance readability.
- 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.
- Ohio Revised Code citations are 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.
- The Department's name is being updated from the Office of Medical Assistance (OMA) to the Ohio Department of Medicaid (ODM) because of the creation of the Ohio Department of Medicaid.
- Paragraph designations are being updated as necessary.
- Phrasing and grammatical changes are being made to improve clarity, comprehension, and readability.

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.

5160-3-06.1

This proposed rule implements federal requirements in 42 C.F.R. 438.6(e), which is entitled "Payments to MCOs and PIHPs for enrollees that are a patient in an institution for mental disease."

5160-3-16.4

This proposed rule implements section 1919(c)(2)(D) of the Social Security Act entitled "Notice on bed-hold policy and readmission."

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

5160-3-06.1

Except as permitted in 42 C.F.R. 438.6(e), federal financial participation (FFP) is not available for individuals who reside in a nursing facility who are under age 65, and age 21 and over, and in certain circumstances age 22 and over, if that facility is found to be an IMD. This rule exceeds federal regulations by requiring termination of Medicaid payments for these individuals in these circumstances pursuant to ORC section 5162.06 (A)(2), which provides that no component of the Medicaid program may be implemented without FFP.

5160-3-16.4

This proposed rule contains numerous provisions not specified in the federal regulations. These provisions provide information necessary for the administration of the Medicaid program with regard to bed-hold days, including reasons for which bed-hold days may be paid, bed-hold day limits, payment, claims submission, admission after depletion of bed-hold days, information and notice prior to leave, emergency hospitalization, residents eligible for payment of bed-hold days, exclusions, and compliance.

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)?**

5160-3-06.1

The public purpose of this regulation is to ensure that Ohio receives all available federal matching Medicaid funds, and that proper payment is made to IMDs according to the specifications of this rule.

5160-3-16.4

The public purpose of this rule is to ensure that, within limits, nursing facility residents who are temporarily absent from the facility, and who have intent to return to the facility, are able

to do so. Allowing residents to return to the same facility after a temporary absence reduces transfer trauma and helps to improve residents' orientation, health, and sense of well-being.

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

5160-3-06.1

The success of this rule will be measured by the extent to which federal matching Medicaid funds are retained, and to which proper payment is made to IMDs according to the specifications of this rule.

5160-3-16.4

The success of this rule will be measured by the extent to which nursing facilities implement the provisions in this rule according to the specifications in it. Success may also be measured by the extent to which this rule promotes the health and well-being of nursing facility residents who use Medicaid bed-hold days.

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 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 draft rule 5160-3-16.4 when the Department of Medicaid emailed the draft rule and a summary of the rule changes to the associations on September 28, 2016. On March 14, 2017, the Department emailed a second draft of rule 5160-3-16.4, along with draft rule 5160-3-06.1 and summaries of the changes, to the provider associations.

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

   5160-3-16.4

   OHCA commented that the definition of hospitalization should be changed to account for situations in which residents are in the hospital on observation status rather than being formally admitted. The Department of Medicaid agreed with this comment and modified the proposed rule accordingly.

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.

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 the Department of Medicaid's 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.**

    The final rules as adopted by the Department of Medicaid will be made available to all stakeholders and to the general public on the Department of Medicaid'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 960 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.

5160-3-06.1

b.) According to paragraph (D)(3)(a) of this rule, 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, and age 21 and over, and in certain circumstances age 22 and over, except as permitted in 42 C.F.R. 438.6(e).

According to paragraph (D)(3)(a) of this rule, if a facility chooses to request a reconsideration of a determination that it is an IMD, it must do so within 30 days from the date the determination notice was mailed.

According to paragraph (E) of this rule, if a facility does not choose to request a reconsideration within that 30 day period, it must wait at least six months after the date of the initial determination if it chooses to request a redetermination survey.

c.) The Department of Medicaid cannot quantify the adverse impact when a nursing facility is determined to be an IMD because the Department does not know the per diem rate of any particular nursing facility that may be determined to be an IMD. Additionally, the Department of Medicaid cannot estimate how many individuals in any particular

facility that has been determined to be an IMD will fall into the age group specified above and will have their Medicaid payments terminated.

The Department of Medicaid cannot estimate the adverse impact when a facility chooses to request a reconsideration of a determination that it is an IMD because the Department does not know which particular facilities that have been determined to be IMDs might choose to request a reconsideration, what their unique per diem rates might be, or how long their payments might be terminated.

The Department of Medicaid cannot estimate the adverse impact when a facility chooses to request a redetermination survey because the Department does not know which particular facilities that have been determined to be IMDs might choose to request a redetermination survey, what their unique per diem rates might be, or how long their payments might be terminated.

The Department of Medicaid cannot estimate the cost of compliance for any particular nursing facility regarding time and effort expended by providers to facilitate IMD reviews, or to request a reconsideration of a determination or a redetermination survey because business practices vary from provider to provider.

5160-3-16.4

b.) In accordance with paragraph (D)(4)(b)(i) and (D)(4)(c)(i) of this rule, any plan to use therapeutic leave days or to use leave days to visit with friends or family must be approved in advance by the resident's primary physician and documented in the resident's medical record. The documentation shall be available for viewing by the County Department of Job and Family Services (CDJFS) and the Department of Medicaid.

In accordance with paragraph (D)(4)(b)(ii) and (D)(4)(c)(iii) of this rule, when a resident uses approved therapeutic leave days or approved leave days to visit with friends or family, the nursing facility provider must make arrangements for the resident to receive required care and services while using the leave days.

In accordance with paragraph (E) of this rule, a nursing facility provider must electronically submit claims for nursing facility bed-hold days in accordance with OAC rule 5160-3-39.1.

In accordance with paragraph (F)(2) of this rule, a nursing facility provider must establish and follow a written policy under which a Medicaid resident who has expended their annual allotment of thirty bed-hold days, and therefore is no longer entitled to a reserved

bed under the Medicaid bed-hold limit, and is considered to be discharged, shall be admitted to the first available Medicaid certified bed in a semiprivate room.

In accordance with paragraph (F)(3)(b) of this rule, a Medicaid resident whose absence from the facility exceeds the bed-hold limit or for whom no bed-hold coverage is available may choose to ensure the timely availability of a specific bed upon return to the facility by making bed-hold payments for any days of absence in excess of the Medicaid limit or for which no bed-hold coverage is available.

In accordance with paragraph (G)(1) of this rule, prior to a resident's use of bed-hold days, a nursing facility provider must furnish the resident and their family member or legal representative written information about the facility's bed-hold policies.

In accordance with paragraph (G)(2) of this rule, at the time a resident is scheduled to use bed-hold days, a nursing facility provider must furnish the resident and their family member or legal representative a written notice that specifies all of the following:

- The maximum duration of Medicaid covered bed-hold days as described in this rule.
- The duration of bed-hold status during which the resident is permitted to return to the nursing facility.
- Whether Medicaid payment will be made to hold a bed and if so, for how many days.
- The resident's option to make payments to hold a bed beyond the Medicaid bed-hold day limit, and the amount of such payments.

In accordance with paragraph (H) of this rule, in the case of emergency hospitalization, a nursing facility provider must furnish the resident and a family member or legal representative a written notice with the specifications listed above within 24 hours of the hospitalization. This requirement is met if the resident's copy of the notice is sent to the hospital with other documents that accompany the resident.

In accordance with paragraph (L)(1)(a) of this rule, if a nursing facility is not in compliance with the provisions of this rule, the Department of Medicaid may require the provider to submit and implement a corrective action plan approved by the Department on a schedule specified by the Department.

In accordance with paragraph (L)(2) of this rule, a nursing facility provider must provide copies of any records requested by the Department of Medicaid in cases of an investigation by the Department for compliance purposes.

c.) The Department of Medicaid estimates it will take a resident's primary physician approximately 15 minutes at the rate of approximately $110.00 per hour (total estimated cost: $27.50) to approve one use of leave days in advance for one resident and to document the approval in the resident's medical record. The Department of Medicaid estimates there will be no cost to have the documentation available for viewing by the CDJFS and by the Department of Medicaid because the documentation will already be available in the resident's medical record.

The Department of Medicaid estimates it will take a nursing facility provider's nurse approximately 1.5 hours at the rate of approximately $20.00 per hour (total estimated cost: $30.00) and a business office staff person approximately 30 minutes at the rate of approximately $12.50 per hour (total estimated cost: $6.25) to make these arrangements. The Department of Medicaid therefore estimates it will cost a nursing facility provider a total of approximately $36.25 to make arrangements for one resident to receive required care and services while using approved therapeutic leave days or approved leave days to visit with friends or family.

The Department of Medicaid estimates it will take a nursing facility staff member approximately 5 minutes at the rate of approximately $12.50 per hour (total estimated cost: $1.04) to electronically submit one claim for bed-hold days.

The Department of Medicaid estimates it will take a nursing facility administrator approximately 2 hours at the rate of approximately $60.00 per hour (total estimated cost: $120.00) to establish the above policy. In addition, the Department of Medicaid estimates it will take a nursing facility provider's admissions coordinator approximately 5 hours at the rate of approximately $20.00 per hour (total estimated cost: $100.00), and a nurse approximately 3 hours at the rate of approximately $20.00 per hour (total estimated cost: $60.00) to arrange for the admission of one individual. The Department of Medicaid therefore estimates it will cost a total of approximately $160.00 for a nursing facility provider to admit one individual.

The Department of Medicaid cannot estimate the cost of compliance to a resident whose absence from the facility exceeds the bed-hold limit or for whom no bed-hold coverage is available may choose to ensure the timely availability of a specific bed upon return to the facility by making bed-hold payments for any days of absence in excess of the Medicaid limit or for which no bed-hold coverage is available because the Department does not

know the number of bed-hold days to be taken or the per diem rate of any specific facility on the specific days the bed-hold days are to be taken.

The Department of Medicaid estimates it will take a nursing facility staff member approximately 30 minutes at the rate of approximately $12.50 per hour (total estimated cost: $6.25) to provide written information about the facility's bed-hold policies prior to a resident's use of bed-hold days.

The Department of Medicaid estimates it will take a nursing facility staff member approximately 30 minutes at the rate of approximately $12.50 per hour (total estimated cost: $6.25) to provide a written notice to the resident and their family member or legal representative that specifies all of the following:

- The maximum duration of Medicaid covered bed-hold days as described in this rule.
- The duration of bed-hold status during which the resident is permitted to return to the nursing facility.
- Whether Medicaid payment will be made to hold a bed and if so, for how many days.
- The resident's option to make payments to hold a bed beyond the Medicaid bed-hold day limit, and the amount of such payments.

The Department of Medicaid estimates it will take a nursing facility staff member approximately 5 minutes at the rate of approximately $12.50 per hour (total estimated cost: $1.04) to provide the resident and a family member or legal representative with a copy of the notice.

The Department of Medicaid cannot estimate the cost of compliance if the Department requires the provider to submit and implement a corrective action plan because the Department does not know what the extent of non-compliance might be for any particular facility, or the complexity of any particular corrective action plan.

The Department of Medicaid cannot estimate the cost of compliance in cases of an investigation by the Department for compliance purposes because the Department does not know what the extent of any particular investigation might be, or the extent of the records that any particular facility might be required to provide.

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

5160-3-06.1

The adverse impact to nursing facilities associated with this rule is justified because of the provisions in section 5162.06 of the Revised Code which do not allow implementation of components of the Medicaid program without federal financial participation (FFP).

5160-3-16.4

The adverse impact to nursing facilities associated with this rule is justified because this rule helps the Department of Medicaid ensure nursing facilities administer the bed-hold day policy on a consistent basis, and helps to ensure the efficient and effective administration of the Medicaid program.

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 regardless of size.

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 Services and Supports at (614) 466-6742.