CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: HB49 – Nursing Facility Budget Rule Package

Rule Number(s): 5160-3-01 (Amend), 5160-3-17 (Rescind), 5160-3-57 (New),

For Informational Purposes Only: 5160-3-41 (Amend), 5160-3-57 (Rescind),

5160-3-58 (Amend), 5160-3-65 (Amend)

Date: Submitted to CSIO April 20, 2018

Rule Type:

- ☑ New
- ☑ Amended
- ☑ 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- ☑ Rescinded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.

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5160-3-01

This rule sets forth definitions used in Chapter 5160-3 of the Administrative Code. This rule is being proposed for amendment. The adverse impacts of this rule are part of the preexisting content of the rule. The proposed changes to the rule are:

- The definition of cost per case mix unit is being deleted because the information in that definition is contained in sections 5165.19 and 5165.36 of the Revised Code. As a consequence of the deletion, paragraphs are being re-lettered as necessary.
- The dates of citations to the Code of Federal Regulations (C.F.R.), the Centers for Medicare and Medicaid Services (CMS), the American Institute of CPAs (AICPA), and the Wall Street Journal are being updated to comply with the Joint Committee on Agency Rule Review (JCARR) rule filing requirements.

5160-3-17

This rule sets forth the payment methodology provisions for outlier services. This rule is being proposed for rescission because Ohio nursing facility providers have not furnished outlier services since 2008, and none are anticipated to do so in the foreseeable future.

5160-3-57 (New)

This rule sets forth provisions for determining the payment rate for tax costs for nursing facilities. This rule is being proposed for rescission, and is being replaced by a new rule with the same number. The differences between the rescinded rule and the new 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), the phrase "per resident per day rate" is being changed to "per medicaid day payment rate" in order to use current terminology and for purposes of clarity.
- Also in paragraph (A), new language is being added in accordance with provisions adopted under Amended Substitute House Bill 49 of the 132nd General Assembly so that the Ohio Department of Medicaid shall now determine each new nursing facility's initial per Medicaid day payment rate for tax costs in accordance with ORC section 5165.151.
- New language in paragraph (B) is being added to specify the documentation required by ODM for purposes of calculating a new nursing facility's initial tax rate.
- New paragraph (B)(1) is being added to specify that the statewide median tax rate for the new facility's peer group for ancillary and support costs will be used as the initial tax rate if any required documentation is not received within 30 days of approval of the

initial provider agreement, or if the documentation is determined to be unsatisfactory.

- New paragraph (B)(2) is being added to specify that the effective date of the initial tax cost rate for a new facility will be the same as the effective date of the new facility's Medicaid provider agreement.
- New paragraph (B)(3) is being added to specify the address for submission of all required documentation.
- In paragraph (C), phrasing changes are being made for purposes of clarity and consistency.

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

   5160-3-01

   ORC 5165.02

   5160-3-17

   ORC 5164.02 and 5165.153

   5160-3-57 (New)

   ORC 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.

   None of the proposed rules implement a federal requirement.

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

   None of the proposed rules exceed a federal requirement.

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)?**

   5160-3-01

   The public purpose of this rule is to enhance efficient and effective administration of the nursing facility program by the Ohio Department of Medicaid by clearly defining certain terms as used in that program.

5160-3-17

Not applicable. This rule is being proposed for rescission.

5160-3-57 (New)

The public purpose of this rule is to ensure the Ohio Department of Medicaid properly and accurately determines the per Medicaid day payment rate for tax costs for both new and existing nursing facilities.

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

5160-3-01

The success of this rule will be measured by the extent to which the definitions in this rule contribute to the efficient and effective administration of the Medicaid program.

5160-3-17

Not applicable. This rule is being proposed for rescission.

5160-3-57 (New)

The success of this rule will be measured by the extent to which accurate determinations are made for nursing facilities' per Medicaid day payment rates for tax costs.

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 the draft rules when the Department of Medicaid emailed the draft rules and summaries of the rule changes to the associations on February 13, 2018.

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

Several comments were received from the Ohio Health Care Association (OHCA). Following are those comments and the Department of Medicaid's response to each comment.

5160-3-57 (New)

1. OHCA suggested that specific tax costs covered by the rule should be specified in the rule, i.e., CAT, real estate, corporate franchise, and personal property. The Department of Medicaid did not accept this suggestion because Schedule B-1 of the Medicaid nursing facility cost report already specifies which types of tax costs are allowable. The Department did, however, include new language in the rule stating that projected tax costs may include any of the type of tax costs reportable on Schedule B-1 of the Medicaid nursing facility cost report.
2. OHCA suggested that the rule should address the submission of projected tax costs for facilities that open between 11/22/17 and 7/1/18. The Department of Medicaid did not implement this suggestion because these facilities already should have submitted their projected tax costs, or should do so by the effective date of the rule, pursuant to ORC 5165.151(A)(4). As a result, their initial rate for tax costs should already have been determined.
3. OHCA requested that the rule give new providers 60 days instead of 30 days from the date they receive their initial provider agreement to submit their prospective tax costs documentation. The Department of Medicaid did not make this requested change because the Department already requires a 90-day notification prior to a new provider's entry into the Medicaid program, which together with the 30 days specified in the rule should give providers sufficient time to

submit the required documentation. In addition, 60 days to submit tax cost documentation would require the Department to determine rates twice for new nursing facilities. Also, for any claims already paid, the Department would need to reprocess those fee-for-service claims at the newly determined rate and managed care payments might need to be adjusted as well.

4. OHCA suggested a timeframe be included in the rule for the Department of Medicaid to take action after a new facility has submitted the required documentation. The Department did not implement this suggestion because the effective date of the initial rate will be retroactive to the effective date of the new facility's Medicaid provider agreement, regardless of when the Department determines the initial rate.
5. OHCA suggested the rule should clarify that the initial tax rate is effective on the same date as the facility's initial Medicaid provider agreement. The Department of Medicaid accepted this suggestion and added new language to that effect.

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 of Medicaid 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 are not considered appropriate.

12. 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.

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 Ohio Department of Medicaid will be posted on 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

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. Provider participation in the Medicaid program is optional and at the provider's discretion.

    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.

5160-3-01

b). and c.) In accordance with paragraph (G)(2)(a)(iii)*(c)* of this rule, a nursing facility provider that transfers an interest or leases an interest in a facility to another nursing facility provider who is a related party must furnish the Department of Medicaid with certified appraisals at least 90 days prior to the date of the actual change of provider agreements. Additionally, a lessor that proposes to lease a nursing facility to a relative of the facility's owner must furnish certified appraisals for each leased facility to the Department of Medicaid at least 90 days prior to the actual date of the change of provider agreements. The Department of Medicaid estimates it will cost a nursing facility provider approximately $1,000.00 to have a real estate appraisal done. The Department of Medicaid further 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 process one appraisal and furnish it to the Department of Medicaid. The Department of Medicaid therefore estimates it will cost a nursing facility provider a total of approximately $1,120.00 to have one real estate appraisal done, process it, and furnish it to the Department of Medicaid.

In accordance with paragraph (G)(2)(c) of this rule, a nursing facility provider must notify the Department of Medicaid in writing and furnish sufficient documentation demonstrating compliance with the provisions of this rule no less than 90 days before the anticipated date of completion of a transfer or lease transaction. The Department of Medicaid estimates it will take a nursing facility provider's accountant approximately 40 hours at the rate of approximately $26.00 per hour (total estimated cost: $1,040.00) to comply with this requirement.

These costs are existing costs of compliance. There are no new costs of compliance associated with the rule amendments.

5160-3-17

Note: This rule is being proposed for rescission; however, the following are the adverse impacts of the rule as it is currently enacted.

b.) and c.) In accordance with paragraph (B)(1) of this rule, in the initial year that a nursing facility is approved as an outlier provider, the provider must submit the projected cost report budget for the initial year of operation; the current calendar year

capital expenditure plan, including detailed asset listing; and the current calendar year plan for basic staffing patterns that includes staff schedule by shift, number of staff in each position, staff position descriptions, base wage rates, and an explanation of contingencies that may require adjustments to the basic staffing patterns. The Department of Medicaid estimates it will take a nursing facility's accountant approximately 10 hours at an estimated rate of approximately $26.00 an hour (total estimated cost: $260.00) to prepare and submit a projected cost report budget and capital expenditure plan. The Department of Medicaid further estimates it will take a nursing facility's administrator approximately 2.5 hours at an estimated rate of approximately $60.00 per hour (total estimated cost: $150.00) to prepare and submit a plan for basic staffing patterns. The Department of Medicaid therefore estimates it will cost a nursing facility provider approximately $410.00 to comply with all the requirements specified in paragraph (B)(1) of this rule.

In accordance with paragraph (B)(2) of this rule, after the initial 3 months of operation as an outlier provider, a nursing facility must submit a cost report for the initial 3 months of services, and current individual plans (IPs) for residents to be served in the period for which an outlier rate is being established. The Department of Medicaid estimates it will take a nursing facility's accountant approximately 15 hours at an estimated rate of approximately $26.00 per hour (total estimated cost: $390.00) to prepare and submit a cost report. The Department of Medicaid cannot estimate the cost for a provider to develop current IPs for residents who receive outlier services in the period for which an outlier rate is being established because the Department does not know how many residents would be receiving services during that period. However, the Department of Medicaid estimates it will take a nursing facility's staff approximately 1.5 hours at the rate of approximately $20.00 per hour (total estimated cost: $30.00) to develop and submit one IP.

In accordance with paragraph (B)(3) of this rule, in each calendar year subsequent to the year of the initial contracted outlier rate, a nursing facility provider must submit the following information:

1. Current IPs for residents to be served in the period for which a rate is being established.

2. Actual year end cost report, along with the current calendar year cost report budget.

3. For-profit providers must submit a balance sheet, income statement, and statement of cash flows relating to the previous calendar year's actual cost report.

4. Non-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.

5. Current calendar year capital expenditure plan, including a detailed asset listing.

6. Current calendar year plan for basic staffing patterns, including staff schedule by shift, number of staff in each position, position descriptions, base wage rates, and a description of contingencies that may require adjustments to the basic staffing patterns.

7. Approved board minutes from the legal entity holding the provider agreement, and all other related legal entities for the calendar year covered by the actual cost report.

For item #1, the Department of Medicaid cannot estimate the cost for a provider to develop current IPs for residents who receive outlier services in the period for which an outlier rate is being established because the Department does not know how many residents would be receiving services during that period. However, the Department of Medicaid estimates it will take a nursing facility's staff approximately 1.5 hours at the rate of approximately $20.00 per hour (total estimated cost: $30.00) to develop and submit one IP.

For item #2, the Department of Medicaid estimates it will take a nursing facility's accountant approximately 20 hours at the rate of approximately $26.00 per hour (total estimated cost: $520.00) to prepare and submit a year-end cost report along with a current calendar year cost report budget.

For item #3, the Department of Medicaid estimates it will take a nursing facility's accountant approximately 5 hours at the rate of approximately $26.00 per hour (total estimated cost: $130.00) to prepare and submit a balance sheet, income statement, and statement of cash flows for a for-profit provider.

For item #4, the Department of Medicaid estimates it will take a nursing facility's accountant approximately 4 hours at the rate of approximately $26.00 per hour (total estimated cost: $104.00) to prepare and submit a statement of financial position, statement of activities, and statement of cash flows for a non-profit provider.

For item #5, the Department of Medicaid estimates it will take a nursing facility's accountant approximately 2 hours at the rate of approximately $26.00 per hour (total estimated cost: $52.00) to prepare and submit a current calendar year capital expenditure plan that includes a detailed asset listing.

For item #6, the Department of Medicaid estimates it will take a nursing facility's administrator approximately 2.5 hours at the rate of approximately $60.00 per hour (total estimated cost: $120.00) to prepare and submit a current calendar year plan for basic staffing patterns.

For item #7, the Department of Medicaid estimates it will take a nursing facility's staff approximately 2 hours at the rate of approximately $13.00 per hour (total estimated cost: $26.00) to locate and submit approved board minutes from the legal entity holding the provider agreement, and all other related legal entities for the calendar year covered by the actual cost report.

5160-3-57 (New)

b.) and c.) In accordance with paragraph (B) of this rule, a new nursing facility may provide the Department of Medicaid with the facility's projected tax costs for the calendar year in which the facility obtains an initial provider agreement. The Department of Medicaid estimates it will take a nursing facility's accountant approximately 3 hours at the rate of approximately $26.00 per hour (total estimated cost: $78.00) to determine the facility's projected tax costs and submit them to the Department of Medicaid.

In accordance with paragraph (B)(1) of this rule, if any documentation required under this rule is not received within 30 days of approval of the initial provider agreement, or is determined to be unsatisfactory, the statewide median tax rate for the new facility's peer group will be used as the initial tax rate. The Department cannot estimate the impact of this provision to a provider because the Department does not know what any particular new nursing facility's projected tax costs might be, or if the application of the statewide median tax rate for the new facility's peer group will result in an increase or decrease in the facility's tax cost rate.

In accordance with paragraph (C) of this rule, if a provider does not have a cost report filed with the Department of Medicaid for the applicable calendar year used to determine the tax cost rate under section 5165.21 of the Revised Code, the provider will be paid a tax cost rate that is the median rate for tax costs for the facility's peer group determined under ORC Section 5165.16. The Department cannot estimate the impact of this provision to a provider because the Department does not know what any particular nursing facility's current tax cost rate might be, or if the application of the tax cost rate

for any particular facility's peer group will result in an increase or decrease in the facility's tax cost rate.

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

5160-3-01

The adverse impact associated with this rule is justified because this rule helps ensure the efficient and effective administration of the Medicaid program.

5160-3-17

Not applicable. This rule is being proposed for rescission.

5160-3-57 (New)

The adverse impact associated with this rule is justified because this rule helps ensure the Department of Medicaid properly and accurately determines a new nursing facility's initial per Medicaid day payment rate for tax costs.

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 facilities 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.

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.