Ohio | Common Sense Initiative

Mike DeWine, Governor
Jon Husted, Lt. Governor

Carrie Kuruc, Director

Business Impact Analysis

Agency, Board, or Commission Name: The Ohio Department of Medicaid
Rule Contact Name and Contact Information:

Tommi Potter, ODM Rules Administrator Rules@medicaid.ohio.gov
Regulation/Package Title (a general description of the rules' substantive content):

Permanent Filing of Public Health Emergency Rules for Nursing Facilities

Rule Number(s): 5160-3-16.4 (Amend), 5160-3-18 (Amend), 5160-3-43.3 (Amend)

5160-3-19 (Amend) for informational purposes only

Date of Submission for CSI Review: August 24, 2020

Public Comment Period End Date: August 31, 2020

Rule Type/Number of Rules:

New/___ rule — No Change/____ rules (FYR? ___)

Amended/__3__ rules (FYR? _No__) — Rescinded/____ rules (FYR? __)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☒ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☐ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

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

   5160-3-16.4 (Amend) - Nursing facilities (NFs): covered days and bed-hold days

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

   - In paragraph (D), language is being modified so payments to reserve a bed beyond 30 days but not exceeding 60 days may be made to a nursing facility provider until December 1, 2020 for Medicaid eligible residents in a certified nursing facility that meets the requirements of Section 14 of Amended Substitute House Bill 197 of the 133rd General Assembly.
   - In paragraph (F)(2), the word "thirty" is being deleted to align with the modifications being made in paragraph (D).

   Rule 5160-3-18 (Amend) - Nursing facilities (NFs): ventilator program

This rule sets forth the provisions for the nursing facility ventilator program and includes provisions regarding ventilator weaning services. The changes to the rule are:

- In paragraph (E)(4), language is being added so that a respiratory care professional, in addition to a registered nurse, may fulfill the on-site 24 hours per day 7 days per week staffing requirement for nursing facilities that are approved to provide ventilator weaning services.
- In paragraph (H), language is being added so that a provider participating in the NF ventilator program does not have to submit quarterly reports if the provider had no ventilator dependent residents during the reporting period.

Rule 5160-3-43.3 (Amend) - Nursing facilities (NFs): calculation of case mix scores

This rule sets forth the provisions for the calculation of case mix scores for nursing facilities. The changes to the rule are:

- In paragraphs (C)(3), (D)(4), and (D)(5), language is being modified to allow the Department of Medicaid to choose whether to assign a penalty score if resident assessment data is not submitted timely by a nursing facility, and when calculating the semiannual facility average Medicaid case mix score.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

5160-3-16.4

Authorizing Statute: ORC 5165.02

Amplifying Statute: ORC 5165.34

5160-3-18

Authorizing Statute: ORC 5165.02, 5165.153

Amplifying Statute: ORC 5165.157

5160-3-43.3

Authorizing Statute: ORC 5165.02, 5165.192

Amplifying Statute: ORC 5165.19, 5165.192

4. **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.

5160-3-16.4

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

5160-3-18

This proposed rule does not implement any federal requirements.

5160-3-43.3

This proposed rule does not implement any federal requirements.

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

5160-3-16.4

This proposed rule contains numerous provisions not specified in federal regulations but which are required by federal regulations to be determined locally. 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, claims submission, admission after depletion of bed-hold days, information and notice prior to leave, emergency hospitalizations, resident eligibility, exclusions, and compliance.

5160-3-18

This proposed rule does not exceed any federal requirements.

5160-3-43.3

This proposed rule does not exceed any federal requirements.

6. **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)?**

5160-3-16.4

The public purpose of this rule is to ensure that payments for bed hold days are made in a consistent and fiscally responsible manner, and to ensure that nursing facility residents are able to return to the nursing facility at which they reside after an intervening hospital stay or visit with family or friends.

5160-3-18

The public purpose of this rule is to ensure that nursing facilities participating in the ventilator program are qualified to do so, and that payments for the provision of ventilator services, including ventilator weaning services, are made in a consistent and fiscally responsible manner.

5160-3-43.3

The public purpose of this rule is to implement provisions contained in ORC section 5165.192 regarding the calculation of quarterly, semiannual, and annual case mix scores for each Ohio nursing facility.

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

5160-3-16.4

The success of this rule will be measured by the extent to which bed hold day payments are made according to the specifications of this rule.

5160-3-18

The success of this rule will be measured by the extent to which the eligibility and payment provisions in this rule are met according to the specifications in the rule. The rule includes provisions for a biannual random sampling of ventilator program providers to review provider eligibility.

5160-3-43.3

The success of this rule will be measured by the extent to which case mix scores are calculated accurately and timely according to the specifications of this rule.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

The proposed rules are not being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93 or 121.931.

Development of the Regulation

9. **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 a meeting conducted through Microsoft Teams on July 29, 2020 to review the amendments being proposed to these draft rules.

Twenty-six staff in the Ohio Department of Medicaid were also involved in review of the draft rules and were emailed the draft rules and a summary of changes on July 24, 2020.

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

Representatives of the nursing facility provider associations provided minimal comments on the draft rules that were discussed during the July 24, 2020 meeting and expressed support of all the proposed rule changes.

No input was provided by ODM staff on the proposed draft rules.

11. 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 this rule.

12. 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 this rule.

13. **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.***

5160-3-16.4

Performance-based regulations are not considered appropriate for this rule.

5160-3-18

This rule incorporates performance-based rate methodology. A nursing facility's rate for ventilator dependent individuals may be decreased by up to 5% if the facility does not maintain a ventilator acquired pneumonia (VAP) rate that is less than the statewide average VAP rate.

5160-3-43.3

Performance-based regulations are not considered appropriate for this rule.

14. **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 this rule does not duplicate any of the Department of Medicaid's rules or any other regulations in the ORC or OAC.

15. **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 rule as adopted by the Ohio Department of Medicaid will be available via the Department's website at http://medicaid.ohio.gov/RESOURCES/LegalandContracts/Rules.aspx. In addition, the Department will notify stakeholders when the final rule becomes effective.

Adverse Impact to Business

16. **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; and**

This rule impacts approximately 960 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 all adverse impact (e.g., 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.

b.) and c.)

5160-3-16.4

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 must be available for viewing by the County Department of Job and Family Services (CDJFS) and the Department of Medicaid. The Department of Medicaid estimates it will take a resident's primary physician approximately 15 minutes at the rate of approximately $125.00 per hour (total estimated cost: $31.25) 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.

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. The Department of Medicaid estimates it will take a nursing facility provider's nurse approximately 1.5 hours at the rate of approximately $22.00 per hour (total estimated cost: $33.00) and a business office staff person approximately 30 minutes at the rate of approximately $16.00 per hour (total estimated cost: $8.00) to make these arrangements. The Department of Medicaid therefore estimates it will cost a nursing facility provider a grand total of approximately $41.00 to make the 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.

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 Administrative Code rule 5160-3-39.1. The Department of Medicaid estimates it will take a nursing facility staff member approximately 5 minutes at the rate of approximately $16.00 per hour (total estimated cost: $1.33) to electronically submit one claim for bed-hold days.

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. The Department of Medicaid estimates it will take a nursing facility administrator approximately 2 hours at the rate of approximately $72.00 per hour (total estimated cost: $144.00) to establish the above policy. In addition, the Department of Medicaid estimates it will take a nursing facility provider's admissions director approximately 5 hours at the rate of approximately $35.00 per hour (total estimated cost: $175.00), and a nurse approximately 3 hours at the rate of approximately $22.00 per hour (total estimated cost: $66.00) to arrange for the admission of one individual. The Department of Medicaid therefore estimates it will cost a grand total of approximately $241.00 for a nursing facility provider to admit one individual.

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 with written information about the facility's bed-hold policies. The Department of Medicaid estimates it will take a nursing facility staff member approximately 30 minutes at the rate of approximately $16.00 per hour (total estimated cost: $8.00) to provide written information about the facility's bed-hold policies prior to a resident's use of bed-hold days.

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 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 30 minutes at the rate of approximately $16.00 per hour (total estimated cost: $8.00) to provide a written notice to the resident and their family member or legal representative that specifies all the above.

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. The Department of Medicaid estimates it will take a nursing facility staff member approximately 5 minutes at the rate of approximately $16.00 per hour (total estimated cost: $1.33) to provide the resident and a family member or legal representative with a copy of the notice.

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. The Department of Medicaid cannot quantify the adverse impact 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. However, if these factors could be determined, the impact could be calculated by multiplying the time needed by each individual staff person to perform the tasks needed to write, submit, and implement the corrective plan by the rate of pay for each of those individuals.

In accordance with paragraph (L)(2) of this rule, a nursing facility provider must furnish copies of any records requested by the Department of Medicaid in cases of an investigation by the Department for compliance purposes. The Department of Medicaid cannot quantify the adverse impact 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. However, the impact would be calculated by multiplying the time needed by a nursing

facility's staff to locate, copy, and furnish any records requested by the rate of pay for that staff.

5160-3-18

In accordance with paragraph (C)(1) of this rule, a nursing facility must be a licensed and Medicaid certified facility and meet the requirements for nursing facilities in accordance with 42 U.S.C. 1396r. The Department of Medicaid estimates it will take a nursing facility's attorney approximately 6 hours at the rate of approximately $400.00 per hour (total estimated cost: $2,400.00) to review one licensure application. The Department further estimates it will take a nursing facility administrator approximately 4 hours at the rate of approximately $72.00 per hour (total estimated cost: $288.00) to prepare and apply for one licensure application. The Department therefore estimates it will cost a total of approximately $2,688.00 for a nursing facility provider to review, prepare, and apply for an application for licensure to operate. Additionally, the Department of Medicaid estimates it will take a nursing facility's attorney approximately 20 hours at the rate of approximately $400.00 per hour (total estimated cost: $8,000.00) to review one application for Medicaid certification. The Department further estimates it will take a nursing facility administrator approximately 640 hours at the rate of approximately $72.00 per hour (total estimated cost: $46,080.00) to prepare and apply for Medicaid certification. The Department therefore estimates it will cost nursing facility a grand total of approximately $48,768.00 to comply with the provisions in this paragraph.

In accordance with paragraph (C)(3) of this rule, a nursing facility must comply with the provisions in Chapters 5164. and 5165. of the Revised Code regarding provider agreements, and with the provisions in rules 5160-3-02 to 5160-3-02.2 of the Administrative Code regarding execution and maintenance of provider agreements between ODM and the operator of a NF. The Department of Medicaid estimates it will take a nursing facility's attorney approximately 2 hours at the rate of approximately $400.00 per hour (total estimated cost: $800.00) and nursing facility administrator approximately 2 hours at the rate of approximately $72.00 per hour (total estimated cost: $144.00) for a total cost of $944.00 to execute one new provider agreement. The Department further estimates it will take a nursing facility administrator approximately 1 hour at the rate of approximately $72.00 per hour (total estimated cost: $72.00) to revalidate the provider agreement at least once every five years after the initial execution of the agreement.

In accordance with paragraph (C)(4) of this rule, a nursing facility must cooperate with ODM or its designee during all provider oversight and monitoring activities. The Department of Medicaid cannot quantify the adverse impact of this because the Department does not know what oversight and monitoring activities any particular nursing facility will undergo, how long those activities will take, or how complicated those activities may become. However, the impact would be calculated by multiplying the number of staff hours required for each oversight or monitoring activity by the applicable hourly staff wage, then adding any additional costs that would be incurred to comply with this regulation.

In accordance with paragraph (C)(5) of this rule, a nursing facility must designate a discrete unit within the NF for the use of individuals in the ventilator program. If there is a change in the size or location of the designated discrete unit or number of beds in the discrete unit, the NF shall notify ODM of the change via email to nfpolicy@medicaid.ohio.gov within five business days of the change. The Department of Medicaid estimates it will take a nursing facility staff person approximately 15 minutes at the rate of approximately $16.00 per hour (total estimated cost: $4.00) to comply with this requirement.

In accordance with paragraph (C)(6) of this rule, if a nursing facility needs to purchase a backup generator, the Department of Medicaid estimates it will cost a facility approximately $300,000.00 for the purchase and installation.

In accordance with paragraph (C)(7)(a) of this rule, a nursing facility that becomes a Special Focus Facility (SFF) under the Centers for Medicare and Medicaid Services (CMS) SFF program must notify the Department of the SFF status within one business day of receipt of the CMS SFF letter via email at NFpolicy@medicaid.ohio.gov and attach a copy of the letter. The Department of Medicaid estimates it will take a nursing facility staff person approximately 15 minutes at the rate of approximately $16.00 per hour (total estimated cost: $4.00) to notify the Department of the SFF status and attach a copy of the SFF letter.

In accordance with paragraph (C)(7)(b) of this rule, when a nursing facility has graduated from the SFF program for a period of six consecutive months, the facility may submit a new request to provide ventilator services in accordance with paragraph (D) of this rule in order to begin admitting new individuals to the ventilator program again. The Department of Medicaid estimates it will take a nursing facility administrator approximately 2 hours at the rate of approximately $72.00 per hour (total estimated cost: $144.00) to submit a new request in accordance with paragraph (D).

In accordance with paragraph (C)(8)(a) of this rule, for at least five hours per week, a nursing facility must provide the services of an respiratory care professional (RCP) or the services of a registered nurse (RN) who has worked for a minimum of one year with ventilator dependent individuals. The Department of Medicaid estimates that, at the rate of approximately $40.00 per hour, it will cost a provider approximately $200.00 to employ an RCP to comply with this requirement. The Department also estimates that, at the rate of approximately $32.12 per hour, it will cost a provider approximately $160.60 to employ a RN to comply with this requirement.

In accordance with paragraph (C)(8)(b) of this rule, if ordered by a physician, a nursing facility must provide initial assessments for physical therapy, occupational therapy, and speech therapy within forty-eight hours of receiving the order for a ventilator dependent individual. The Department of Medicaid estimates it will take a physical therapist approximately 0.75 hours at the rate of approximately $42.00 per hour (total estimated cost: $31.50) to assess one ventilator dependent individual. The Department also estimates it will take an occupational therapist approximately 1 hour at the rate of approximately $42.00 per hour (total estimated cost: $42.00) to assess the same individual. The Department further estimates it will take a speech pathologist approximately 0.5 hours at the rate of approximately $36.00 per hour (total estimated cost: $18.00) to assess the individual. The Department therefore estimates it will cost nursing facility a grand total of $91.50 to comply with this requirement.

In accordance with paragraph (C)(8)(c) of this rule, if ordered by a physician, a nursing facility must provide up to two hours of therapies per day, six days per week for each ventilator dependent individual. The Department of Medicaid is unable to quantify the adverse impact of this requirement because the Department does not know which types of therapies a physician will order on any particular day, or how many hours per day will be ordered. However, the impact could be calculated by determining the number of hours of therapy provided to one individual in a single day, multiplying those hours by the applicable rate of pay of the therapist who provided the service, then adding the results.

In accordance with paragraph (C)(8)(d) of this rule, in emergency situations as determined by a physician, a nursing facility must provide access to laboratory services that are available 24 hours per day, 7 days per week with a turnaround time of 4 hours. The Department of Medicaid estimates it will cost a nursing facility approximately $100.00 in special service fees to have a laboratory service provide testing results for one individual within a 4-hour turnaround time.

In accordance with paragraph (C)(8)(e) of this rule, for new admissions, a nursing facility must administer pain medications to a ventilator dependent individual within 2 hours from the receipt of the physician order. The Department of Medicaid cannot quantify the adverse impact of this requirement because the Department does not know what particular pain medications will be ordered for any particular individuals. However, the impact is generally minimal and usually is not more than $5.00 per dose.

In accordance with paragraph (D)(1) of this rule, a nursing facility that chooses to participate in the ventilator program must email a completed ODM 10227 "Request to Participate in the ODM Nursing Facility Ventilator Program" to nfpolicy@medicaid.ohio.gov. The Department of Medicaid estimates it will take a nursing facility administrator approximately 2 hours at the rate of approximately $72.00 per hour (total estimated cost: $144.00) to comply with this provision.

In accordance with paragraphs (D)(3), (F)(4)(d)(ii), (I)(2)(c), and (I)(3)(b) of this rule, if a NF's request to participate in the ventilator program is not approved, the NF may request a reconsideration by the Medicaid director or designee. The Department of Medicaid estimates it will take a nursing facility administrator approximately 4 hours at the rate of approximately $72.00 per hour (total estimated cost: $288.00) to prepare one reconsideration request and submit it to the Department.

In accordance with paragraphs (C)(9), (D)(4), and (D)(5) of this rule, a nursing facility that that wants to participate in the ODM NF ventilator program must have an approved ODM 10198 form "Addendum to ODM Provider Agreement for Ventilator Services in NFs." The Department of Medicaid estimates it will take a nursing facility administrator approximately 15 minutes at the rate of approximately $72.00 per hour (total estimated cost: $18.00) to sign and return the ODM 10198. In accordance with paragraph (I)(3) of this rule, this cost is incurred at least once every five years during a provider's revalidation process and whenever there is a change of operator (CHOP).

In accordance with paragraph (E)(1) of this rule, nursing facilities that are approved to participate in the NF ventilator program may provide ventilator weaning services if they have an approved ODM 10198 form with approval to provide ventilator weaning services. A facility that has an approved ODM 10198 and wishes to provide weaning services may send a written request to nfpolicy@medicaid.ohio.gov. The Department of Medicaid estimates it will take a nursing facility administrator approximately 0.5 hours at the rate of approximately $72.00 per

hour (total estimated cost: $36.00) to send a written request to the Department to provide ventilator weaning services.

In accordance with paragraph (E)(2) of this rule, a nursing facility that is approved to provide ventilator weaning services must have a weaning protocol in place that is established by a physician trained in pulmonary medicine. The Department of Medicaid cannot quantify the adverse impact of this provision because some nursing facilities may already have this level of staffing in place prior to becoming approved to provide ventilator weaning services under the ODM NF ventilator program. However, the impact might be quantified by identifying the individuals responsible for developing the protocol with the physician, determining the number of hours required to develop the protocol, then multiplying the hours worked by both the identified individuals and the physician by the applicable average pay rate plus benefits and adding these costs together.

In accordance with paragraph (E)(3) of this rule, a nursing facility that is approved to provide ventilator weaning services must have a respiratory care professional (RCP) with training in basic life support on-site eight hours per day, seven days per week and available by phone during the remaining hours of the day while weaning services are provided. The Department of Medicaid estimates it will cost a nursing facility that provides ventilator weaning services approximately $40.00 per hour to employ an RCP, which will cost approximately $2,240.00 per week or $8,960.00 per month.

In accordance with paragraph (E)(4) of this rule, a nursing facility that is approved to provide ventilator weaning services must have a registered nurse, or respiratory care professional (RCP) with training in basic life support, on-site 24 hours per day, seven days per week while weaning services are provided. The Department of Medicaid estimates it will cost a facility approximately $32.12 per hour (estimated cost per day: $770.88) to employ a registered nurse. The Department also estimates it will cost a facility approximately $40.00 per hour (estimated cost per day: $960.00) to employ an RCP.

In accordance with paragraph (F)(4) of this rule, once the Department of Medicaid calculates a NF's ventilator acquired pneumonia (VAP) baseline rate and the VAP threshold rate, for any quarter thereafter in which a NF's VAP baseline rate exceeds the VAP threshold rate, the NF must submit a plan of action. In addition, if the Department determines that a plan of action is deficient, a NF will be notified to submit a revised plan of action. If ODM approves a plan of action or a revised plan of action, the NF must submit a statement of completion of its plan of action within 15 calendar days of the completion date via email. The Department of Medicaid

cannot quantify the adverse impact because the Department cannot anticipate which of these steps a NF will be required to complete, and the number and extent of deficiencies that will need to be addressed. Additionally, the Department cannot anticipate the strategy a NF use may use to comply with each of these requirements or the various staff and processes they may decide to use. However, the impact could be quantified by identifying which of the steps a NF is required to complete, the tasks necessary to complete each step, the persons responsible for each task, and the number of hours required for the process, then multiplying the staff hours needed by the average pay rate plus benefits for each staff person and adding these costs together. If a NF's VAP rate exceeds the VAP threshold rate for two consecutive quarters, the Department may reduce a NF's ventilator program payment rate by a maximum of five percent for one full quarter. The Department cannot quantify the adverse impact of this provision because the Department cannot know in advance what percentage, if any, a NF's rate for ventilator only services or for ventilator weaning services will be reduced or the number of individuals who might be impacted by a reduction in rates. However, the cost could be calculated by multiplying the number of individuals receiving services by the rate reduction for the period of sanction.

In accordance with paragraph (H)(1) of this rule, each NF ventilator program provider must submit quarterly reports to the Department of Medicaid. The Department estimates that it will take a nursing facility's admissions director approximately 6 hours per quarter at the rate of approximately $35.00 per hour (total estimated annual cost: $840.00) to maintain the information required for quarterly reporting. The Department further estimates it will take the nursing facility administrator an additional 2 hours at the rate of approximately $72.00 per hour (total estimated annual cost: $576.00) to submit quarterly reports. Therefore, the Department estimates it will cost a nursing facility a grand total of $1,416.00 per year to submit quarterly reports for the ventilator program.

In accordance with paragraph (I)(2) of this rule, a nursing facility that fails to continue to meet the requirements of the rule will be terminated from the ventilator program. The Department of Medicaid cannot quantify the adverse impact to a nursing facility that is terminated from either portion of the ventilator program because the Department cannot predict the number of individuals in any particular facility's ventilator program. However, if a nursing facility continues to provide ventilator services outside ODM's NF ventilator program, the adverse impact could be quantified by calculating the difference between the enhanced NF ventilator program per diem rate and the regular NF per diem rate multiplied by the number of individuals on a ventilator at that facility.

In accordance with paragraph (J) of this rule, a NF that chooses to no longer provide ventilator weaning services or to no longer participate in the ODM NF ventilator program must send notice of withdrawal to the Department of Medicaid via email. The Department of Medicaid estimates it will take a nursing facility administrator approximately 15 minutes at the rate of approximately $72.00 per hour (total estimated cost $18.00) to comply with this requirement.

5160-3-43.3

The Department of Medicaid may assign a nursing facility a quarterly facility average total case mix penalty score that is 5% less than the facility's quarterly facility average total case mix score for the preceding calendar quarter if the facility does not meet the following requirements:
1.) The facility submitted its resident assessment information by the filing date and the data included resident assessments for all residents in Medicaid certified beds as of the reporting period end date, and the data that was submitted timely provided sufficient information for accurately classifying at least 90% of all residents in Medicaid certified beds into RUG non-default groups.
2.) The facility's data was submitted timely and corrected timely and provided sufficient information for accurately classifying at least 90% of all residents in Medicaid certified beds in RUG non-default groups, and there were no errors that prevented the Department of Medicaid from verifying the records to be used in determining the quarterly facility average total case mix score.
3.) Prospective payment system (PPS) other Medicare required assessments (OMRAs) were not selected for calculating case mix scores.

The Department of Medicaid may assign a nursing facility a quarterly facility average Medicaid case mix penalty score that is 5% less than the quarterly facility average Medicaid case mix score for the preceding calendar quarter if the facility does not meet the following requirements:
1.) The facility's data that was submitted timely provided at least 90% of records identified as Medicaid records into RUG non-default groups.
2.) The data that was submitted timely and corrected timely provided sufficient information for accurately classifying at least 90% of all residents into RUG nondefault groups, and there were no errors that prevented the Department of Medicaid from verifying the records to be used in determining the quarterly facility average Medicaid case mix score.

Additionally, this rule requires that, if a facility was subject to an exception review for the preceding quarter in accordance with OAC rule 5160-3-43.4, the assigned quarterly total facility average case mix score shall be 5% less than the score determined by the exception review.

When penalty scores are assigned, the Department cannot quantify the adverse impact to providers because the Department does not know how many nursing facilities will incur the 5% penalties by not meeting the requirements as specified above or how many separate penalties any particular nursing facility may incur. Additionally, the impact of the 5% penalty on a particular nursing facility's rate will vary from facility to facility depending on the unique characteristics of the individual residents in that particular facility. However, case mix scores are used to calculate the direct care component of a nursing facility's Medicaid per diem rate, so a reduction in a facility's case mix score could impact the rate and cause the facility to receive reduced Medicaid payments.

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

5160-3-16.4

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

5160-3-18

The adverse impact associated with this rule is justified because qualified nursing facility providers receive an enhanced per diem rate to provide specialized services to ventilator dependent residents. The adverse impact is also justified because the rule helps ensure the integrity of the ventilator program, including rates paid, and that only qualified providers participate in the program.

5160-3-43.3

The adverse impact associated with this rule is justified because the rule helps ensure the Department of Medicaid has timely, accurate, and complete resident assessment data to use in calculating case mix scores, which in turn helps to ensure the setting of timely and accurate nursing facility rates.

Regulatory Flexibility

18. 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.

19. 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.

20. What resources are available to assist small businesses with compliance of the regulation?

Providers in need of assistance may contact the Department of Medicaid, Bureau of Long-Term Services and Supports at (614) 466-6742.