Ohio | Common Sense Initiative

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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

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Regulation/Package Title (a general description of the rules' substantive content):

Nursing Facility-Based Level of Care Process and Timelines and Preadmission and Resident Review (PASRR) Program

Rule Number(s): 5160-3-14 (Amend), 5160-3-15.1 (Amend)

Date of Submission for CSI Review: 12/3/2020

Public Comment Period End Date: 12/10/2020

Rule Type/Number of Rules:

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

Amended/__2_ rules (FYR? ___) — Rescinded/____ rules (FYR?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.

   OAC 5160-3-14

   An individual seeking Medicaid payment for a nursing facility stay or who is seeking enrollment on a home and community-based services (HCBS) waiver must be assessed to determine their level of care (LOC). A nursing facility-based level of care is necessary for Medicaid payment for a nursing facility stay or HCBS waiver enrollment. Current rules establish and define the process for determining level of care.

   On March 13, 2020 the President of the United States issued a proclamation that the COVID-19 outbreak constituted a national emergency. As a response to a significant decrease in access to services and resources as well as several national restrictions on travel, ODM sought to implement additional flexibilities that would allow LOC determinations to continue so that individuals may have uninterrupted access to the services they need. The proposed amended rules were initially approved as emergency

rules in response to the pandemic and certain flexibilities are now being proposed as permanent changes. Proposed changes to the rule are outlined below.

Changes to rule 5160-3-14 include:

- State agency name references, form numbers, and rule number references were updated to reflect statutory and Administrative Code changes.
- Allowing the submission of the physician certification to occur electronically in addition to standard mail.
- Allowing face-to-face level of care assessments and determinations to occur by telephone, desk review, or video conference unless an individual requires a face-to-face visit.
- Added language to clarify that adverse level of care determinations must occur face-to-face.
- Removing requirement for a delayed face-to-face visit for individuals seeking admission from a hospital, receiving adult protective services, or currently residing in a NF and requesting a change from a non-Medicaid payor to Medicaid payment for their continued nursing facility stay.

OAC 5160-3-15.1

For a state to have its Medicaid plan approved by the Centers for Medicare and Medicaid Services (CMS), it must maintain a Preadmission and Resident Review (PASRR) program. PASRR is a process to ensure that all individuals seeking admission into a Medicaid-certified nursing facility are thoroughly evaluated, that they are placed in nursing facilities *only* when appropriate, and that they receive all necessary services while they are there.

PASRR Regulations, specifically, Chapter 42 of the Code of Federal Regulations, Sections 483.100 through 483.138 requires that states administer a PASRR program that has two steps. First, all individuals who apply for admission to Medicaid-certified nursing facilities (NFs) must be "screened" for evidence of serious mental illness (SMI) and/or developmental disabilities (DD) or related conditions, regardless of payor source. The C.F.R. calls this screening a Level I screen.

Individuals who show indications of an SMI and/or DD are then referred to the Ohio Department of Mental Health and Addiction Services (OhioMHAS) and/or Ohio Department of Developmental Disabilities (DODD) and receive a more in-depth evaluation to determine whether they have such a disability. The C.F.R. calls this a Level II evaluation. The Level II evaluation produces recommendations for the setting in which services should be received and recommendations for specialized services, and these recommendations are intended to inform the individual's plan of care.

Medicaid-certified NFs are prohibited from admitting individuals who have

indications of either SMI and/or DD prior to obtaining a PASRR Level II evaluation and determination. To ensure that residents with known PASRR disability are having their total needs met, the state must periodically review the SMI/DD status of NF residents. The Resident Review is initiated by the NF whenever a resident undergoes a significant change in status and that change has a material impact on their functioning as it relates to their SMI/DD status.

On March 13, 2020 the President of the United States issued a proclamation that the COVID-19 outbreak constituted a national emergency. As a response to a significant decrease in access to services and resources as well as several national restrictions on travel, ODM sought to implement additional flexibilities that would allow PASRR evaluations to continue so that individuals may be appropriately placed in nursing facilities. The proposed amended rules were initially approved as emergency rules in response to the pandemic and certain flexibilities are now being proposed as permanent changes. Proposed changes to the rule are outlined below.

Changes to rule 5160-3-15.1 include:

- Allowing PASRR evaluations to occur by telephone, desk review, or video conference as well as face-to-face visits.
- Corrected language pertaining to categorical determinations.

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.**

OAC 5160-3-14

Ohio Revised Code Section 5164.02, Section 5162.03, and Section 5165.04.

OAC 5160-3-15.1

Ohio Revised Code Section 5164.02 and Section 5119.40.

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.

OAC 5160-3-14

Yes. An assessment of an individual's level of care is needed for two different purposes:

- To allow Medicaid payment for a nursing facility stay; and
- For enrollment onto a Medicaid home and community-based services (HCBS)

waiver.

Medicaid Payment for a Nursing Facility Stay

Nursing facility services are required to be provided by state Medicaid programs for individuals age 21 or older who qualify. States may not limit access to the service, or make it subject to waiting lists, as they may for HCBS waivers. Need for nursing facility services is defined by states, all of whom have established nursing facility-based level of care criteria.

Medicaid HCBS Waivers

In order for the Centers for Medicare and Medicaid Services (CMS) to approve a 1915(c) HCBS waiver, a state must make certain assurances concerning the operation of the waiver. As described in 42 C.F.R. 441.302., states are required to conduct a level of care assessment initially and annually thereafter. The level of care criteria for waiver services mirrors that for a nursing facility stay because an HCBS waiver is a service provided in the community in lieu of a nursing facility stay.

OAC 5160-3-15.1

Yes; the proposed rules implement the federal Preadmission Screening and Resident Review (PASRR) requirement governed by 42 C.F.R. 483, Subpart C. The agency is required to regulate the PASRR process pursuant to section 1919(e)(7) of the Social Security Act, as in effect on January 1, 2019, and Chapter 42 of the Code of Federal Regulations, Sections 483.100 through 483.138.

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

OAC 5160-3-14

The proposed rules do not exceed any federal requirements.

OAC 5160-3-15.1

The proposed rules do 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)?**

OAC 5160-3-14

The public purpose of this regulation is to ensure that individuals residing in a nursing

facility are having their needs met in the least restrictive setting possible. In addition, it is the responsibility of the Ohio Department of Medicaid (ODM) to ensure Medicaid funding (both state and federal dollars) is being spent appropriately on care for individuals with needs that can be met safely in a community setting or in a nursing facility.

OAC 5160-3-15.1

The public purpose of this regulation is to identify if individuals have indications of SMI or DD and are placed accordingly in the least restrictive setting possible while having their long-term services and support needs met. The agency is required to regulate this process pursuant to section 1919(e)(7) of the Social Security Act, as in effect on January 1, 2019, and Chapter 42 of the Code of Federal Regulations, Sections 483.100 through 483.138.

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

OAC 5160-3-14

Successful outcomes will be measured through a finding of compliance in accordance with the standards described in the rules.

OAC 5160-3-15.1

Successful outcomes will be measured through a finding of compliance in accordance with the standards described in the rules.

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.

OAC 5160-3-14

None of the proposed rules are being submitted pursuant to these specified sections of the Revised Code.

OAC 5160-3-15.1

None of the proposed rules are being submitted pursuant to these specified sections of the Revised Code.

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.

   OAC 5160-3-14

   - Ohio Department of Aging (ODA)
   - Ohio Department of Developmental Disabilities (DODD)
   - Ohio Department of Mental Health and Addiction Services (MHAS)

   OAC 5160-3-15.1

   - Ohio Department of Developmental Disabilities (ODA)
   - Ohio Department of Mental Health and Addiction Services (DODD)
   - Ohio Department of Aging (MHAS)
   - Ohio Department of Health (ODH)

   Ohio's three nursing facility providers associations, which are:

   - Ohio Healthcare 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 nonprofit facilities. In addition to representing and advocating for nursing facilities, the associations are informational and educational to Ohio's nursing facilities, their suppliers, consultants, and the public at large.

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

    OAC 5160-3-14

    After the proclamation of a national emergency on March 13, 2020, ODM sought to implement additional flexibilities in the level of care assessment process through emergency

rules. After the emergency rules became effective June 12, 2020, ODM met again with ODA on July 6, 2020 and with MHAS and DODD on July 15, 2020 to discuss feedback from their administrative agencies regarding which, if any, flexibilities could be made permanent. The result of collaboration with stakeholders lead to the proposed rule amendments.

OAC 5160-3-15.1

The rules submitted as a part five-year rule review process were distributed on June 12, 2019 to the stakeholders included in question 9 and those stakeholders provided comments and questions that were addressed by ODM on June 25, 2019. The comments and questions led to the previously adopted rule revisions.

After the proclamation of a national emergency on March 13, 2020, ODM sought to implement additional flexibilities in the PASRR assessment process through emergency rules. After the emergency rules became effective June 12, 2020, ODM met again with ODA on July 6, 2020 and with MHAS and DODD on July 15, 2020 to discuss feedback from their administrative agencies regarding which, if any, flexibilities could be made permanent. The result of collaboration with stakeholders lead to the proposed rule amendments.

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?

OAC 5160-3-14

Scientific data was not applicable to the development of the proposed rules.

OAC 5160-3-15.1

Scientific data was not applicable to the development of the proposed rules.

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?

OAC 5160-3-14

No alternative regulations were considered. The level of care criteria and determination process have historically been promulgated in the Ohio Administrative Code.

OAC 5160-3-15.1

No alternative regulations were considered. The Department of Medicaid considers the federal and state regulations that govern PASRR, specifically 42 C.F.R. 483, Subpart C, and

the Ohio Administrative Code rules the most appropriate type of regulations for the provisions contained in the proposed rules.

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.***

OAC 5160-3-14

A performance-based regulation is not deemed appropriate for this process.

OAC 5160-3-15.1

A performance-based regulation is not deemed appropriate for this process.

14. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

OAC 5160-3-14

Because the nursing facility-based level of care process is administered solely by the Ohio Department of Medicaid (ODM), the rules specific to this level of care are not duplicated by any existing regulation in Ohio. All regulation regarding nursing facility-based level of care are promulgated by ODM. The regulation was reviewed by ODM's legal and legislative staff to ensure that there is no duplication within the rules.

OAC 5160-3-15.1

The Ohio Department of Medicaid (ODM) collaborated with Ohio Department of Aging (ODA), Ohio Department of Mental and Addiction Services (MHAS) and Ohio Department of Developmental Disabilities (DODD) as partner agencies also responsible for the implementation of PASRR to ensure that the agencies' respective rules and the processes set forth therein are well coordinated and are not duplicative.

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.**

OAC 5160-3-14

Ohio Department of Medicaid (ODM) is coordinating with Ohio Department of Aging (ODA) to implement rule flexibilities and assist their administrative agencies in the transition. ODM continues to engage stakeholders throughout the process to gather feedback and assist with inquiries from all impacted parties.

OAC 5160-3-15.1

The Ohio Department of Medicaid (ODM) has coordinated with Ohio Department of Aging (ODA), Ohio Mental and Addiction Services (MHAS), and Ohio Department of Developmental Disabilities (DODD) as partner agencies also responsible for the implementation of PASRR to implement new rules for a smooth and uniform transition throughout Ohio. ODM provided training that remains posted on the ODM website and made available to the public. ODM also continues to coordinate with and engage ODA, MHAS, and DODD to implement rule flexibilities and gather feedback.

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

b. Identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance,); and

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a. Identify the scope of the impacted business community;

OAC 5160-3-14

The businesses impacted by these rules are nursing facilities in Ohio.

OAC 5160-3-15.1

This rule impacts approximately 954 nursing facilities in Ohio that choose to participate in the Medicaid program.

b. Identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance,); and

OAC 5160-3-14

This rule requires that a level of care assessment is completed for individuals seeking enrollment on a nursing facility-based home and community-based services (HCBS) waiver or Medicaid payment for a long-term nursing facility stay. After a level of care assessment has been completed, the nursing facility must complete a level of care request in order to receive Medicaid payment. When a level of care request is determined to be incomplete and the submitter does not complete the request within the allotted fourteen-calendar day timeframe, the request is denied and the nursing facility would not be eligible for payment from Medicaid for an individual without a qualifying level of care.

OAC 5160-3-15.1

Compliance with PASRR regulations is mandatory in accordance with 42 C.F.R. 483.100-483.138. Medicaid-certified nursing facilities are required to screen individuals seeking admission to a Medicaid-certified nursing facility for indications of serious mental illness (SMI) and/or a developmental disability (DD) and not admit such individuals unless a thorough evaluation indicates that such placement is appropriate and adequate services will be provided regardless of payor source prior to admission.

In order to complete the preadmission screening process, nursing facilities must submit a level 1 screening via ODM's designated electronic system. Nursing facilities must also submit specific forms to report an individual being admitted directly from a hospital or admitted for short-term stay under a categorical determination of an emergency or respite NF stay. Nursing facilities must also provide individuals with notice of any adverse determinations made during the screening process.

c. Quantify the expected adverse impact from the regulation

OAC 5160-3-14

This rule requires that a level of care assessment be submitted for individuals seeking enrollment on a nursing facility-based HCBS waiver or Medicaid payment for a long-term nursing facility stay. The rule also requires that a subsequent level of care request be submitted for nursing facilities seeking Medicaid payment for individuals. The denial of an incomplete level of care request would have an adverse impact on nursing facilities as the facility would not be eligible for payment from Medicaid for an individual without a qualifying level of care.

OAC 5160-3-15.1

Medicaid-certified nursing facilities are responsible for ensuring that individuals seeking admission to their facility are screened for evidence of serious mental illness (SMI) and/or developmental disabilities (DD) or related conditions, regardless of payor source, and for referring individuals who show indications of an SMI and/or DD to Ohio Department of Mental Health and Addiction Services (MHAS) and/or Ohio Department of Developmental Disabilities (DODD) for a Level II evaluation and determination prior to granting admission.

The previous adoption of these rules as part of the five-year rule review process required that both Level I screenings and resident review submissions be conducted electronically, which proved beneficial in reducing the amount of time previously spent manually submitting screening requirements. Electronic submission has also enabled the nursing facility to receive instant determinations for individuals that do not have indications of an SMI and/or DD and allow for immediate referral to MHAS and/or DODD for a Level II evaluation, when applicable. Electronic submission has enabled nursing facilities to track the screening and resident reviews which is useful for follow ups. Overall, electronic submission of preadmission screening and resident reviews has proven beneficial to individuals seeking admission to a Medicaid-certified nursing facility by eliminating unnecessary delays when processing required PASRR documents.

The costs associated with completing the required PASRR documents would be estimated by calculating the average timeframe to complete the screening or review and the average hourly salary of the employee submitting the screening or review.

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

OAC 5160-3-14

The intent of a level of care determination process is to ensure an individual's needs can safely be met either in a nursing facility or in the community via a home and community-based services (HCBS) waiver. It is important that the individual's needs are met in the least restrictive setting possible. Any adverse impact on the provider community is consistent with other Ohio Medicaid provider practices related to ensuring the safety and well-being of the individuals served by the Medicaid program.

By offering the flexibilities in the proposed amendments, there is potential for reduction in costs associated with level of care assessments. In collaboration with Ohio Department of Aging (ODA), Ohio Department of Medicaid (ODM) confirmed that the existence of the telephonic option has improved timeliness in submitting the assessments. While preliminary cost estimates have not been finalized, preliminary data suggests administrative agencies will experience reduction in time and resources needed to complete level of care assessments.

OAC 5160-3-15.1

The adverse impact associated with the proposed rules are justified because the rules implement the federally mandatory program pursuant to 42 C.F.R. 483, Subpart C.

Additionally, the proposed rule amendments to allow multiple means of screening and evaluation including telephonic, video conference, or desk review will further remove unnecessary delays and be more efficient.

Regulatory Flexibility

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

OAC 5160-3-14

Not applicable for this program.

OAC 5160-3-15.1

No. The provisions in the proposed rules are the same for all Medicaid-certified nursing facilities.

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?

OAC 5160-3-14

ORC section 119.14 is not applicable to these regulations.

OAC 5160-3-15.1

ORC section 119.14 is not applicable to these regulations.

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

OAC 5160-3-14

All impacted entities may contact the Bureau of Long-Term Services and Supports and send inquiries via email at PASRR@medicaid.ohio.gov. Entities may also request copies of previous trainings via the aforementioned email.

OAC 5160-3-15.1

Nursing facilities and all impacted entities in need of assistance may contact the Bureau of Long-Term Services and Supports and send inquiries via email at PASRR@medicaid.ohio.gov and access trainings via the Ohio Department of Medicaid website.