CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Department of Medicaid

Regulation/Package Title: Five-Year Review – Nursing Facility Cost Report Rules

Rule Number(s): 5160-3-20 (Amend), 5160-3-42.1 (Rescind)

Date: September 8, 2016

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- ☑ Rescinded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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5160-3-20

This rule sets forth the Medicaid cost report filing, record retention, and disclosure provisions for nursing facilities and state operated intermediate care facilities for individuals with intellectual disabilities (ICFs-IID). This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being proposed for amendment. The changes to the rule are:

- The rule title is being modified to be consistent with the titles of other nursing facility rules in Chapter 5160-3 of the Administrative Code.
- Throughout the rule, "ICF-MR" is being changed to "ICF-IID" because the terminology has been updated.
- In the opening paragraph, reference to the Medicaid Nursing Facility Cost Report as found in Appendix A to OAC rule 5101:3-3-42.1 (now 5160-3-42.1), including its supplements and attachments or other approved forms for state operated ICFs-IID, is being deleted. The reference to the cost report is being deleted because Appendix A to rule 5160-3-42.1 was removed from the rule in a previous rule filing and the cost report is now posted on the Department of Medicaid's website. The reference to other approved forms for state operated ICFs-IID is being deleted because it is no longer necessary.
- New language is being added in the opening paragraph that requires nursing facilities to file the Medicaid cost report via the Medicaid Information Technology System (MITS) web portal or other electronic means designated by the Department of Medicaid because web portal submission currently is the Department's preferred method of filing cost reports and is consistent with the method currently used by other Medicaid providers.
- Also in the opening paragraph, the provision that the Department shall issue the appropriate software for an electronically submitted cost report not later than 60 days prior to the initial due date of the cost report is being deleted because the provision is contained in the Revised Code. Additionally, the provision that requires the Department of Medicaid to issue an approved list of vendors is being deleted because the provision is obsolete.
- In paragraph (A)(1)(a), language is being changed to specify that, for the first calendar year a provider has a provider agreement, if the provider agreement goes into effect after October first of that calendar year, the provider shall file the first cost report for the immediately following calendar year. This change is being made to be consistent with statute, and because this rule is eliminating language regarding three-month cost reports.
- Provisions regarding three-month cost reports for a new facility or in cases of a change of operator are being deleted because the Department of Medicaid no longer requires nursing facilities to file three-month cost reports.
- In paragraph (A)(3), a sentence is being added to clarify that the late file penalty may be assessed even if the Department of Medicaid has provided written notice of termination to a facility. Also in paragraph (A)(3), the requirement regarding adjustment of the late file penalty for inflation each July first is being deleted because that provision is no longer

contained in the Revised Code. Additionally, the late file penalty period is being changed to begin on the day after the original due date or, if applicable, on the day after the extension due date instead of on the date the Department of Medicaid issues its written notice in order to be consistent with current Department of Medicaid practices.

- In paragraph (C), the provision is being deleted that requires the Department of Medicaid to notify the facility of any information on the cost report that requires further support before issuing the preliminary determination of whether the reported costs are allowable costs. In addition, the sequence of activities is being changed so that the facility shall provide any documentation or other information requested by the Department of Medicaid and may submit any information it believes supports its reported costs after the Department notifies the facility of any costs preliminarily determined not to be allowable and the reasons for the determination. These changes are being made in order to be consistent with current Department of Medicaid practices.
- In new paragraph (H), language regarding publicly owned and traded corporations is being deleted so the ownership disclosure requirements for these types of nursing facilities are consistent with the ownership disclosure requirements for non-publicly owned and traded corporations.
- In new paragraph (H)(5), references to the Social Security Act are being updated and dates are being added in order to comply with Joint Committee on Agency Rule Review (JCARR) rule filing requirements.
- In new paragraph (H)(6), in order to be consistent with current Department of Medicaid procedure, the Office of the Auditor of State is being added to the list of organizations for which a provider must identify previous employment for individuals who are currently employed by or under contract with the provider or related party organization in a managerial, accounting, auditing, legal, or similar capacity.
- In new paragraph (I), the reference to audit provisions contained in 42 C.F.R. 420 subpart (D) is being deleted because the reference is not necessary.
- In new paragraph (J), new language is being added specifying that financial, statistical, and medical records supporting cost reports or claims shall also be available to the Department of Medicaid's authorized agent in order to be consistent with current Department of Medicaid practices.
- In new paragraph (K)(1), the depreciation value of depreciable equipment is being changed from $500 or more per item to $5,000 or more per item.
- Also in new paragraph (K)(1), the provision regarding costs of equipment acquired by an operating lease executed before December 1, 1992 reported in the ancillary/support cost component of the cost report is being deleted because it is no longer necessary.
- Ohio Administrative Code references are being updated due to the creation of the Ohio Department of Medicaid by Am. Sub. HB 59 of the 130th General Assembly and the subsequent renumbering of rules by the Legislative Services Commission.
- Ohio Revised Code citations are being updated because Am. Sub. HB 59 of the 130th

General Assembly created the Ohio Department of Medicaid, and subsequently relocated and reorganized many Revised Code provisions governing the Medicaid program.

- The Department's name is being updated from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM) because of the creation of the Ohio Department of Medicaid.
- Paragraph references and designations are being updated as necessary.
- Phrasing and grammatical changes are being made to improve clarity, comprehension, and readability.

5160-3-42.1

This rule sets forth sets forth provisions regarding the Medicaid nursing facility cost report. This rule was reviewed pursuant to a five-year rule review. As a result of that review, this rule is being proposed for rescission because the provisions in it are contained in other rules in Chapter 3 of the Administrative Code.

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

   Ohio Revised Code section 5165.02.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

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   This rule does not implement any federal requirement.

   5160-3-42.1

   Not applicable. This rule is being proposed for rescission.

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

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   Not applicable. This rule does not exceed any federal requirement.

   5160-3-42.1

   Not applicable. This rule is being proposed for rescission.

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)?**

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The public purpose of this rule is to ensure the integrity of the information in Medicaid nursing facility cost reports so that nursing facility rates may be set and paid accurately.

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Not applicable. This rule is being proposed for rescission.

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

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The success of this rule will be measured by the extent to which the various requirements specified in this rule are met, in particular the provisions regarding submission due dates and submission of revised and amended cost reports.

5160-3-42.1

Not applicable. This rule is being proposed for rescission.

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 July 1, 2016.

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

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Two stakeholders commented that costs reported on the disputed costs addendum should no longer be considered in establishing a facility's prospective rate. The Department of Medicaid did not amend the draft rule as a result of this comment because the disputed costs on the addendum may be relevant for rebasing purposes.

Two stakeholders commented that language regarding costs of equipment acquired by an operating lease executed before December 1, 1992 should be removed from the draft rule because any equipment lease from that time should now be paid off. The Department of Medicaid agreed with this comment and amended the draft rule as a result.

One stakeholder requested a blanket waiver of the cost report requirement for closing facilities. The Department of Medicaid did not amend the draft rule as a result of this comment because the Department uses these cost reports to compare depreciable costs of assets as reported by the exiting provider and the entering provider in cases of a change of provider. They also are used for revenue information to ensure franchise fees don't exceed the federal regulatory maximum.

One stakeholder suggested eliminating several schedules and attachments from the cost report because they feel the schedules and attachments are no longer necessary due to the current nursing facility pricing system. The Department of Medicaid did not eliminate any schedules or attachments from the cost report as a result of this comment because the Department believes the schedules and attachments in question are valuable reporting tools.

One stakeholder made numerous suggestions for changes to the cost report. The Department of Medicaid did not make any changes to the cost report at this time as a result of this comment because the Department will consider these suggested changes when it implements future changes to the cost report for operational purposes.

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No input was provided by stakeholders.

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 were not considered appropriate.

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

    These rules have been reviewed by the Department of Medicaid's staff, including legal and legislative staff, to ensure there is no duplication within the Department of Medicaid's rules or any others in the OAC.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

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

Adverse Impact to Business

14. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**
    a. **Identify the scope of the impacted business community;**

Provider participation in the Medicaid program is optional and at the provider's discretion. These rules impact approximately 960 nursing facilities and 10 state operated ICFs-IID in Ohio that choose to participate in the Medicaid program.

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

Compliance with Medicaid program requirements is mandatory for providers who choose to participate in the program, and may result in administrative costs as detailed below.

c. Quantify the expected adverse impact from the regulation.

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

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b.) Nursing facilities and state operated intermediate care facilities for individuals with intellectual disabilities (ICFs-IID) must file Medicaid cost reports with the Department of Medicaid within 90 days after the end of the reporting period via the Medicaid Information Technology System (MITS) web portal or other electronic means designated by the Department.

Providers that want a cost report filing extension must submit a written request to the Department of Medicaid explaining the circumstances resulting in the need for an extension.

Facilities may incur a late file penalty of $2.00 per patient day for each day a complete and adequate cost report is not received by the original due date, or by an approved extension due date if applicable, regardless of the written notification of termination.

After the Department of Medicaid notifies facilities of any costs preliminarily determined by a desk review not to be allowable and the reasons for the determination, facilities must provide any documentation or other information requested by the Department of Medicaid and may submit any information they believe supports their reported costs.

A facility may revise a cost report within 60 days after the original due date without the revised information being considered an amended cost report.

After final rates have been issued, a provider that disagrees with a desk review decision may request a rate reconsideration.

Not later than three years after a provider files a Medicaid cost report, the provider may amend the cost report if the provider discovers a material error in the cost report or additional information to be included in the cost report.

Providers are required to identify on the cost report all known related parties as set forth under paragraph (G) of OAC rule 5160-3-01.

Providers are required to provide upon request all contracts in effect during the cost report period for which the cost of the service from any individual or organization is $10,000.00 or more in a 12-month period.

c.) The Department of Medicaid estimates it will take a nursing facility or state operated ICF-IID provider's accountant approximately 15 hours at the rate of approximately $25.32 per hour (total estimated cost: $379.80) to prepare one Medicaid cost report and file it via the MITS web portal or other electronic means designated by the Department of Medicaid.

The Department of Medicaid estimates it will take a provider's attorney approximately 1 hour at the rate of approximately $250.00 per hour (total estimated cost: $250.00) to prepare and submit one written request for a cost report filing extension.

The Department of Medicaid cannot estimate the cost of compliance to facilities regarding the $2.00 per patient day late file penalty because the Department of Medicaid does not know how many facilities will file late cost reports and incur late file penalties.

The Department of Medicaid estimates it will take a facility's accountant approximately 2 hours at the rate of approximately $25.32 per hour (total estimated cost: $50.64) to prepare and submit documentation and information requested by the Department of Medicaid, and to submit any information the facility believes supports its reported costs after the Department of Medicaid notifies the facility of any costs preliminarily determined by a desk review not to be allowable.

The Department of Medicaid estimates it will take a facility's accountant approximately 8 hours at the rate of approximately $25.32 per hour (total estimated cost: $202.56) to prepare and submit one revised cost report.

The Department of Medicaid estimates it will take a provider's attorney approximately 2 hours at the rate of approximately $250.00 per hour (total estimated cost: $500.00) to prepare a rate reconsideration. The Department of Medicaid further estimates it will take a provider's accountant approximately 8 hours at the rate of approximately $25.32 per hour (total estimated cost: $202.56) to assist in the preparation of the rate reconsideration. The Department of Medicaid therefore estimates it will cost a total of approximately $702.56 to prepare and submit one rate reconsideration.

The Department of Medicaid estimates it will take a provider's accountant approximately 8 hours at the rate of approximately $25.32 per hour (total estimated cost: $202.56) to prepare and submit one amended cost report.

The Department of Medicaid estimates it will take a provider's office staff approximately 1 hour at the rate of approximately $12.50 per hour (total estimated cost: $12.50) to identify all known related parties.

The Department of Medicaid estimates it will take a provider's office staff approximately 1 hour at the rate of approximately $12.50 per hour (total estimated cost: $12.50) to provide upon request all contracts in effect during the cost report period for which the cost of the service from any individual or organization is $10,000 or more in a 12-month period.

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b.) Nursing facility providers must file cost reports as required in OAC rules 5160-3-20 and 5160-3-42 using software that is available on the Department of Medicaid website at least sixty days before the due date of the cost report for each cost reporting period via the Medicaid Information Technology System (MITS) web portal or other electronic means designated by the Department.

c.) The Department of Medicaid estimates it will take a nursing facility provider's accountant approximately 15 hours at the rate of approximately $25.32 per hour (total estimated cost: $379.80) to prepare and file one Medicaid nursing facility cost report via the MITS web portal.

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

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The adverse impact to nursing facilities and state operated ICFs-IID associated with this rule is justified because this rule amplifies ORC section 5165.10, which requires nursing facility and ICF-IID providers to file annual cost reports for each facility they own/operate that participates in the Medicaid program. It sets forth provisions that are not contained in the Revised Code such as filing deadlines and extensions, late file penalties, and submission of revised and amended cost reports that are important to the efficient and effective administration of the Medicaid program and to the business operations of nursing facility providers.

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The adverse impact to nursing facilities associated with this rule is justified because this rule helps ensure the efficient filing of Medicaid cost reports for approximately 960 Ohio nursing facilities.

Regulatory Flexibility

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

No. The provisions in these rules are the same for all nursing facility and state operated ICF-IID providers regardless of the size of the facility.

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 because these regulations do not impose any fines or penalties for paperwork violations as defined in ORC section 119.14.

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

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