CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Nursing Facility Personal Needs Allowance (PNA) Rule

Rule Number(s): 5160-3-16.5 (Amend)

Date: May 11, 2017

Rule Type:

New	☑ 5-Year Review
☑ Amended	Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

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

This rule sets forth the provisions for the management and use of nursing facility personal needs allowance accounts and other resident funds. This rule is being proposed for amendment. The changes to the rule are:

- In the opening paragraph, the date of a Code of Federal Regulations citation is being

updated in order to comply with Joint Committee on Agency Rule Review (JCARR) rule filing requirements.

- References to several Division 1 rules are being deleted because these rules have been rescinded. In one such instance, in paragraph (F)(1)(a), the reference to the rescinded Division 1 rules is being replaced with references to the supplemental security income resource limits specified in the Social Security Act.
- In new paragraph (A)(1), the acronym PNA is being spelled out for purposes of clarity.
- In paragraph (H)(3)(b), a correction is being made to the name to which checks or money orders are to be made payable when PNA funds are transferred to ODM.
- Also in paragraph (H)(3)(b), the revision date of the ODM 09405 form is being updated, and the name of the form is being corrected.
- In paragraph (I)(3), language is being added so that a NF provider that operates multiple facilities only must submit copies of the multi-facility surety bond or reasonable alternative to ODM for review and approval upon request.
- In paragraph (M)(2), language is being added to clarify that the items that may be charged to a resident's PNA account include a cellular phone, and personal computer or other electronic device.
- In paragraph (N), language is being changed so that the CDJFS must monitor PNA accounts at least annually instead of at least once a quarter.
- Paragraph references are being updated as necessary.
- Grammatical changes are being made to improve readability.

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

   Ohio Revised Code section 5165.02

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

   This proposed rule implements federal requirements in 42 CFR 483.10(f)(10) through (f)(11), which specify resident rights concerning resident funds, including:

   - deposit of funds
   - accounting and records
   - notice of certain balances
   - conveyance of funds upon discharge, eviction, or death
   - assurance of financial security
   - items and services that may be charged to residents' funds
   - requests for items and services.

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

The Department believes the provisions in this rule that exceed federal requirements are necessary to ensure that residents have access to their personal funds on deposit with the provider, and that those funds are properly managed. Provisions in this rule that exceed federal requirements include the following:

- A provider must explain to the resident or the resident's representative that PNA funds are for the resident to use as he or she chooses.
- Upon request, a provider must furnish receipts to a resident or the resident's representative for purchases made with the resident's PNA funds.
- Within 30 days after the end of each quarter, a provider must provide a written quarterly statement to each resident or resident's representative of the financial transactions made by the provider on the resident's behalf.
- Requires the local County Department of Job and Family Services (CDJFS) to monitor PNA accounts.

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)?**

The public purpose of this rule is to implement federal resident rights regulations regarding resident funds. It is also to ensure that nursing facility residents have access to their personal funds and that those funds are properly managed.

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

The success of this rule will be measured by the extent to which 1) residents have access to their personal funds, and 2) residents' personal funds are well managed by providers.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
If applicable, please include the date and medium by which the stakeholders were initially contacted.

The primary stakeholders are Ohio's three nursing facility provider associations. The nursing facility provider associations in Ohio are:

- Ohio Health Care Association (OHCA)
- The Academy of Senior Health Sciences, Inc.
- LeadingAge Ohio

Ohio's nursing facility provider associations represent and advocate for small and large nursing facilities and nursing facilities with both individual and group ownership, publicly-traded and government-owned properties, and for-profit and non-profit facilities. In addition to representing and advocating for nursing facilities, the associations are informational and educational resources to Ohio's nursing facilities, their suppliers, consultants, and the public at large.

The nursing facility provider associations were involved in review of draft rule 5160-3-16.5 when the Department of Medicaid emailed the draft rule and a summary of the rule changes to the associations on May 1, 2017.

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

   No clearance comments were received from the nursing facility provider associations.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

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

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    No alternative regulations were considered. The Department considers Administrative Code rules the most appropriate type of regulation for the provisions contained in these rules.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    Performance-based regulations were not considered appropriate.

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

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

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

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

Adverse Impact to Business

14. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**
    a. **Identify the scope of the impacted business community;**
    Provider participation in the Medicaid program is optional and at the provider's discretion. These rules impact approximately 960 nursing facilities in Ohio that choose to participate in the Medicaid program.

    b. **Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and**
    Compliance with Medicaid program requirements is mandatory for providers who choose to participate in the program, and may result in administrative costs as detailed below.

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

b.) In accordance with paragraph (C)(3), upon authorization by a resident, a nursing facility provider must hold, safeguard, manage, and account for personal funds deposited with the provider.

In accordance with paragraph (C)(4), a nursing facility provider must explain verbally and in writing to a resident or the resident's representative that PNA funds are for the resident to use as he or she chooses.

In accordance with paragraph (D)(2), if a resident's PNA account funds are in excess of $50.00, a nursing facility provider must deposit the funds in an interest bearing account (or

accounts) separate from any of the provider's operating accounts within 5 banking days from the date the balance exceeds $50.00.

In accordance with paragraph (D)(3), a nursing facility provider must credit any interest earned on a resident's PNA funds to the resident's PNA account balance. If pooled accounts are used, the provider must prorate interest per resident on the basis of actual earnings or end-of-quarter balance.

In accordance with paragraph (E)(1), a nursing facility provider must establish and maintain a system that ensures full, complete, and separate accounting of each resident's PNA account funds.

In accordance with paragraph (E)(3), a nursing facility provider must provide a resident with access to petty cash (less than $50.00) on an ongoing basis and must arrange for the resident to access larger funds ($50.00 or more).

In accordance with paragraph (E)(3), a nursing facility provider must give residents a receipt for every PNA transaction, and the provider must retain a copy of the receipt.

In accordance with paragraph (E)(4), a nursing facility provider must obtain a resident's signature upon the resident's receipt of PNA funds.

In accordance with paragraph (E)(5), a nursing facility provider must maintain an individual ledger account of revenue and expenses for each PNA account managed by the facility. The ledger account must meet the following criteria:

- Specify all funds received by or deposited with the NF provider. For PNA account funds deposited in banks, monies must be credited to the resident's bank account within 3 business days.
- Specify the dates and reasons for all expenditures.
- Specify at all times the balance due the resident, including interest earned as last reported by the bank to the provider.
- Be available to the resident or the resident's representative for review.

In accordance with paragraph (E)(6), upon request, a nursing facility provider must provide receipts to a resident or the resident's representative for purchases made with the resident's PNA funds.

In accordance with paragraph (E)(7), within 30 days after the end of the quarter, a nursing facility provider must provide a written quarterly statement to each resident or resident's representative of all financial transactions made by the provider on the resident's behalf.

In accordance with paragraph (F)(1)(a), a nursing facility provider must give written notification to each resident who receives Medicaid benefits, and whose funds are managed by the provider, when the amount in the resident's PNA account reaches $200 less than the supplemental security income resource limit specified in the Social Security Act. In accordance with paragraph (F)(1)(c), a copy of the notice to the resident must be retained in the resident's file.

In accordance with paragraph (F)(2), a nursing facility provider must report to the county Department of Job and Family Services (CDJFS) any PNA account balance in excess of the resource limit.

In accordance with paragraph (F)(3), if a resident is considering using PNA funds to purchase life insurance, grave space, a burial account, or other item that may be considered a countable resource, the nursing facility provider must refer the resident or the resident's representative to the CDJFS for an explanation of the effect the purchase may have on the resident's Medicaid eligibility.

In accordance with paragraph (G)(1), upon discharge of a resident, a nursing facility provider must release all the resident's funds, up to and including the maximum resource limit amount.

In accordance with paragraphs (H)(1) and (H)(2), within 30 or 60 days after the death of a resident, whichever is applicable, if letters testamentary or letters of administration are issued, or an application for release from administration is filed, a nursing facility provider must transfer the funds in a resident's PNA account and provide a final accounting of those funds to the administrator, executor, commissioner, or person who filed the application for release from administration.

In accordance with paragraph (H)(3)(a), if within 60 days after a resident's death letters testamentary or letters of administration are not issued, or an application for release from administration is not filed, the nursing facility provider must transfer all the resident's PNA account funds to the Department of Medicaid no earlier than 60 and no later than 90 days after the death of the resident.

In accordance with paragraph (H)(3)(b), a nursing facility provider that transfers PNA account funds to the Department of Medicaid must pay by check or money order made payable to Attorney General's Office. The check must be accompanied by a completed ODM

09405 form entitled Personal Needs Allowance (PNA) Account Remittance Notice, and both must be mailed to the Ohio Attorney General's office.

In accordance with paragraph (H)(3)(c), a nursing facility provider must use PNA account funds to pay funeral and/or burial expenses for a deceased resident if those expenses have not been paid and all the resident's resources other than the PNA have been exhausted.

In accordance with paragraph (I), a nursing facility provider must purchase a surety bond or provide a reasonable alternative to a surety bond as described in this rule to protect all resident funds deposited with and managed by the provider. In accordance with paragraph (I)(1), the surety bond must meet the following requirements:

- Executed by a licensed surety company pursuant to ORC Chapters 1301., 1341., and 3929.
- At a minimum, must have coverage that protects at all times the full amount of resident funds deposited with the provider, including interest earned and refundable deposit fees.
- Provides for repayment of funds lost due to any failure of the provider, whether by commission, bankruptcy, omission, or otherwise, to hold, safeguard, manage, and account for resident funds.
- Designates either the provider, or ODM on behalf of the resident, as the obligee.
- If an entity purchases a surety bond that covers more than one of its facilities, the surety bond must protect the full amount of all resident funds on deposit in all the entity's facilities.

In accordance with paragraph (I)(2), a nursing facility provider that elects not to purchase a surety bond must submit a proposal of an alternative to the Department of Medicaid for approval. An acceptable alternative must meet all the following criteria:

- At a minimum, protect at all times the full amount of resident funds deposited with the provider, including interest earned and refundable deposit fees.
- Designate either ODM or the residents of the facility as the entity or entities that will collect payment for lost funds.
- Guarantee repayment of funds lost due to any failure of the provider, whether by commission, bankruptcy, omission, or otherwise, to hold, safeguard, manage, and account for resident funds.
- Be managed by a third party unrelated in any way to the provider or its management.
- Not name the provider as a beneficiary.

In accordance with paragraph (I)(3), a nursing facility provider or entity that operates multiple facilities must submit copies of either the multi-facility surety bond or a reasonable

alternative to the multi-facility surety bond to the Department of Medicaid upon request for review and approval.

In accordance with paragraph (I)(3), if a nursing facility provider, surety company, or issuer of an ODM-approved surety bond alternative cancels the required surety bond or reasonable alternative to a surety bond, the provider must notify the Department of Medicaid by certified mail 30 days prior to the effective date of the cancellation.

In accordance with paragraph (J)(2), a nursing facility provider must inform residents of the coverage and limitations of the Medicare and Medicaid programs. If a resident's representative is the payee for the resident's PNA account, the provider also must explain the coverage and limitations to the representative.

In accordance with paragraph (L)(3), when a resident requests an item or service for which a charge to the resident's PNA account will be made, the nursing facility provider shall inform the resident that there will be a charge and the amount of the charge.

In accordance with paragraph (M)(1), if a resident clearly expresses a desire for a particular brand or item not available from a nursing facility provider, PNA funds may be used as long as a comparable item of reasonable quality is available to the resident from the provider at no charge. In such cases, the provider must charge the resident's PNA account only the difference in cost between the available item and the resident's preferred item.

c.) The Department of Medicaid cannot estimate the adverse impact to a nursing facility provider to hold, safeguard, manage, and account for personal funds deposited with the provider because the Department cannot estimate the amount of personal funds any particular facility might manage or how many transactions the facility might handle, and because business practices vary widely from provider to provider.

The Department of Medicaid estimates nursing facility staff will spend approximately 20 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $4.13) to explain verbally and in writing to a resident or the resident's representative that PNA funds are for the resident to use as he or she chooses.

The Department of Medicaid cannot estimate the adverse impact to a nursing facility provider to deposit a resident's PNA account funds in excess of $50.00 in an interest bearing account because business practices vary from provider to provider, and banking processes and fees vary.

The Department of Medicaid estimates nursing facility staff will spend approximately 5 minutes per month at an estimated rate of approximately $12.50 per hour (total estimated cost: $1.04) to credit any interest earned on a resident's PNA funds to the resident's PNA account balance.

The Department of Medicaid cannot estimate the adverse impact to a nursing facility provider to establish and maintain a system that ensures full, complete, and separate accounting of each resident's PNA account funds because business practices vary from provider to provider, and the Department cannot estimate how many PNA accounts any particular facility might manage at any particular time.

The Department of Medicaid cannot estimate the adverse impact to a nursing facility provider to provide a resident with access to petty cash (less than $50.00) on an ongoing basis and arrange for the resident to access larger funds ($50.00 or more) because business and operational practices vary widely from provider to provider, and banking processes and fees vary.

The Department of Medicaid estimates nursing facility staff will spend approximately 5 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $1.04) to provide and retain a receipt for one PNA transaction.

The Department of Medicaid estimates nursing facility staff will spend approximately 5 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost $1.04) to obtain a resident's signature upon the resident's receipt of PNA funds.

The Department of Medicaid cannot estimate the adverse impact to a nursing facility provider to maintain an individual ledger account of revenue and expenses for each PNA account managed by the facility because business practices vary from provider to provider, and the Department cannot estimate how many transactions any particular facility might need to record in any particular time period for any particular resident.

The Department of Medicaid estimates nursing facility staff will spend approximately 5-15 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $1.04 - $3.13) to provide receipts to a resident or the resident's representative for purchases made with the resident's PNA funds.

The Department of Medicaid cannot estimate the adverse impact to a nursing facility provider to provide a written quarterly statement to each resident or resident's representative of all financial transactions made by the provider on the resident's behalf because the

Department does not know how many PNA accounts any particular facility might manage or how many transactions any particular resident might make, and because business practices vary from provider to provider.

The Department of Medicaid estimates nursing facility staff will spend approximately 15 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $3.13) to give written notification to a resident who receives Medicaid benefits, and whose funds are managed by the provider, when the amount in the resident's PNA account reaches $200 less than the supplemental security income resource limit specified in the Social Security Act, and to keep a copy of the notice in the resident's file.

The Department of Medicaid estimates nursing facility staff will spend approximately 10 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $2.08) to report to the county Department of Job and Family Services (CDJFS) any PNA account balance in excess of the resource limit.

The Department of Medicaid estimates nursing facility staff will spend approximately 15 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $3.13) to refer a resident or the resident's representative to the CDJFS for an explanation of the effect a purchase may have on the resident's Medicaid eligibility if the resident is considering using PNA funds to purchase life insurance, grave space, a burial account, or other item that may be considered a countable resource.

The Department of Medicaid cannot estimate the adverse impact to a nursing facility provider to release all a resident's funds upon discharge of the resident because business practices vary from provider to provider, and banking processes and fees vary.

The Department of Medicaid cannot estimate the adverse impact to a nursing facility provider to transfer the funds in a resident's PNA account and provide a final accounting of those funds to the administrator, executor, commissioner, or person who filed the application for release from administration because business practices vary from provider to provider, and banking processes and fees vary.

The Department of Medicaid estimates nursing facility staff will spend approximately 20 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $4.13) to transfer all a resident's PNA account funds to the Department of Medicaid after the death of the resident.

The Department of Medicaid estimates nursing facility staff will spend approximately 20 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $4.13) to

send a check or money order and a completed ODM 09405 form to the Ohio Attorney General's office when transferring PNA account funds to the Department of Medicaid.

The Department of Medicaid estimates nursing facility staff will spend approximately 5 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $1.04) to pay funeral and/or burial expenses for a deceased resident.

The Department of Medicaid cannot estimate the adverse impact to a nursing facility provider to purchase a surety bond or provide a reasonable alternative to a surety bond as described in this rule to protect all resident funds deposited with and managed by the provider and that meets the requirement of this rule because the Department cannot estimate the amount of resident funds deposited at any particular time with any particular nursing facility.

The Department of Medicaid estimates it will take a nursing facility provider's attorney approximately 1-2 hours at the rate of approximately $250.00 per hour (total estimated cost: $250.00 - $500.00) to submit a proposal of a surety bond alternative that meets the criteria in this rule to the Department of Medicaid for approval.

The Department of Medicaid estimates nursing facility staff will spend approximately 10 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $2.08) to submit copies of either the multi-facility surety bond or a reasonable alternative to the multi-facility surety bond to the Department of Medicaid upon request for review and approval.

The Department of Medicaid estimates nursing facility staff will spend approximately 15 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $3.13) to notify ODM if a surety bond or reasonable alternative to a surety bond is cancelled. Additionally, the Department of Medicaid estimates it will cost $6.59 to send the notification by certified mail with return receipt (green card) via the U.S. Postal Service. The Department of Medicaid therefore estimates the total cost of this requirement is approximately $9.72.

The Department of Medicaid estimates nursing facility staff will spend approximately 5 minutes – 1 hour at an estimated rate of approximately $12.50 per hour (total estimated cost: $1.04 - $12.50) to inform a resident, and the resident's representative if the representative is the resident's payee, of the coverage and limitations of the Medicare and Medicaid programs. The Department of Medicaid estimates the amount of time necessary to inform the resident and the resident's representative will depend upon whether the method used is written or face-to face, or a combination of the two.

The Department of Medicaid estimates nursing facility staff will spend approximately 5 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $1.04) to inform a resident that there will be a charge and the amount of the charge when the resident requests an item or service for which there will be a charge to the resident's PNA account.

The Department of Medicaid estimates nursing facility staff will spend approximately 5 minutes at an estimated rate of approximately $12.50 per hour (total estimated cost: $1.04) to charge a resident's PNA account the difference in cost between the resident's preferred item and a comparable item of reasonable quality available from the provider at no charge.

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

    The adverse impact to providers associated with this rule is justified because this rule implements federal regulations specified in 42 CFR 483.10(f)(10) through (f)(11).

Regulatory Flexibility

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

    No. The provisions in these rules are the same for all nursing facility providers regardless of size.

17. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

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

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

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