CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

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

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

Date: July 9, 2019

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- ☑ Rescinded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.

5160-3-20 (Rescind)

This rule sets forth the Medicaid cost report filing, disclosure requirement, and records retention provisions for nursing facilities (NFs) 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 rescission, and is being replaced by new rule 5160-3-20.

5160-3-20 (New)

This rule sets forth the Medicaid cost report filing, disclosure requirement, and records retention provisions for nursing facilities. The differences between the rescinded rule and the new rule are:

1. References to and provisions for state operated intermediate care facilities for individuals with intellectual disabilities (ICFs-IID) are being removed because provisions for state operated ICFs-IID are addressed in a separate rule of the Ohio Administrative Code.
2. A new opening paragraph is being added to incorporate Revised Code sections 5165.10 through 5165.109 into this rule.
3. Most of the provisions in the old opening paragraph are being moved to new paragraphs (A) and (B) and reorganized for enhanced readability.
4. Because it is contained in section 5165.10 of the Revised Code, the provision in the old opening paragraph is being deleted that states a cost report shall cover a calendar year or the portion of a calendar year during which a nursing facility participated in the Medicaid program, except as otherwise specified in this rule.
5. The provisions in old paragraph (A) are being added to new paragraphs (B) and (B)(1) for purposes of reorganization.
6. The provisions in old paragraphs (A)(1), and (A)(1)(a) are being deleted because they are contained in section 5165.10 of the Revised Code.
7. The provisions in old paragraphs (A)(1)(b) and (A)(1)(c) are being moved to new paragraphs (B)(4)(b) and (B)(4)(c) for purposes of reorganization.
8. The provisions in old paragraph (A)(2) are being deleted because they are contained in section 5165.106 of the Revised Code.
9. The provisions in old paragraph (A)(3) are being moved to new paragraph (B)(5) and reorganized for enhanced readability.
10. The provisions in old paragraph (B) are being deleted because they are contained in section 5165.105 of the Revised Code or are no longer necessary.
11. The provisions in paragraph (C) are being deleted because they are contained in section 5165.108 of the Revised Code.
12. The provisions in old paragraph (C)(1) are being moved to existing paragraph (C) for purposes of reorganization and is being slightly re-worded to better reflect the Department's desk review process.
13. Most of the provisions in existing paragraph (D) are being deleted because they are contained in

section 5165.107 of the Revised Code.

14. The interest provision contained in old paragraph (D)(2) is being moved to existing paragraph (D) for purposes of reorganization.
15. The dates cited for Title XVIII, Title XIX, and Title XX of the Social Security Act are being updated to comply with the Joint Committee on Agency Rule Review (JCARR) rule filing requirements.
16. Phrasing and grammatical changes are being made to improve clarity and readability.
17. Paragraph references are being updated as necessary.

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

5160-3-20 (Rescind) and 5160-3-20 (New)

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.

5160-3-20 (Rescind) and 5160-3-20 (New)

These rules do not implement any federal requirements.

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

5. 5160-3-20 (Rescind) and 5160-3-20 (New)

Not applicable. These rules do not exceed any federal requirements.

5. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

5160-3-20 (Rescind)

The public purpose of this rule is to ensure the integrity of the information in Medicaid NF and ICF-IID cost reports so that rates for these facilities may be set and paid accurately.

5160-3-20 (New)

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.

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

5160-3-20 (Rescind)

Not applicable. This rule is being proposed for rescission.

5160-3-20 (New)

The success of this rule will be measured by the extent to which cost reports are filed timely and in accordance with the requirements of this rule.

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 May 30, 2019.

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

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?**

5160-3-20 (Rescind)

Not applicable. This rule is being proposed for rescission.

5160-3-20 (New)

Scientific data was not applicable to the development of this rule.

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?**

5160-3-20 (Rescind)

Not applicable. This rule is being proposed for rescission.

5160-3-20 (New)

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.

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.***

5160-3-20 (Rescind)

Not applicable. This rule is being proposed for rescission.

5160-3-20 (New)

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?**

5160-3-20 (Rescind)

Not applicable. This rule is being proposed for rescission.

5160-3-20 (New)

The Department of Medicaid's staff reviewed the applicable ORC and OAC to ensure these rules do not duplicate any of the Department of Medicaid's rules or any other regulations in the ORC or OAC.

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

5160-3-20 (Rescind)

Not applicable. This rule is being proposed for rescission.

5160-3-20 (New)

The final rules as adopted by the Ohio Department of Medicaid will be posted on the Department's website at http://medicaid.ohio.gov/RESOURCES/LegalandContracts/Rules.aspx.

In addition, the Department will notify stakeholders during regular Provider Association meetings when the final rules become effective.

Adverse Impact to Business

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

b. and c.

5160-3-20 (Rescind)

In accordance with the opening paragraph of this rule, nursing facilities and state operated 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. The Department of Medicaid estimates it will take a provider's accountant approximately 15 hours at the rate of approximately $26.00 per hour (total estimated cost: $390.00) to prepare one Medicaid cost report and file it via the MITS web portal or other electronic means designated by the Department of Medicaid.

In accordance with paragraph (A) of this rule, a provider may submit a cost report within 14 days after the original due date if written approval from the Department of Medicaid is received prior to the original due date of the cost report. The provider also must submit a request for an extension in writing and explain the circumstances resulting in the need for an extension. The Department of Medicaid estimates it will take a facility's accountant approximately 1 hour at the rate of approximately $26.00 per hour (total estimated cost: $26.00) to comply with these requirements.

In accordance with paragraph (A)(2) of this rule, if a facility does not submit a cost report within 14 days after the original due date, or by the extension date granted by the Department of Medicaid, or submits an incomplete or inadequate report, the Department shall provide immediate written notice to the facility that it's provider agreement will be terminated in 30 days unless the facility submits a complete and adequate cost report within 30 days of receiving the notice. The adverse impact will be determined by the amount of the per diem rate multiplied by the number of residents multiplied by the number of days the facility would have received Medicaid payment if its provider agreement had not been terminated.

In accordance with paragraph (A)(3) of this rule, if a cost report is not received by the original due date, or by an approved extension due date if applicable, a nursing facility provider may be assessed a late file penalty for each day a complete and adequate cost report is not received. The Department of Medicaid cannot estimate the cost of compliance because the department does not know how many days any particular

nursing facility may be late in filing a cost report. However, the late file penalty is $2.00 per patient day, and the cost of compliance will be determined by using the prorated Medicaid days paid in the late file period multiplied by the $2.00 late file penalty.

In accordance with paragraph (B) of this rule, facilities must include an Addendum for Disputed Costs that may be used by a facility to set forth costs the facility believes may be disputed by the Department of Medicaid. The Department of Medicaid estimates it will take a facility's accountant approximately 1/2 hour at the rate of approximately $26.00 per hour (total estimated cost: $13.00) to provide an Addendum of Disputed Costs for inclusion with the cost report.

In accordance with paragraph (C) of this rule, a provider must furnish any documentation or other information requested by the Department of Medicaid when the Department conducts a desk review of the facility's cost report. The Department of Medicaid estimates it will take a provider's accountant approximately 1-3 hours at the rate of approximately $26.00 per hour (total estimated cost: $26.00 - $78.00) to comply with this requirement.

In accordance with paragraph (C)(2) of this rule, 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. The Department of Medicaid estimates it will take a facility's accountant approximately 8 hours at the rate of approximately $26.00 per hour (total estimated cost: $208.00) to prepare and submit one revised cost report.

In accordance with paragraph (C)(4) of this rule, a provider that disagrees with a desk review decision may request a rate reconsideration after final rates have been issued. 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 $26.00 per hour (total estimated cost: $208.00) to assist in the preparation of the rate reconsideration. The Department of Medicaid therefore estimates it will cost a total of approximately $708.00 to prepare and submit one rate reconsideration.

In accordance with paragraph (D) of this rule, a provider may amend a cost report if the provider discovers a material error in the cost report or additional information to be included in the cost report. The Department of Medicaid estimates it will take a provider's accountant approximately 1 – 3 hours at the rate of approximately $26.00 per hour (total estimated cost: $26.00 - $78.00) to amend one cost report.

In accordance with paragraph (D)(1) of this rule, if a nursing facility provider may not amend a cost report because ODM has notified the provider that an audit of the cost report or a cost report of the provider for a subsequent cost reporting period is to be conducted, the provider may provide the Department of Medicaid with information that affects the costs included in the cost report. The Department of Medicaid estimates it will take a nursing facility provider's accountant approximately 2 hours at the rate of approximately $26.00 per hour (total estimated cost: $52.00) to provide the department with information that affects the costs included in a cost report.

In accordance with paragraph (G) of this rule, 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. The Department of Medicaid estimates it will take a provider's accountant approximately 1 hour at the rate of approximately $26.00 per hour (total estimated cost: $26.00) to identify all known related parties.

Providers are required to identify all the entities specified in paragraph (H) of this rule. The Department of Medicaid estimates it will take a provider's accountant approximately 2 hours at the rate of approximately $26.00 per hour (total estimated cost: $52.00) to comply with this requirement.

In accordance with paragraph (I) of this rule, 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 or more in a 12-month period, or for the services of a sole proprietor or partnership where there is no cost incurred and the imputed value of the service is $10,000 or more in a 12-month period. The Department of Medicaid estimates it will take a provider's accountant approximately 1 hour at the rate of approximately $26.00 per hour (total estimated cost: $26.00) to comply with this requirement.

In accordance with paragraphs (J) through (J)(3) of this rule: Failure of a nursing facility to retain financial, statistical, and medical records supporting the cost reports or claims for services rendered to residents for the greater of 7 years after the cost report is filed if the Department of Medicaid issues an audit report, or 6 years after all appeal rights relating to the audit report are exhausted records renders the provider liable for a penalty of $1,000 per audit, or 25% of the amount by which the undocumented cost increased the Medicaid payments to the provider during the fiscal year. Failure to retain the required records to the extent that filed cost reports are not auditable shall result in the imposition of the same penalty. Providers whose records have been found to be not auditable will be allowed 60 days to provide the necessary documentation. If at the end

of the 60 days the required records have been provided and are determined auditable, the proposed penalty will be withdrawn. If ODM, after review of the documentation submitted during the 60-day period, determines the records are still not auditable, ODM shall impose the penalty. If a nursing facility provider refuses legal access to financial, statistical, or medical records, the penalty of $1,000 per audit or 25% of the amount by which the undocumented cost increased the Medicaid payments to the provider during the fiscal year shall be imposed for outstanding medical services until such time as the requested information is made available to the Department of Medicaid.

5160-3-20 (New)

In accordance with paragraph (B) of this rule, nursing facilities 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. The Department of Medicaid estimates it will take a nursing facility provider's accountant approximately 15 hours at the rate of approximately $26.00 per hour (total estimated cost: $390.00) to prepare one Medicaid cost report and file it via the MITS web portal or other electronic means designated by the Department of Medicaid.

In accordance with paragraph (B)(1) of this rule, cost reports may be submitted within 14 days after the original due date for good cause shown if written approval is received from the Department of Medicaid prior to the original due date. Requests for extensions must be in writing and explain the circumstances resulting in the need for an extension. The Department of Medicaid estimates it will take a nursing facility provider's accountant approximately 1 hour at the rate of approximately $26.00 per hour (total estimated cost: $26.00) to request an extension.

In accordance with paragraph (B)(5) of this rule, if a cost report is not received by the original due date, or by an approved extension due date if applicable, a nursing facility provider may be assessed a late file penalty for each day a complete and adequate cost report is not received. The Ohio Department of Medicaid cannot estimate the cost of compliance because the department does not know how many days any particular nursing facility may be late in filing a cost report. However, the late file penalty is $2.00 per patient day, and the cost of compliance will be determined by using the prorated Medicaid days paid in the late file period multiplied by the $2.00 late file penalty.

In accordance with paragraph (C)(1) of this rule, 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. The Department of Medicaid estimates it will take a facility's

accountant approximately 8 hours at the rate of approximately $26.00 per hour (total estimated cost: $208.00) to prepare and submit one revised cost report.

In accordance with paragraph (C)(3) of this rule, a provider that disagrees with a desk review decision may request a rate reconsideration after final rates have been issued. 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 $26.00 per hour (total estimated cost: $208.00) to assist in the preparation of the rate reconsideration. The Department of Medicaid therefore estimates it will cost a total of approximately $708.00 to prepare and submit one rate reconsideration.

In accordance with paragraph (F) of this rule, providers are required to identify on the cost report all known related parties as set forth under paragraph (F) of OAC rule 5160-3-01. The Department of Medicaid estimates it will take a provider's accountant approximately 1 hour at the rate of approximately $26.00 per hour (total estimated cost: $26.00) to identify all known related parties.

Providers are required to identify all the entities specified in paragraph (F) of this rule. The Department of Medicaid estimates it will take a provider’s accountant approximately 2 hours at the rate of approximately $26.00 per hour (total estimated cost: $52.00) to comply with this requirement.

In accordance with paragraph (H) of this rule, 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 or more in a 12-month period, or for the services of a sole proprietor or partnership where there is no cost incurred and the imputed value of the service is $10,000 or more in a 12-month period. The Department of Medicaid estimates it will take a provider's accountant approximately 1 hour at the rate of approximately $26.00 per hour (total estimated cost: $26.00) to comply with this requirement.

In accordance with paragraphs (I) through (I)(3) of this rule: Failure of a nursing facility to retain financial, statistical, and medical records supporting the cost reports or claims for services rendered to residents for the greater of 7 years after the cost report is filed if the Department of Medicaid issues an audit report, or 6 years after all appeal rights relating to the audit report are exhausted records renders the provider liable for a penalty of $1,000 per audit, or 25% of the amount by which the undocumented cost increased the Medicaid payments to the provider during the fiscal year. Failure to retain

the required records to the extent that filed cost reports are not auditable shall result in the imposition of the same penalty. Providers whose records have been found to be not auditable will be allowed 60 days to provide the necessary documentation. If at the end of the 60 days the required records have been provided and are determined auditable, the proposed penalty will be withdrawn. If ODM, after review of the documentation submitted during the 60-day period, determines the records are still not auditable, ODM shall impose the penalty. If a nursing facility provider refuses legal access to financial, statistical, or medical records, the penalty of $1,000 per audit or 25% of the amount by which the undocumented cost increased the Medicaid payments to the provider during the fiscal year shall be imposed for outstanding medical services until such time as the requested information is made available to the Department of Medicaid.

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

5160-3-20 (Rescind)

Not applicable. This rule is being proposed for rescission.

5160-3-20 (New)

The adverse impact to nursing facilities associated with this rule is justified because this rule amplifies ORC section 5165.10, which requires nursing facility providers to file annual cost reports for each facility they own/operate that participates in the Medicaid program. This rule sets forth provisions that are important to the efficient and effective administration of the Medicaid program and to the business operations of nursing facility providers.

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 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.

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 Services and Supports at (614) 466-6742.