Ohio | Common Sense Initiative

Mike DeWine, Governor
Jon Husted, Lt. Governor

Sean McCullough, Director

Business Impact Analysis

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

Rule Contact Name and Contact Information:

Tommi Potter, ODM Rules Administrator Rules@medicaid.ohio.gov

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

Nursing Facility Payment and Provider Agreement Rules

Rule Number(s): 5160-3-39 (Rescind), 5160-3-02 (Amend), 5160-3-02.2 (Amend), 5160-3-02.3 (Amend), 5160-3-02.4 (Amend)

For informational purposes only: 5160-3-02.1 (Amend)

Date of Submission for CSI Review: 9/14/21

Public Comment Period End Date: 9/21/21

Rule Type/Number of Rules:

New/___ rules

No Change/____ rules (FYR? ___)

Amended/__4__ rules (FYR? _Yes__)

Rescinded/_1___ rules (FYR? _Yes__)

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.

Rule 5160-3-39, entitled "Payment and adjustment process for nursing facilities (NFs)" sets forth the payment and adjustment provisions for nursing facilities. This rule is being proposed for rescission because provisions in this rule either are being moved to OAC rule 5160-3-02 or are obsolete.

Rule 5160-3-02, entitled "Nursing facilities (NFs): provider agreements" sets forth the general provisions for nursing facility provider agreements. The changes to this rule are:

- In paragraph (B)(2), language is being added so that a nursing facility provider must apply for and maintain Medicaid certification as well as a valid operating license to reflect current requirements.
- Language in new paragraph (B)(7) is being added regarding submission of data related to resident admission, discharge, and death in order to reflect current processes. In particular, language is being added to point providers to the ODM 09401 form for the electronic process and to require reporting within 10 days of the nursing facility becoming aware of a new or pending Medicaid application for one of their residents.
- Paragraph (B)(9)(b) regarding maintenance of a written list of requests for admission is being deleted in order to eliminate an unnecessary administrative burden on nursing facility

providers.

- In new paragraph (B)(9)(b)(v), the number of days a Medicaid application may be pending before a nursing facility may decline to admit a Medicaid applicant is being changed from 60 days to 45 days in order to comply with federal regulations.
- Also in new paragraph (B)(9)(b)(v), the references to PASRR rules are being removed because they are not relevant to the prolonged pending application provisions for nursing facility residents.
- In new paragraph (B)(10), language regarding claims submission is being modified to reflect current processes.
- New paragraph (B)(11) is being added regarding use of the ODM 10203 form to reflect current processes.
- Language in new paragraph (B)(15) is being deleted because it is not necessary.
- Paragraph (G) regarding use of the ODM 09401 to communicate with nursing facilities regarding the assessment of payment for specific individuals is being deleted because the process is obsolete.
- In several instances, the terms “reimburse” and reimbursed” are being replaced with the terms “pay” and “paid” in order to use updated terminology.
- Regulatory restrictions are being removed throughout the rule.
- Several changes in phrasing are being made for purposes of increased clarity and accuracy.
- Ohio Revised Code, Ohio Administrative Code, and federal regulatory citations throughout the rule are being updated or removed as necessary.
- Paragraph references throughout the rule are being updated as necessary.

Rule 5160-3-02.2, entitled "Nursing facilities (NFs): termination, denial, and non-revalidation of provider agreements” sets forth the provisions that require the Ohio Department of Medicaid to terminate, deny, or not revalidate a nursing facility’s provider agreement, and the provisions that give the Department discretion whether to do so. This rule also sets forth provisions regarding adjudication orders, and provisions regarding the impact of provider actions on CMS-imposed reasonable assurance periods. The changes to this rule are:

- In paragraph (C)(1)(d), the term “renewed” is being updated with the term “revalidated” in order to use current terminology.
- Regulatory restrictions are being removed throughout the rule.
- The dates of federal regulations and a federal publication are being updated to comply with Joint Committee on Agency Rule Review (JCARR) rule filing requirements.

Rule 5160-3-02.3, entitled "Nursing facilities (NFs): institutions eligible to participate in medicaid as NFs” sets forth the provisions under which various types of institutions are eligible to participate in the Medicaid program as nursing facilities. 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 this rule are:

- Paragraph (B)(2)(a) regarding institutions licensed or approved as tuberculosis hospitals is being deleted because it is an obsolete provision.
- Paragraph (D)(1)(b) regarding veteran’s homes operated under ORC Chapter 5907. Is being deleted because veteran’s homes do not receive Medicaid funding.
- Regulatory restrictions are being removed throughout the rule.
- Dates of federal regulations and an Ohio Department of Medicaid form are being updated to

comply with Joint Committee on Agency Rule Review (JCARR) rule filing requirements.
- Paragraph references are being updated as necessary.

Rule 5160-3-02.4, entitled "Nursing facilities (NFs): mandatory dual participation in the medicare program" sets forth the provisions for which Ohio nursing homes that are certified to participate in the Medicaid program must also be certified to participate in the Medicare program. The changes to this rule are:

- Paragraph (B)(2)(b) regarding veteran's homes operated under ORC Chapter 5907. Is being deleted because veteran's homes do not receive Medicaid funding.
- In paragraph (D)(3), in order to reflect current processes, language is being modified so that the rule specifies the Ohio Department of Medicaid is notified by the state survey agency that a facility has passed their survey and is certified for participation in the Medicare program, rather than specifying that the Department is notified by CMS that the facility operator's request for Medicare certification has been approved.
- Regulatory restrictions are being removed throughout the rule.
- Paragraph references are being updated as necessary.

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

5160-3-39

Statutory Authority: 5164.02

Amplifies: 5162.03

5160-3-02

Statutory Authority: 5164.02, 5165.02

Amplifies: 5164.30, 5165.06, 5165.07, 5165.08

5160-3-02.2

Statutory Authority: 5164.02, 5165.02

Amplifies: 109.85, 3721.071, 5164.32, 5164.33, 5164.35, 5164.38, 5165.072, 5165.073, 5165.106, 5165.77, 5165.771, 5165.79, 5165.85, 5165.87, 5168.52

5160-3-02.3

Statutory Authority: 5165.02

Amplifies: 3702.521, 3721.02, 3721.09, 5155.011, 5165.082

5160-3-02.4

Statutory Authority: 5165.02

Amplifies: 5165.082

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.

5150-3-39

This rule does not implement any federal requirements.

5160-3-02

This rule requires nursing facilities to comply with federal regulations contained in Titles VI and VII of the Civil Rights Act of 1964 and in the Americans with Disabilities Act of 1990.

5160-3-02.2

In order to maintain a Medicaid provider agreement, this rule requires nursing facilities to comply with federal regulations regarding the employment of individuals, the provision of services, and the purchase of goods and services contained in section 504 of the Rehabilitation Act of 1973, the Civil Rights Act of 1964, or the Americans with Disabilities Act of 1990.

5160-3-02.3

This rule does not implement any federal requirements.

5160-3-02.4

This rule does not implement any federal requirements.

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

5160-3-02

The Department of Medicaid believes the provisions in this rule that exceed federal requirements are necessary to ensure compliance with numerous regulations in the Revised Code and Administrative Code related to the execution and maintenance of a Medicaid provider agreement between the Ohio Department of Medicaid and the operator of a nursing facility, as well as to comply with the core principles of the Medicaid program.

5160-3-02.2

The Department of Medicaid believes the provisions in this rule that exceed federal requirements are necessary to ensure compliance with numerous regulations in the Revised Code and Administrative Code regarding reasons for termination, denial, or non-revalidation of a Medicaid provider agreement between the Ohio Department of Medicaid and the operator of a nursing facility.

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

5160-3-39

Not applicable. This rule is being proposed for rescission.

5160-3-02

The public purpose of this rule is to implement provisions found in the Revised Code related to the execution and maintenance of a Medicaid provider agreement between the Ohio Department of Medicaid and the operator of a nursing facility. Additionally, this rule implements federal regulations in Titles VI and VII of the Civil Rights Act of 1964 and in the Americans with Disabilities Act of 1990.

5160-3-02.2

The public purpose of this rule is to implement numerous provisions contained in the Revised Code and Administrative Code regarding reasons for which the Ohio Department of Medicaid may, and in some cases shall terminate, deny, or not revalidate a nursing facility's Medicaid provider agreement. Additionally, this rule helps ensure the integrity of the Medicaid program, and the health, safety, and welfare of Medicaid beneficiaries residing in nursing facilities.

5160-3-02.3

The public purpose of this rule is to implement provisions contained in the Revised Code and Administrative Code regarding qualifications of institutions or facilities to participate in the Medicaid program.

5160-3-02.4

The public purpose of this rule is to implement ORC section 5165.082 regarding mandatory full and dual participation of Ohio nursing facilities in both the Medicare and Medicaid programs.

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

5160-3-39

Not applicable. This rule is being proposed for rescission.

5160-3-02

The success of this rule will be measured by the extent to which nursing facilities execute and maintain Medicaid provider agreements according to the specifications of this rule.

5160-3-02.2

The success of this rule will be measured by the extent to which the Ohio Department of Medicaid terminates, denies, and does not revalidate nursing facilities' Medicaid provider agreements according to the specifications of this rule.

5160-3-02.3

The success of this rule will be measured by the extent to which Ohio nursing facilities are qualified to participate in the Medicaid program according to the specifications of this rule.

5160-3-02.4

The success of this rule will be measured by the extent to which Ohio nursing facilities fully and dually participate in both the Medicare and Medicaid programs according to the specifications of this rule.

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

   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 a summary of the rule changes to the associations on May 24, 2021

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

The Academy of Senior Health Sciences expressed concern regarding the removal of the regulatory restriction "shall" throughout the draft rules. Because state agencies have been advised to remove this and other regulatory restrictions from rules being proposed for adoption or amendment, the agency made no changes to the draft rules regarding this input.

No other input was received on these draft rules.

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

Scientific data was not applicable to the development of these 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?

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.

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.***

Performance-based regulations are not considered appropriate for these regulations.

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

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

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

The final rules as adopted by the Ohio Department of Medicaid will be posted via 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

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

These rules impact approximately 970 nursing facilities in Ohio that choose to participate in the Medicaid program. Provider participation in the Medicaid program is optional and at the provider's discretion.

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

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

c. Quantify the expected adverse impact from the regulation.

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

5160-3-39

b.) and c.)

In accordance with paragraphs (B), (C), (D), and (E) of this rule, nursing facilities must notify the County Department of Job and Family Services (CDJFS) of a new admission, death, or discharge of a resident, or when a resident elects to receive Medicaid hospice services by completing and forwarding the ODM 09401 form. The Department of Medicaid estimates it will take nursing facility staff approximately 10 minutes at the rate of approximately $16.00 per hour (total estimated cost: $2.66) to make one notification to the CDJFS.

However, these costs are existing costs. There are no new costs as this rule is being proposed for rescission.

5160-3-02

b.) and c.)

In accordance with paragraph (B)(1) of this rule, nursing facility providers must execute the Medicaid provider agreement in the format provided by the Department of Medicaid. The Department estimates it will take a nursing facility provider's attorney approximately 1.5 hours at the rate of approximately $400.00 per hour (total estimated cost: $600.00) to review one provider agreement. The Department further estimates it will take a nursing facility administrator approximately 1 hour at the rate of approximately $72.00 per hour (total estimated cost: $72.00) to prepare one provider agreement in the format provided by the Department. The Department therefore estimates it will cost a total of approximately $672.00 for a nursing facility provider to execute one Medicaid provider agreement in the format provided by the Department.

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

In accordance with paragraph (B)(3) of this rule, nursing facility providers must comply with the terms of the Medicaid provider agreement and all applicable federal, state, and local laws and rules. The Department of Medicaid cannot estimate the cost to nursing facility providers to comply with this requirement because it is not feasible for the Department to provide an estimate of the cost to comply with all applicable state, federal, and local regulations, and the Department does not know what local regulations apply to any particular nursing facility provider. However, the cost would be calculated by multiplying the number of staff hours required to comply with each regulation by the applicable hourly staff wage, then adding any additional costs that would be incurred to comply with each regulation.

In accordance with paragraph (B)(4) of this rule, nursing facility providers must keep records and file cost reports as specified in rule 5150-3-20 of the Administrative Code. The Department of Medicaid estimates it will take a nursing facility provider's accountant approximately 15 hours at the rate of

approximately $32.00 per hour (total estimated cost: $480.00) to prepare and file one Medicaid cost report. The Department cannot estimate the cost for nursing facility providers to keep records because it does not know the extent of the record keeping needed for any particular nursing facility. However, the cost would be calculated by multiplying the number of staff hours needed to do the record keeping by the applicable hourly staff wage.

In accordance with paragraph (B)(5) of this rule, nursing facility providers must open all records relating to the costs of its services for inspection and audit by the Department of Medicaid and otherwise comply with rule 5160-3-20 of the Administrative Code. The Department of Medicaid estimates it will take a nursing facility provider's bookkeeper approximately 10 hours per year at the rate of approximately $20.00 per hour (total estimated cost: $200.00 per year) to open records related to the costs of the facility's services for inspection and audit by the Department. The Department further estimates it will take a nursing facility provider's accountant approximately 15 hours at the rate of approximately $32.00 per hour (total estimated cost: $480.00) to prepare and file one Medicaid cost report. Additionally, the Department estimates it will take a nursing facility administrator approximately 20 hours per year at the rate of approximately $72.00 per hour (total estimated cost: $1,440 per year) to comply with the other cost report provisions specified in OAC rule 5160-3-20 regarding provision of information. The Department therefore estimates it will cost a total of approximately $1,920.00 to comply with the provisions in this paragraph.

In accordance with paragraph (B)(6) of this rule, nursing facility providers must supply to the Department of Medicaid information the Department requires concerning nursing facility services to individuals who are Medicaid eligible or who have applied to be Medicaid recipients. The Department of Medicaid estimates it will take a nursing facility provider's bookkeeper approximately 1 hour per week at the rate of approximately $20.00 per hour (total estimated cost: $20.00 per week) to comply with this requirement.

In accordance with paragraph (B)(7) of this rule, nursing facility providers must submit data related to admission, discharge, and death via the electronic process outlined in the ODM 09401 form for individuals receiving Medicaid, including dual eligible individuals, and individuals who have a pending Medicaid application or are newly applying for Medicaid. The Department of Medicaid estimates it will take a nursing facility provider's staff person approximately 5 minutes at the rate of approximately $16.00 per hour (total estimated cost: $1.33) to submit data for one instance of admission, discharge, or death.

In accordance with paragraph (B)(8) of this rule, nursing facility providers must retain as a resident any individual who is Medicaid eligible, becomes Medicaid eligible, or applies for Medicaid eligibility. The Department of Medicaid estimates it will take a nursing facility provider's admissions coordinator approximately 5 hours at the rate of approximately $35.00 per hour (total estimated cost: $175.00) and a nurse approximately 3 hours at the rate of approximately $25.00 per hour (total estimated cost: $75.00) to arrange for the admission of one individual. The Department therefore estimates it will cost a total of $250.00 for a nursing facility provider to admit one

individual. If a facility admits an individual with a pending Medicaid application and that individual's application is subsequently denied, the Department estimates the potential cost to the nursing facility provider is approximately $6,237.00 per month for an average nursing facility stay of approximately 3 months (total estimated potential cost: $18,711.00). The Department further estimates it will take a nursing facility provider's office manager approximately 20 hours at the rate of approximately $25.00 per hour (total estimated cost: $500.00) to collect the estimated $18,711.00 cost of care from an individual if the individual's pending Medicaid application is denied. If it is necessary to involve an attorney in collection, the Department estimates it will cost an additional $15,000.00 at minimum.

In accordance with paragraph (B)(10) of this rule, nursing facility providers must submit accurate and valid claims to the Department of Medicaid in accordance with rule 5160-3-39.1 of the Administrative Code. The Department of Medicaid estimates it will take a nursing facility provider's staff person approximately 5 minutes at the rate of approximately $16.00 per hour (total estimated cost: $1.33) to submit one claim to the Department as required in OAC rule 5160-3-39.1.

In accordance with paragraph (B)(11)(a) of this rule, when a nursing facility is a resident's Medicaid authorized representative and the facility becomes aware of a change that may affect the individual's Medicaid eligibility, the facility must notify the county Department of Job and Family Services (CDJFS) in accordance with rule 5160:1-2-08 of the Administrative Code. The Department of Medicaid estimates it will take a nursing facility provider's staff person approximately 10 minutes at the rate of approximately $16.00 per hour (total estimated cost: $2.67) to notify the CDJFS of one such change.

In accordance with paragraph (B)(12) of this rule, nursing facility providers must permit access to the facility and the facility's records for inspection by the Department of Medicaid, the Ohio Department of Health, the county Department of Job and Family Services, the State Long Term Care Ombudsman, and any other state or local government entity having authority to inspect, to the extent of that entity's authority. The Department of Medicaid estimates it will take a nursing facility provider's staff person approximately 1 hour per month at the rate of approximately $16.00 per hour (total estimated cost: $16.00 per month) to permit access to the facility and the facility's records for inspection by the specified entities.

In accordance with paragraph (B)(13)(a) of this rule, exiting nursing facility operators or owners must provide a written notice to the Department of Medicaid as provided in section 5165.51 of the Revised Code when a change of operator occurs. The Department of Medicaid estimates it will take an exiting nursing facility operator's attorney approximately 2 hours at the rate of approximately $400.00 per hour (total estimated cost: $800.00) to review a notice of a change of operator. The Department further estimates it will take a nursing facility administrator approximately 1 hour at the rate of approximately $72.00 per hour (total estimated cost: $72.00) to prepare the written notice. The Department therefore estimates it will cost a total of approximately $872.00 to comply with the requirement in this paragraph.

In accordance with paragraph (B)(13)(b) of this rule, entering nursing facility operators must submit documentation of any transaction requested by the Department of Medicaid to determine whether a change of operator has occurred. The Department of Medicaid estimates it will take a nursing facility administrator approximately 0.5 hours per request at the rate of approximately $72.00 per hour (total estimated cost: $36.00 per request) comply with this requirement.

In accordance with paragraph (B)(13)(c) of this rule, entering nursing facility operators must submit an application for participation in the Medicaid program and a written statement of intent to abide by Department of Medicaid rules, the provisions of the assigned provider agreement, and any existing CMS 2567 "Statement of Deficiencies and Plan of Correction" submitted by the exiting operator. The Department of Medicaid estimates it will take an entering nursing facility operator's attorney approximately 3 hours at the rate of approximately $400.00 per hour (total estimated cost: $1,600.00) to review an application for participation in the Medicaid program and a statement of intent to abide by ODM rules, the provisions of the assigned provider agreement and any existing CMS 2567 submitted by the exiting operator. The Department further estimates it will take a nursing facility administrator approximately 3 hours at the rate of approximately $72.00 per hour (total estimated cost: $216.00) to prepare and submit the application and statement of intent. The Department therefore estimates it will cost and entering nursing facility operator a total of approximately $1,816.00 to comply with the requirements in this paragraph.

In accordance with paragraph (B)(14) of this rule, nursing facility providers must ensure the security of all personal funds of residents in accordance with rule 5160-3-16.5 of the Administrative Code. The Department of Medicaid estimates it will take a nursing facility provider's staff person approximately 15 minutes per month at the rate of approximately $16.00 per hour (total estimated cost: $4.00 per month) to ensure the security of one resident's personal needs allowance (PNA) account by properly managing that account. Proper management of a PNA account includes: maintenance of ledger accounts showing deposit and credit of funds, as well as credit of any interest earned; provision to the resident of access to petty cash; provision of receipts for all transactions; provision of quarterly statements; notification to a resident when the amount in the resident's PNA account reaches $200.00 less than the resource limit; notification to the county Department of Job and Family Services when a resident's PNA account balance exceeds the resource limit; and release of funds upon discharge or conveyance of funds upon death.

In accordance with paragraph (B)(15) of this rule, nursing facility providers must comply with Titles VI and VII of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990. The Department of Medicaid cannot estimate the cost to nursing facility providers to comply with these federal regulations because the cost of compliance is not uniform and will vary from provider to provider. However, the cost would be calculated by multiplying the number of hours nursing facility staff would spend in complying with any particular federal requirement by the applicable hourly staff wage, then adding any additional costs that would be incurred to comply with that particular requirement.

In accordance with paragraph (B)(16) of this rule, nursing facility providers must furnish notice to the Department of Medicaid within 30 days of any bankruptcy or receivership pertaining to the provider. The Department of Medicaid estimates it will take a nursing facility provider's attorney approximately 3 hours at the rate of approximately $400.00 per hour (total estimated cost: $1,200.00) to review a notice of bankruptcy or receivership. The Department further estimates it will take a nursing facility administrator approximately 1 hour at the rate of approximately $72.00 per hour (total estimated cost: $72.00) to prepare the notice and furnish it to the Department. The Department therefore estimates it will cost a total of approximately $1,272.00 to comply with the requirement in this paragraph.

In accordance with paragraph (B)(17) of this rule, nursing facility providers must provide a statement to individuals explaining the individual's obligation to reimburse the cost of care provided during the Medicaid application process if it is not covered by Medicaid. The Department of Medicaid estimates it will take a nursing facility provider's admissions coordinator approximately 15 minutes per individual at the rate of approximately $35.00 per hour (total estimated cost: $8.75 per individual) to comply with this requirement.

In accordance with paragraph (B)(18) of this rule, nursing facility providers must comply with the requirements to repay the Department of Medicaid the federal share of payments under the circumstances required by sections 5165.71 and 5165.85 of the Revised Code. The Department of Medicaid cannot estimate the cost to nursing facility providers to comply with this requirement because the Department does not know which facilities might undergo exit interviews, what the date of any particular exit interview might be, what any particular nursing facility's per diem rate would be on any particular date, or what Ohio's federal financial participation (FFP) rate would be on any particular date. However, the cost would be calculated by multiplying the facility's Medicaid per diem rate by the FFP rate by the number of days during the 6-month period following the exit interview during which the facility did not substantially correct the deficiency or deficiencies in accordance with the plan of correction submitted under section 5165.69 of the Revised Code.

In accordance with paragraph (B)(19) of this rule, nursing facility providers must give the Department of Medicaid, the residents or their guardians, and the residents' sponsors a written notice of a facility closure or voluntary withdrawal from the Medicaid program at least 90 days prior to the event. The Department of Medicaid estimates it will take a nursing facility provider's attorney approximately 1 hour at the rate of approximately $400.00 per hour (total estimated cost: $400.00) to review a notice of closure or voluntary withdrawal. The Department further estimates it will take a nursing facility administrator approximately 5 hours at the rate of approximately $72.00 per hour (total estimated cost: $360.00) to prepare a written notice and furnish it to the Department and residents' sponsors. Additionally, the Department estimates it will take a nursing facility administrator approximately 15 minutes per resident at the rate of approximately $72.00 per hour (total estimated cost: $18.00 per resident) to furnish and explain the notice to each resident. Therefore, in an average size nursing facility with 100 residents, the Department estimates the cost will be $1,800.00 to furnish and explain the notice to all residents. The Department therefore

estimates the total cost to a nursing facility with 100 residents will be approximately $2,560.00 to comply with the requirements in this paragraph.

In accordance with paragraph (B)(20)(a) of this rule, when a nursing facility provider voluntarily withdraws from the Medicaid program, the provider must continue to provide nursing facility services to residents of the facility who were residing in the facility on the day before the effective date of the withdrawal, including those residents who were not entitled to medical assistance as of that date. The Department of Medicaid cannot estimate the cost to nursing facility providers to comply with this requirement because the Department does not know how many providers might choose to voluntarily withdraw from the Medicaid program, which providers those might be, or what the cost of the services furnished by those providers might be. However, the cost would be calculated by multiplying the Medicaid per diem rate on the effective date of withdrawal by the number of Medicaid residents in the facility on the effective date of the withdrawal by the number of days those residents remain in the facility, then adding the cost of any services not included in the Medicaid per diem rate that are provided to these residents during their remaining time in the facility.

In accordance with paragraph (B)(20)(b) of this rule, nursing facility providers must provide residents admitted after the effective date of withdrawal with information that the facility is not participating in the Medicaid program with respect to those residents. The Department of Medicaid estimates it will take a nursing facility provider's admissions coordinator approximately 15 minutes per resident at the rate of approximately $35.00 per hour (total estimated cost: $7.00 per resident) to comply with this requirement.

In accordance with paragraph (B)(20)(c) of this rule, when a nursing facility voluntarily withdraws from the Medicaid program, nursing facility providers must furnish notice to the Department of Medicaid within 14 days after the last Medicaid funded resident has been relocated. The Department of Medicaid estimates it will take a nursing facility administrator approximately 15 minutes at the rate of approximately $72.00 per hour (total estimated cost: $7.00) to comply with this requirement.

5160-3-02.2

b.) and c.)

In accordance with paragraph (B)(2)(a) of this rule, nursing facility providers must fully and accurately disclose information to the Department of Medicaid as required by the provider agreement or any rule contained in Chapter 5160-3 of the Administrative Code. The Department of Medicaid cannot estimate the cost to nursing facility providers to comply with this requirement because it is not feasible to do so. However, the cost would be calculated by multiplying the number of staff hours necessary to comply with any particular requirement by the applicable hourly staff wage, then adding any other costs that would be incurred in order to comply with that particular requirement.

In accordance with paragraph (B)(2)(b) of this rule, nursing facility providers must abide by or have the capacity to comply with the terms and conditions of the provider agreement and/or rules and regulations promulgated by the Department of Medicaid. The Department of Medicaid cannot estimate the cost to nursing facility providers to comply with this requirement because the Department does not have the ability to assess the capacity of any particular nursing facility provider to comply with the terms and conditions of the provider agreement and/or the rules and regulations promulgated by the Department. However, the cost would be calculated by multiplying the number of staff hours necessary to comply with any particular regulation by the applicable hourly staff wage, then adding any other costs that would be incurred in order to comply with that particular regulation.

In accordance with paragraph (B)(2)(d), of this rule, nursing facility providers must file cost reports as required in rule 5160-3-20 of the Administrative Code. The Department of Medicaid estimates it will take a nursing facility provider's accountant approximately 15 hours at the rate of approximately $32.00 per hour (total estimated cost: $480.00) to file one cost report in accordance with OAC rule 5160-3-20.

In accordance with paragraph (B)(2)(f) of this rule, nursing facility providers must cooperate or provide requested records or documentation for purposes of an audit or review of any provider activity by any federal, state, or local agency. The Department of Medicaid estimates it will take a nursing facility provider's staff person approximately 40 hours per year at the rate of approximately $16.00 per hour (total estimated cost: $640.00 per year) to comply with this requirement.

In accordance with paragraph (B)(2)(k) of this rule, nursing facility providers must pay the full amount of a franchise permit fee installment when due pursuant to section 5168.52 of the Revised Code. Franchise permit fees are assessed according to the number of beds in each nursing facility. The franchise permit fee for state fiscal year 2020 is $13.16 per bed for beds 1-200, and $8.63 per bed for beds in excess of 200. The amount of the franchise permit fee for any particular facility would be the sum of the number of beds in the facility from 1-200 multiplied $13.16 and the number of beds in the facility in excess of 200 multiplied by $8.63.

In accordance with paragraph (C)(1)(d) of this rule, nursing facility providers must hold any license, permit, or certificate that is required by the Department of Medicaid, and the terms of the provider agreement must not have been denied, suspended, revoked, or not revalidated. The Department of Medicaid estimates it will take a nursing facility's attorney approximately 6 hours at the rate of approximately $400.00 per hour (total estimated cost: $2,400.00) to review a licensure application. The Department further estimates it will take a nursing facility administrator approximately 4 hours at the rate of approximately $72.00 per hour (total estimated cost: $288.00) to prepare and submit a licensure application. The Department therefore estimates it will cost a total of approximately $2,688.00 for a nursing facility provider to comply with the requirements of this paragraph.

In accordance with paragraph (C)(2)(c) of this rule, nursing facility providers must comply with the requirements of section 3721.071 of the Revised Code for the installation of fire extinguishing and

fire alarm systems. The Department of Medicaid estimates it will cost an average size nursing facility with 100 beds approximately $200,000.00 - $250,000.00 to install a completely new fire alarm and fire extinguishing system.

In accordance with paragraph (C)(2)(e) of this rule, nursing facility providers must file a cost report required by section 5165.10 of the Revised Code by the date it is due or by the date, if any, to which the due date is extended pursuant to division (D) of section 5165.10 of the Revised Code. The Department of Medicaid estimates it will take a nursing facility provider's accountant approximately 15 hours at the rate of approximately $32.00 per hour (total estimated cost: $480.00) to comply with this requirement.

In accordance with paragraph (C)(2)(f) of this rule, nursing facility providers must ensure the nursing facility's full participation in the Medicare program as a skilled nursing facility (SNF) pursuant to section 5165.082 of the Revised Code and rule 5160-3-02.4 of the Administrative Code. The Department of Medicaid estimates it will take a nursing facility provider's attorney approximately 20 hours at the rate of approximately $400.00 per hour (total estimated cost: $8,000.00) to review one application for Medicare certification. The Department further estimates it will take a nursing facility administrator approximately 640 hours at the rate of approximately $72.00 per hour (total estimated cost: $46,080.00) to prepare and submit a Medicare certification application. The Department therefore estimates it will cost a nursing facility a total of approximately $54,080.00 to comply with the requirements of this paragraph.

In accordance with paragraph (C)(2)(g) of this rule, nursing facility providers must maintain eligibility for the provider agreement as set forth in rule section 5165.06 of the Revised Code. The Department of Medicaid cannot estimate the cost for a nursing facility provider to comply with this requirement because it is not feasible to estimate the cost to comply with all applicable state and federal laws and rules. However, the cost would be calculated by multiplying the number of staff hours needed to comply with any particular state or federal regulation by the applicable hourly staff wage, then adding any other costs that would be incurred in order to comply with that particular regulation.

In accordance with paragraph (C)(2)(h) of this rule, nursing facility providers must file a complete application for revalidation within the time and in the manner required by the revalidation process as specified by the Department of Medicaid. The Department of Medicaid estimates it will take a nursing facility administrator approximately 2 hours at the rate of approximately $72.00 per hour (total estimated cost: $144,00) to comply with this requirement.

However, all the above costs are existing costs. There are no new costs associated with this rule filing.

5160-3-02.3

b.) and c.)

In accordance with paragraph (C)(1) and (D)(1) of this rule, the operator of an institution must meet Ohio Department of Health licensure standards that area specified in section 3721.02 of the Revised Code , or meet licensure standards of a political subdivision certified under section 3721.09 of the Revised Code, to operate as a nursing home that subsequently is eligible for certification to participate in the Medicaid program as a nursing facility. The Department of Medicaid estimates it will take an operator's attorney approximately 6 hours at the rate of $400.00 per hour (total estimated cost: $2,400.00) to review a licensure application to operate as a nursing home under ORC Chapter 3721. The Department further estimates it will take an operator's nursing home administrator approximately 4 hours at the rate of approximately $72.00 per hour (total estimated cost: $288.00) to prepare and submit a licensure application. The Department therefore estimates it will cost a total of approximately $2,688.00 for an operator of an institution to review, prepare, and submit an application for licensure to operate as a nursing home under ORC Chapter 3721.

In accordance with paragraph (C)(2) of this rule, operators of nursing homes must be certified by the Ohio Department of Health or by the state survey agency of another state as being in compliance with applicable federal regulations for Medicaid participation as a nursing facility with a minimum of four nursing facility certified beds. The Department of Medicaid estimates it will take a nursing home operator's attorney approximately 20 hours at the rate of approximately $400.00 per hour (total estimated cost: $8,000.00) to review an application for participation in the Medicaid program as a nursing facility. The Department further estimates it will take a nursing home administrator approximately 640 hours at the rate of approximately $72.00 per hour (total estimated cost: $46,080.00) to prepare and submit a certification application. The Department therefore estimates it will cost a nursing home operator a total of approximately $54,080.00 to comply with the requirement in this paragraph.

In accordance with paragraph (C)(3) of this rule, nursing facilities must have a current, completed, and signed Ohio Medicaid provider agreement on file with the Department of Medicaid. The Department of Medicaid estimates it will take a nursing facility's attorney approximately 1.5 hours at the rate of approximately $400.00 per hour (total estimated cost: $600.00) to review one Ohio Medicaid provider agreement. The Department further estimates it will take a nursing facility administrator approximately 1 hour at the rate of approximately $72.00 per hour (total estimated cost: $72.00) to prepare one provider agreement. The Department therefore estimates it will cost a total of approximately $672.00 to comply with this requirement.

In accordance with paragraph (E) of this rule, an Ohio nursing facility must comply with the provisions in section 5165.082 of the Revised Code and rule 5160-3-02.4 of the Administrative Code requiring dual participation as a skilled nursing facility/nursing facility (SNF/NF) in both the Medicare and Medicaid programs. The Department of Medicaid estimates it will take a nursing facility's attorney approximately 20 hours at the rate of approximately $400.00 per hour (total estimated

cost: $8,000.00) to review an application for Medicare certification. The Department further estimates it will take a nursing facility administrator approximately 640 hours at the rate of approximately $72.00 per hour (total estimated cost: $46,080.00) to prepare and submit one Medicare certification application. The Department therefore estimates it will cost a nursing facility a total of approximately $54,080.00 to review, prepare and submit an application for Medicare certification in order to dually participate as a SNF/NF in both the Medicare and Medicaid programs.

In accordance with paragraph (G) of this rule, the operator of an out-of-state nursing facility must hold a valid state-required license, registration, or equivalent from its respective state that specifies the levels of care the facility is qualified to provide. The operator of an out-of-state nursing facility also must hold a valid and current provider agreement from its respective state as a nursing facility that participates in Medicaid, or as a skilled nursing facility/nursing facility that participates in both the Medicare and Medicaid programs. Additionally, out-of-state providers must have a current, completed, and signed Ohio Medicaid provider agreement on file with the Ohio Department of Medicaid and must obtain resident specific and date specific prior authorization from the Ohio Department of Medicaid in accordance with rule 5160-1-11 of the Administrative Code. The Department of Medicaid estimates it will cost the operator of an out-of-state nursing facility approximately the same amounts as it will cost the operator of an Ohio nursing facility (as estimated above) to meet the requirements regarding licensure, certification, and provider agreements, with the exception that an out-of-state provider must hold provider agreements from both its respective state and from Ohio. Additionally, the Department estimates it will take a nursing facility administrator approximately 4 hours at the rate of approximately $72.00 per hour (total estimated cost: $288.00) to obtain resident specific and date specific prior authorization from the Ohio Department of Medicaid.

However, all the above costs are existing costs. There are no new costs associated with this rule filing.

5160-3-02.4

b.) and c.)

In accordance with paragraph (C)(2) of this rule, nursing facility providers must ensure a nursing facility's dual participation in the Medicare program. The Department of Medicaid estimates it will take a nursing facility provider's attorney approximately 20 hours at the rate of approximately $400.00 per hour (total estimated cost: $8,000.00) to review an application for Medicare certification. The Department further estimates it will take a nursing facility administrator approximately 640 hours at the rate of approximately $72.00 per hour (total estimated cost: $46,080.00) to prepare and submit one Medicare certification application. The Department therefore estimates it will cost a nursing facility a total of approximately $54,080.00 to review,

prepare, and submit an application for Medicare certification in order to dually participate in the Medicare program.

In accordance with paragraph (D)(1) of this rule, operators of new Ohio nursing homes that are requesting participation in the Medicaid program must provide documentation to the Department of Medicaid that they also have requested participation in the Medicare program. The Department of Medicaid estimates it will take a new nursing home administrator approximately 1 hour at the rate of approximately $72.00 per hour (total estimated cost: $72.00) to comply with this requirement.

In accordance with paragraph (E)(1) of this rule, a facility operator requesting readmission to the Medicaid program must provide documentation to the Department of Medicaid of the request for admission or readmission, and of the facility's full participation in the Medicare program. The Department of Medicaid estimates it will take a nursing home administrator approximately 1 hour at the rate of approximately $72.00 per hour (total estimated cost: $72.00) to comply with this requirement.

However, all the above costs are existing costs. There are no new costs associated with this rule filing.

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

5160-3-39

Not applicable. This rule is being proposed for rescission.

5160-3-02

The adverse impact to nursing facilities associated with this rule is justified because this rule implements numerous provisions found in the Revised Code related to the execution and maintenance of the Medicaid provider agreement. Additionally, this rule implements federal regulations in Titles VI and VII of the Civil Rights Act of 1964 and in the Americans with Disabilities Act of 1990.

5160-3-02.2

The adverse impact to nursing facilities associated with this rule is justified because this rule helps ensure the integrity of the Medicaid program, and helps ensure the health, safety, and welfare of Medicaid beneficiaries residing in nursing facilities.

5160-3-02.3

The adverse impact to nursing facilities associated with this rule is justified because this rule implements provisions contained in the Revised Code and Administrative Code regarding qualifications of institutions or facilities to participate in the Medicaid program.

5160-3-02.4

The adverse impact to nursing facilities associated with this rule is justified because this rule implements provisions contained in ORC section 5165.082 regarding mandatory dual participation of Ohio nursing facilities in both the Medicare and Medicaid programs.

Regulatory Flexibility

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

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

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

ORC section 119.14 is not applicable to these regulations.

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

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

5160-3-02 **Nursing facilities (NFs): provider agreements.**

In addition to provisions in Chapters 5164. and 5165. of the Revised Code regarding provider agreements, and provisions in rules 5160-3-02.1 and 5160-3-02.2 of the Administrative Code, execution and maintenance of a provider agreement between the Ohio department of medicaid (ODM) and the operator of a NF also are contingent upon compliance with requirements set forth in this rule.

(A) Definitions.

(1) "Closure" means the discontinuance of the use of the building or part of the building that houses the facility as a NF, and that results in the relocation of the facility's residents who continue to ~~require~~ need NF services. If the building is converted to a different use and acquires a new type of license, residents who ~~require~~ need services offered under the new license type may remain.

(a) A facility's closure occurs regardless of whether there is a replacement of the facility whereby the operator completely or partially replaces the facility's physical plant through the construction of a new physical plant or the transfer of the facility's license from one physical plant location to another.

(b) Facility closure occurs regardless of whether residents of the closing facility elect to be relocated to the operator's replacement facility or to another NF.

(c) A facility closure occurs regardless of action taken by the Ohio department of health (ODH) related to the facility's certification under Title XIX of the Social Security Act, 42 U.S.C. 1396 (~~April 16, 2015~~INSERT ORIGINAL FILE DATE), that may result in the transfer of part of the facility's survey findings to a replacement facility, or related to retention of a license as a NF under Chapter 3721. of the Revised Code.

(d) The last effective date of the provider agreement of a closed facility will be the date of the relocation of the last resident.

(2) "Continuing care" and "life care" refer to the living setting that provides the individual with different types of care based on a resident's need over time and may include an apartment or lodging, meals, maintenance services, and when necessary, nursing home care. All services are provided on the premises of the continuing care or life care community. The individual signs a contract that

identifies the continuum of services to be covered by the individual's initial entrance fee and subsequent monthly charges. If a continuing care or life care contract provides for a living arrangement that specifically states that all health care services including nursing home services are met in full, medicaid payment cannot be made for those services covered by the contract. If a continuing care or life care contract provides for only a portion of the resident's health care services, that portion ~~shall~~ should be deducted from the actual cost of nursing home care and medicaid ~~shall~~ should pay the difference up to the medicaid maximum per diem. An individual who entered into a life care or continuing care contract may be eligible for medicaid under the conditions in rule ~~5160:1-3-05.1~~5160:1-6-02.3 of the Administrative Code.

(3) "Failure to pay" means that an individual has failed, after reasonable and appropriate notice, to pay or to have the medicare or medicaid program pay on the individual's behalf, for the care provided by the NF. An individual ~~shall~~ should be considered to have failed to have the individual's care paid for when the individual has a medicaid application in pending status, if both of the following are the case:

(a) The individual's application, or a substantially similar previous application, has been denied by the county department of job and family services (CDJFS); and

(b) If the individual appealed the denial pursuant to division (C) of section 5101.35 of the Revised Code, the director of ODM upheld the denial.

(4) "Medicaid eligible" means an individual has been determined eligible by the CDJFS under Chapters ~~5160:1-3~~ 5160:1-1 to 5160:1-6 of the Administrative Code and has been issued an effective date of health care coverage for the time period in question.

(5) "Operator" means the individual, partnership, association, trust, corporation, or other legal entity that operates a NF.

(6) "Voluntary withdrawal" means that the operator of a NF, in compliance with section 1919(c)(2)(F) of the Social Security Act, voluntarily elects to withdraw from participation in the medicaid program but chooses to continue providing services of the type provided by NFs.

(B) A provider of a NF ~~shall~~should:

(1) Execute the provider agreement in the format provided by ODM.

(2) Apply for and maintain medicaid certification and a valid license to operate ~~if required by law.~~

(3) Comply with the provider agreement and all applicable federal, state, and local laws and rules.

(4) Keep records and file cost reports as ~~required~~specified in rule 5160-3-20 of the Administrative Code.

(5) Open all records relating to the costs of its services for inspection and audit by ODM and otherwise comply with rule 5160-3-20 of the Administrative Code.

(6) Supply to ODM such information as the department requires concerning NF services to individuals who are medicaid eligible or who have applied to be medicaid recipients.

(7) Submit data related to admission, discharge, and death via the electronic process outlined in the ODM 09401 form:

(a) Within ten business days of the change for individuals receiving medicaid, including dual eligible individuals; and

(b) Within ten business days of the NF identifying that an individual has a pending medicaid application or is newly applying for medicaid.

~~(7)~~(8) Unless the conditions described in paragraph (~~H~~G) of this rule are applicable, retain as a resident any individual who is medicaid eligible, becomes medicaid eligible, or applies for medicaid eligibility. Residents in a NF who are medicaid eligible, become medicaid eligible, or apply for medicaid eligibility are considered residents in the NF during any absence for which bed-hold days are ~~reimbursed~~paid in accordance with rule 5160-3-16.4 of the Administrative Code.

~~(8)~~(9) Unless the conditions described in paragraph (~~H~~G) of this rule are applicable, admit as a resident an individual who is medicaid eligible, whose application for medicaid is pending, or who is eligible for both medicare and medicaid, and whose level of care determination is appropriate for the admitting facility. This applies unless at least twenty-five per cent of the NF's medicaid certified beds are occupied by medicaid recipients at the time the individual would otherwise be admitted, in accordance with section 5165.08 of the Revised Code.

(a) In order to comply with these provisions, the NF admission policy ~~shall~~ should be designed to admit individuals sequentially based on the following:

(i) The requested admission date.

(ii) The date and time of receipt of the request.

(iii) The availability of the level of care or range of services necessary to meet the needs of the applicants.

(iv) Gender: sharing a room with a resident of the same sex (except married couples who agree to share the same room).

~~(b) The NF shall maintain a written list of all requests for each admission. The list shall include the name of the potential resident; date and time the request was received; the requested admission date; and the reason for denial if not admitted. This list shall be made available upon request to the staff of ODM, the CDJFS, and ODH.~~

~~(c)~~(b) The following are exceptions to paragraph (B)(~~9~~8) of this rule:

(i) Bed-hold days are exhausted.

Medicaid eligible residents of NFs who are on hospital stays, visiting with family and friends, or participating in therapeutic programs and have exhausted coverage for bed-hold days under rule 5160-3-16.4 of the Administrative Code ~~must~~ should be readmitted to the first available semi-private bed in accordance with the provisions of rule 5160-3-16.4 of the Administrative Code.

(ii) Facility is a county home.

Any county home organized under Chapter 5155. of the Revised Code may admit individuals exclusively from the county in which the county home is located.

(iii) Facility has a religious sponsor.

Any religious or denominational NF that is operated, supervised, or controlled by a religious organization may give preference to persons of the same religion or denomination.

(iv) NF has continuing care or life care contracts.

A NF may give preference to individuals with whom it has contracted to provide continuing care or life care.

(v) Prolonged "medicaid pending" application status.

A NF may decline to admit a medicaid applicant if that facility has a resident whose application ~~was pending upon admission and~~ has been pending for more than ~~sixty~~ forty-five days, as verified by the CDJFS. ~~The NF shall submit the necessary documentation in a timely manner as required in rules 5160-3-15.1 and 5160-3-15.2 of the Administrative Code.~~

~~(9)~~(10) ~~Provide the following necessary information to ODM and the CDJFS to process records for payment and adjustment:~~Submit accurate and valid claims to ODM in accordance with rule 5160-3-39.1 of the Administrative Code.

~~(a) Submit the ODM 09401 "Facility/CDJFS Transmittal" (7/2014) to the CDJFS to inform the CDJFS of any information regarding a specific resident for maintenance of current and accurate records at the CDJFS and the facility.~~

~~(b) Submit claims to ODM as required in rule 5160-3-39.1 of the Administrative Code.~~

(11) Responsibilities regarding notifications to the CDJFS.

(a) When a NF is a resident's medicaid authorized representative and the NF becomes aware of a change that may affect the individual's medicaid eligibility, the NF should notify the CDJFS in accordance with rule 5160:1-2-08 of the Administrative Code. The NF may notify the CDJFS via the ODM 10203, "Report A Change For Medical Assistance" (4/2017).

(b) When a NF is not a resident's medicaid authorized representative and the NF becomes aware of a change that may affect the individual's medicaid eligibility, the NF may provide the ODM 10203 to the resident, the resident's family, medicaid authorized representative, guardian, or other representative. The NF may complete and submit the ODM 10203 on behalf of a resident.

~~(10)~~(12) Permit access to the facility and the facility's records for inspection by ODM, ODH, the CDJFS, representatives of the office of the state long-term care ombudsman, and any other state or local government entity having authority to inspect, to the extent of that entity's authority.

~~(11)~~(13) In the case of a change of operator as defined in section 5165.01 of the Revised Code, follow the procedures in paragraphs (B)(~~11~~13)(a) to (B)(~~11~~13)(d) of this rule.

(a) The exiting operator or owner and entering operator ~~must~~ should provide a written notice to ODM, as provided in section 5165.51 of the Revised Code, at least forty-five days prior to the effective date of any actions that constitute a change of operator for the NF, but at least ninety days if residents are to be relocated. An exiting operator that does not give proper notice is subject to the penalties specified in section 5165.42 of the Revised Code.

(b) The entering operator ~~must~~ should submit documentation of any transaction (e.g., sales agreement, contract, or lease) as requested by ODM to determine whether a change of operator has occurred. ~~as specified in section 5165.51 of the Revised Code.~~

(c) The entering operator ~~shall~~ should submit an application for participation in the medicaid program and a written statement of intent to abide by ODM rules, the provisions of the assigned provider agreement, and any existing CMS 2567 "Statement of Deficiencies and Plan of Correction" (rev. 2/1999) submitted by the exiting operator.

(d) An entering operator is subject to the same survey findings as the exiting operator unless the entering operator does not accept assignment of the exiting operator's provider agreement. Refusal to accept assignment results in termination of certification on the last day of the exiting operator's participation in medicaid. An entering operator who refuses assignment may reapply for medicaid participation and ~~must~~ should undergo a complete initial certification survey by ODH. There may be gaps in medicaid coverage at the facility.

~~(12)~~(14) Ensure the security of all personal funds of residents in accordance with rule 5160-3-16.5 of the Administrative Code.

~~(13)~~(15) Comply with Title VI and Title VII of the Civil Rights Act of 1964, 42 U.S.C. ~~1971~~2000d and 2000e et seq respectively, ~~(July 27, 2006)~~ and the Americans with Disabilities Act of 1990, 42 U.S.C. 12101 et seq (~~March 15, 2011~~INSERT ORIGINAL FILE DATE)~~, and shall not discriminate against any resident on the basis of race, color, age, sex, creed, national origin, or disability~~.

~~(14)~~(16) Provide notice to ODM within thirty days of any bankruptcy or receivership pertaining to the provider. Notice ~~shall~~ should be mailed to: "Office of Legal

Services, Ohio Department of Medicaid, P.O. Box 182709, Columbus, Ohio 43218" and to: "Office of the Attorney General, 30 East Broad Street, 14th Floor, Columbus, Ohio 43215".

~~(15)~~(17) Provide a statement to the individual explaining the individual's obligation to ~~reimburse~~ pay the cost of care provided during the medicaid application process if it is not covered by medicaid.

~~(16)~~(18) Comply with the requirements ~~in rule 5160-3-04.1 of the Administrative Code~~ to repay ODM the federal share of payments under the circumstances required by sections 5165.71 and 5165.85 of the Revised Code.

~~(17)~~(19) During a closure or voluntary withdrawal from the medicaid program, provide ODM, the resident or guardian, and the residents' sponsors a written notice at least ninety days prior to the closure or voluntary withdrawal. A NF that does not issue the proper notice to ODM is subject to the penalties specified in section 5165.42 of the Revised Code.

~~(18)~~(20) Comply with the following requirements when voluntarily withdrawing from the medicaid program:

(a) Continue to provide NF services to residents of the facility who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to medical assistance as of such day).

(i) A NF operator's voluntary withdrawal from participation in the medicaid program is not an acceptable basis for the transfer or discharge of these residents.

(ii) Nothing in this provision invalidates other legal grounds for NF-initiated discharge of medicaid residents after the effective date of withdrawal.

(b) Provide residents admitted after the effective date of withdrawal with information that the facility is not participating in the medicaid program with respect to those residents.

(c) Provide notice to ODM within fourteen days after the last medicaid funded resident has been relocated.

(C) A provider of a NF ~~shall~~ should not:

(1) Charge fees for the application process of a medicaid individual or applicant.

(2) Charge a medicaid individual an admission fee.

(3) Charge a medicaid individual an advance deposit. However, a NF may charge an individual whose medicaid eligibility is pending, typically in the form of a pre-admission deposit or payment for services after admission. A NF that has charged a resident for services between the first month of eligibility established by the state and the date notice of eligibility is received is obligated to refund any payments received for that period less the state's determination of any resident's share of the NF costs for that same period.

(4) ~~Require~~ Make a third party ~~to~~ accept personal responsibility for paying the facility charges out of his or her own funds. However, the facility may ~~require~~ make a representative who has legal access to an individual's income or resources available to pay for facility care ~~to~~ sign a contract, without incurring personal financial liability, to provide facility payment from the individual's income or resources if the individual's medicaid application is denied and if the individual's cost of care is not being paid by medicare or another third-party payor. A third-party guarantee is not the same as a third-party payor (i.e., an insurance company), and this provision does not preclude the facility from obtaining information about medicare and medicaid eligibility or the availability of private insurance. The prohibition against third-party guarantees applies to all individuals and prospective individuals in all certified NFs regardless of payment source. This provision does not ~~prohibit~~ prevent a third party from voluntarily making payment on behalf of an individual.

(D) ODM ~~shall~~should:

(1) Execute a provider agreement in accordance with the certification provisions set forth by the secretary of health and human services (HHS) and ODH.

(2) In the case of a change of operator, issue an assigned provider agreement to the entering operator contingent upon the entering operator's compliance with paragraph (B)(~~11~~13)(c) of this rule.

(3) Provide access on the ODM website to a listing of the rules ODM has filed for adoption, admendment, or rescission under section 119.03 or 111.15 of the Revised Code.

(4) Make payments in accordance with Chapter 5165. of the Revised Code and Chapter 5160-3 of the Administrative Code to the NF for services to individuals eligible and approved for payment under the medicaid program.

(E) ODM may terminate, suspend, not enter into, or not revalidate, the provider agreement upon thirty days written notice to the provider for violations of Chapters 5164. and 5165. of the Revised Code; Chapters 5160-1 and 5160-3 of the Administrative Code; and if applicable, subject to Chapter 119. of the Revised Code.

(F) Any NF violating provisions defined in paragraphs (B)(~~7~~8) and (B)(~~8~~9) of this rule will be subject to a penalty in accordance with provisions of section 5165.99 of the Revised Code.

~~(G) The CDJFS shall use the ODM 09401 to communicate with NFs regarding the assessment of payment for specific individuals.~~

~~(H)~~(G) Exclusions.

The provisions of paragraphs (B)(~~7~~8) and (B)(~~8~~9) of this rule do not ~~require~~ apply to an individual to be admitted or retained at the NF if the individual meets one of the following conditions:

(1) The individual ~~requires~~ needs a level of care or range of services that the NF is not certified or otherwise qualified to provide.

(2) The individual has a medicaid application in pending status and meets the definition of "failure to pay" in this rule.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5165.02
Rule Amplifies:	5164.30, 5165.06, 5165.07, 5165.08
Prior Effective Dates:	07/03/1980, 07/07/1980, 09/01/1982, 11/10/1983, 01/20/1985 (Emer.), 07/01/1985, 08/01/1987, 09/30/1987 (Emer.), 12/28/1987, 03/30/1988, 01/01/1995, 07/01/1997, 09/30/2001, 07/01/2003, 07/01/2005, 08/01/2009, 07/01/2010, 01/10/2013, 06/24/2016

5160-3-02.1 **Nursing facilities (NFs): length and type of provider agreements.**

(A) Definitions.

(1) "Reasonable assurance period" means a certain period of time, determined by the centers for medicare and medicaid services (CMS), for which a nursing facility operator whose provider agreement has been involuntarily terminated is required to operate without recurrence of the deficiencies that were the basis for termination. Participation in the medicare and medicaid programs may resume only following that period. If corrections were made before submission of a new request for participation, the period of compliance before the new request is counted as part of the period.

(2) "State survey agency" means the agency that is under contract with the state medicaid agency and that inspects nursing facilities for the purposes of survey and certification. The state survey agency in Ohio is the Ohio department of health (ODH). The state medicaid agency in Ohio is the Ohio department of medicaid (ODM).

(B) Effective dates.

(1) Initial certification of NFs and skilled nursing facilities/nursing facilities (SNF/NFs).

(a) Effective dates of NF and SNF/NF provider agreements generally are assigned by the state survey agency on the basis of findings of compliance or substantial compliance with standards of certification.

(b) The effective date ~~shall not~~ cannot be earlier than the date on which compliance is documented via the state survey agency's onsite visits to the facility.

(c) The effective date of a provider agreement of a nursing facility that participates in the medicaid program as a SNF/NF ~~shall~~ should be the same as that of the facility's medicare provider agreement.

(2) NFs subsequently approved to operate as SNF/NFs.

(a) Upon approval from CMS of a NF to participate in the medicare program as a SNF/NF, and upon authorization from the state survey agency, ODM ~~shall~~ should issue a SNF/NF provider agreement.

(b) The effective date of this provider agreement ~~shall~~ should be the same as that of the facility's medicare provider agreement.

(3) Re-entry into the program following involuntary termination.

(a) Following involuntary termination of the medicaid provider agreement for a nursing facility, the provider agreement effective date of a facility re-entering the medicaid program ~~shall~~ should be the same effective date as the date CMS issues for the facility's medicare provider agreement.

(b) Re-entry may occur only after the successful completion of a reasonable assurance period as determined by CMS.

(C) Term limits.

(1) A NF or SNF/NF provider agreement ~~shall~~ should expire no later than five years from the effective date of the agreement in accordance with section 5164.32 of the Revised Code. The process for revalidation of a NF or SNF/NF provider agreement is specified in rule 5160-1-17.4 of the Administrative Code.

(2) The term of a NF or SNF/NF provider agreement ~~shall be~~is determined by the period of certification established by the state survey agency, which is based upon compliance with certification standards. The term of a NF or SNF/NF provider agreement may be less than, but shall not exceed, five years.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.32
Prior Effective Dates:	04/04/1977, 12/30/1977, 01/01/1979, 03/23/1979, 08/31/1979, 11/01/1979, 07/01/1980, 07/07/1980, 10/01/1987, 01/01/1995, 05/16/2002, 09/29/2005, 02/15/2011, 01/10/2013, 06/24/2016

5160-3-02.2 **Nursing facilities (NFs): termination, denial, and non-revalidation of provider agreements.**

(A) Written notice.

(1) The Ohio department of medicaid (ODM) may terminate, deny, or not revalidate a NF provider agreement upon thirty days written notice to the NF.

(2) Notices and termination orders ~~must~~ should comply with provisions set forth in sections 5164.38 and 5165.77 of the Revised Code.

(B) Reasons for which ODM may terminate, deny, or not revalidate a NF provider agreement.

(1) In accordance with section 5164.33 of the Revised Code, ODM may terminate, deny, or not revalidate a NF provider agreement if ODM determines such an agreement is not in the best interests of the state or the medicaid residents of the NF.

(2) ODM may terminate, deny, or not revalidate a NF provider agreement on the basis of best interest including, but not limited to, the following reasons:

(a) The provider has not fully and accurately disclosed information to ODM ~~as required by~~in accordance with the provider agreement or any rule contained in Chapter 5160-3 of the Administrative Code.

(b) The provider has failed to abide by or to have the capacity to comply with the terms and conditions of the provider agreement and/or rules and regulations promulgated by ODM.

(c) The provider has been found liable by a court for negligent performance of professional duties.

(d) The provider has failed to file cost reports ~~as required in~~ in accordance with rule 5160-3-20 of the Administrative Code.

(e) The provider has made false statements or has altered records, documents, or charts. Alteration does not include properly documented correction of records.

(f) The provider has failed to cooperate or provide requested records or documentation for purposes of an audit or review of any provider activity by any federal, state, or local agency.

(g) The provider has been found in violation of section 504 of the Rehabilitation Act of 1973, 29 U.S.C 794 (~~March 24, 2014~~November 29, 1991), the Civil Rights Act of 1964, 42 U.S.C. ~~1971~~2000e et seq (~~July 27, 2006~~November 21, 1991) or the Americans with Disabilities Act of 1990, 42 U.S.C. 12101 et seq (March 15, 2011) in relation to the employment of individuals, the provision of services, or the purchase of goods and services.

(h) The attorney general, auditor of state, or any board, bureau, commission, or department has recommended ODM terminate the provider agreement where the reason for the request bears a reasonable relationship to the administration of the medicaid program or the integrity of state and/or federal funds.

(i) In accordance with rule 5160-1-13.1 of the Administrative Code, the provider has violated the prohibition against billing medicaid residents for covered services, or has requested the resident to share in the cost of covered services through deductibles, coinsurance, co-payments, or other similar charges, other than medicaid co-payments as defined in rule 5160-1-09 of the Administrative Code.

(j) The facility has been found by the Ohio department of health (ODH) during a survey of the facility to have an emergency that is the result of a deficiency or cluster of deficiencies, and that constitutes immediate jeopardy.

(k) The provider fails to pay the full amount of a franchise permit fee (FPF) installment when due pursuant to section 5168.52 of the Revised Code.

(C) Reasons for which ODM ~~shall~~ should terminate, deny, or not revalidate a NF provider agreement.

(1) ODM ~~shall~~ should terminate, deny, or not revalidate a NF provider agreement for, but not limited to, the following reasons:

(a) The provider has been terminated, suspended, or excluded by the medicare program and/or by the United States centers for medicare and medicaid services (CMS) and that action is binding on participation in the medicaid program or renders federal financial participation unavailable

for participation in the medicaid program. Under these conditions, medicaid termination and payment sanction dates shall be the same as medicare termination and payment sanction dates.

(b) The facility has been decertified by ODH and/or the United States department of health and human services.

(c) The provider has pled guilty to or been convicted of a criminal activity materially related to either the medicare or medicaid program.

(d) Any license, permit, or certificate that is ~~required~~ mandated by ODM or the terms of the provider agreement has been denied, suspended, revoked, or not ~~renewed~~revalidated.

(2) ODM ~~shall~~ should terminate, deny, or not revalidate a NF provider agreement for, but not limited to, the following reasons set forth in Chapters 5164. and 5165. of the Revised Code, and Chapters 5160-1 and 5160-3 of the Administrative Code:

(a) In accordance with division (D) of section 5164.35 of the Revised Code, there has been a conviction of, or the entry of a judgment in either a criminal or civil action against the provider or its owner, officer, authorized agent, associate, manager, or employee in an action brought pursuant to section 109.85 of the Revised Code.

(b) The provider has committed medicaid fraud as defined in rule 5160-1-29 of the Administrative Code.

(c) In accordance with section 5165.073 of the Revised Code, the provider does not comply with the ~~requirements~~ provisions of section 3721.071 of the Revised Code for the installation of fire extinguishing and fire alarm systems.

(d) Any of the scenarios specified under division (B) of section 5165.771 of the Revised Code regarding the special focus facility program apply to the provider.

(e) In accordance with section 5165.106 of the Revised Code, the provider fails to file a cost report ~~required by~~ pursuant to section 5165.10 of the Revised Code by the date it is due or by the date, if any, to which the due date is extended pursuant to division (D) of section 5165.10 of the Revised Code, unless the provider submits a complete and adequate cost report within thirty days after notice of termination by ODM.

(f) The provider has failed to ensure a nursing facility's full participation in the medicare program as a skilled nursing facility (SNF) pursuant to section 5165.082 of the Revised Code and rule 5160-3-02.4 of the Administrative Code.

(g) In accordance with section 5165.072 of the Revised Code, the provider fails to maintain eligibility for the provider agreement as set forth in section 5165.06 of the Revised Code.

(h) In accordance with division (B)(1) of section 5164.32 of the Revised Code, the provider fails to file a complete application for revalidation within the time and in the manner ~~required~~necessitated by the revalidation process as specified by ODM.

(3) If ODH terminates certification of a nursing facility, ODM ~~shall~~ should terminate the facility's provider agreement pursuant to section 5164.38 and section 5165.79 of the Revised Code.

(D) Adjudication order.

(1) In accordance with section 5164.38 of the Revised Code, the director of ODM ~~shall~~ should terminate, deny, or not revalidate an existing NF provider agreement by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code, unless such action occurred as the result of events described in division (E) of section 5164.38 of the Revised Code.

(2) In accordance with division (E) of section 5165.77 of the Revised Code, if ODM issues a termination order as the result of events set forth in paragraph (B)(2)(j) of this rule, the termination may take effect prior to or during the pendency of the proceeding under Chapter 119. of the Revised Code.

(E) Impact of provider actions on CMS-imposed reasonable assurance periods.

(1) When seeking reentry to the medicaid program, providers are subject to procedures set forth in CMS publication 100-07 entitled "State Operations Manual" at Chapter 7 section 7321 (~~6/12/14~~11/16/18) for SNFs and NFs, to comply with the provisions at 42 CFR 489.57 (October 1, ~~2015~~2020) that govern reinstatement after termination, ~~and require~~ including that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur.

(2) After CMS has initiated involuntary termination action for a dually certified SNF/NF, or after ODH has initiated involuntary termination action for a medicaid-

certified NF, a provider of a NF who is permitted to voluntarily terminate, voluntarily withdraw, or undergoes a change of operator, or the subsequent operator of the same facility, ~~shall be~~ is subject to reasonable assurance requirements set by CMS when seeking reentry to the medicaid program.

(3) CMS or ODH initiates a termination action when it sends a provider the initial notice certifying noncompliance and proposing termination.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5165.02
Rule Amplifies:	109.85, 3721.071, 5164.32, 5164.33, 5164.35, 5164.38, 5165.072, 5165.073, 5165.106, 5165.77, 5165.771, 5165.79, 5165.85, 5165.87, 5168.52
Prior Effective Dates:	04/07/1977, 12/30/1977, 01/01/1979, 03/23/1979, 08/31/1979, 11/01/1979, 07/01/1980, 07/07/1980, 10/01/1987, 01/01/1995, 05/16/2002, 09/29/2005, 02/15/2011, 01/10/2013, 06/24/2016

5160-3-02.3 **Nursing facilities (NFs): institutions eligible to participate in medicaid as NFs.**

(A) Definitions.

(1) "Certification" means the process by which the state survey agency certifies its findings to the federal centers for medicare and medicaid services (CMS) or the Ohio department of medicaid (ODM) with respect to a facility's compliance with health, safety, and resident rights ~~requirements~~ regulations of divisions (a), (b), (c), and (d) of section 1919 of the Social Security Act, 42 U.S.C. 1396r (~~December 20, 2006~~March 23, 2010).

(2) "Certified beds" mean beds that are counted in a provider facility that meets medicaid standards. A count of facility beds may differ depending on whether the count is used for certification, licensure, eligibility for medicare or medicaid payment formulas, or other purposes.

(3) "Distinct part" means a portion of an institution or institutional complex that is certified to provide skilled nursing facility (SNF) and/or nursing facility (NF) services. A distinct part ~~shall~~ should be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. A distinct part may be a separate building, wing, floor, hallway, or one side of a corridor. A hospital-based SNF or NF is a distinct part by definition. A long term care facility with both SNF and NF distinct parts is one facility, even though the distinct parts are certified separately for medicare and medicaid. "Distinct part", when applied to NFs or SNF/NFs, has the same definition and ~~requirements~~ criteria as in 42 C.F.R. 483.5 (October 1, ~~2015~~2020).

(4) "Dually participating" means simultaneous participation of an institution or institutional complex in both the medicare and medicaid programs.

(5) "Dually participating long term care facility" means an institution that participates as both a SNF under the medicare program, and as a NF under the medicaid program. Such a facility is referred to as a SNF/NF.

(6) "Facility" means the entity subject to certification and approval in order for the provider to be approved for medicaid payment. A facility may be an entire institution such as a free-standing nursing home, or may be a distinct part of an institution such as a hospital or continuing care retirement community.

(7) "Long term care facility" means a NF, SNF, or dually participating SNF/NF.

(8) "Long term care institutional services" means those medicaid funded, institutional medical, health, psycho-social, habilitative, rehabilitative, and/or personal care services that may be provided to eligible individuals in a NF or SNF/NF.

(9) "NF services" means those services available in institutions, or parts of institutions, that are certified as nursing facilities by the Ohio department of health (ODH) or by the state survey agency of another state.

(10) "Religious non-medical health care institution" (RNHCI) means an institution as defined in ~~section 1861(ss)(1) of the Social Security Act,~~ 42 U.S.C. 1395x (ss)~~-~~(1) (~~August 5, 1997~~October 24, 2018), such as the "Christian Science RNHCIs" accredited by the "Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc." RNHCIs are subject to conditions of participation in the medicaid program according to 42 C.F.R. 403 subpart G (October 1, ~~2015~~2020).

(11) "State survey agency" means the agency designated as the state health standard setting authority, and state health survey agency responsible for certifying and determining compliance of long term care facilities with the ~~requirements~~ provisions for participation in the medicaid program. The state survey agency in Ohio is ODH.

(B) Types of long term care institutional services.

(1) The types of long term care institutional services covered in compliance with the provisions of Chapter 5160-3 of the Administrative Code are NF services provided to eligible residents ~~requiring~~ needing either a skilled level of care or an intermediate level of care as set forth in rule 5160-3-08 of the Administrative Code.

(2) Institutions not eligible for participation are:

~~(a) An institution licensed or approved as a tuberculosis hospital.~~

~~(b)~~(a) A prison, juvenile criminal facility, or an institution used to incarcerate individuals involuntarily who have committed a violation of a criminal or civil law.

~~(c)~~(b) An institution for mental diseases, as defined in rule 5160-3-06.1 of the Administrative Code, for persons under sixty-five years old.

(C) ~~Requirements~~Provisions for participation.

To participate in the Ohio medicaid program and receive payment from ODM for long term care institutional services to eligible residents, operators of long term care facilities ~~shall~~ should meet all of the following ~~requirements~~criteria:

(1) Operate an institution that meets the licensure, registration, and other applicable state standards as set forth in this rule.

(2) Operate an institution certified by ODH or by the state survey agency of another state as being in compliance with applicable federal regulations for medicaid participation as a NF with a minimum of four NF certified beds.

(3) Operate an institution for which a current, completed, and signed ODM 03623 "Ohio Medicaid Provider Agreement for Long Term Care Facilities (NFs, SNF/NFs and ICFs-IID)" (rev. ~~4/2014~~7/2019) is on file with ODM.

(D) Qualified types of Ohio NFs.

To be eligible for certification as a NF, an institution ~~shall~~ should qualify as one of the following:

(1) A nursing home licensed by ODH under section 3721.02 of the Revised Code, or a nursing home licensed by a political subdivision certified under section 3721.09 of the Revised Code. Licensed nursing homes eligible for medicaid certification include RNHCIs; or~~:~~

~~(a) RHNCIs.~~

~~(b) Veterans' homes operated under Chapter 5907. of the Revised Code.~~

(2) A county home, county nursing home, or district home owned by the county and operated by the county commissioners in accordance with Chapter 5155. of the Revised Code, or operated by the board of county hospital trustees in accordance with section 5155.011 of the Revised Code; or

(3) A unit of any hospital registered under section 3701.07 of the Revised Code that contains beds categorized before August 5, 1989, as skilled nursing facility beds in accordance with section 3702.521 of the Revised Code; or

(4) A unit of any hospital registered under section 3701.07 of the Revised Code that contains beds categorized as long term care beds as defined in section 3702.51 of the Revised Code.

(E) Mandatory dual participation.

To participate as a NF, all Ohio facilities ~~shall~~ should comply with the provisions in section 5165.082 of the Revised Code and in rule 5160-3-02.4 of the Administrative Code regarding dual participation in the medicare program as a SNF/NF.

(F) Certification of NFs and beds subject to certification survey.

(1) Certification.

A facility's certification as a NF by ODH or by the state survey agency of another state governs the types of services the operator of the facility may provide.

(2) Provider agreements.

(a) A provider agreement with the operator of an Ohio NF or SNF/NF ~~shall~~ should include any part of the facility that meets standards for certification of compliance with federal and state laws and rules for participation in the medicaid program.

(b) Exceptions to this provision are NFs or SNFs that between July 1, 1987 and July 1, 1993 added beds licensed as nursing home beds under Chapter 3721. of the Revised Code. Such facilities ~~are not required~~ do not need to include those beds in a provider agreement, unless otherwise ~~required by~~ necessary to comply with federal law. This exception continues to apply if such facilities subsequently undergo a change of operator.

(3) Beds subject to certification survey.

(a) All beds in a medicaid participating NF or SNF/NF, except those licensed nursing home beds added between July 1, 1987 and July 1, 1993, ~~shall~~ should be surveyed to determine compliance with the applicable certification standards and, if certifiable, included in the provider agreement as NF or SNF/NF beds.

(b) Beds that could quality as NF or SNF/NF beds and were added between July 1, 1987 and July 1, 1993 may be surveyed for compliance at the discretion of the operator. Such facilities ~~are not required~~do not need to include those beds in a provider agreement, unless otherwise ~~required by~~necessary to comply with federal law.

(c) All other beds that meet NF or SNF/NF standards ~~shall~~ should be certified as NF or SNF/NF beds.

(4) The only other basis for allowing nonparticipation of a portion of an Ohio NF or SNF/NF that is not hospital-based is certification of noncompliance by ODH.

(G) ~~Requirements for out~~Out-of-state providers of long term care institutional services.

(1) To participate in the Ohio medicaid program and receive payment from ODM for long term care institutional services to eligible Ohio residents, an operator of a long term care facility located outside Ohio ~~shall~~ should meet all of the following ~~requirements~~criteria in their state of origin:

(a) The operator of the facility ~~shall~~ should hold a valid state ~~required~~ license, registration, or equivalent from the respective state that specifies the level(s) of care the facility is qualified to provide.

(b) The operator of the facility ~~shall~~ should hold a valid and current medicaid provider agreement from the respective state as a NF or SNF/NF provider type.

(2) Additionally, out-of-state providers ~~shall~~ should meet the following Ohio ~~requirements~~criteria:

(a) The operator of the facility ~~shall~~ should have a current, completed and signed ODM 03623 on file with ODM.

(b) The operator of the facility ~~shall~~ should obtain resident-specific and date-specific prior authorization from ODM in accordance with rule 5160-1-11 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
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5160-3-02.4 **Nursing facilities (NFs): mandatory dual participation in the medicare program.**

(A) Definitions.

(1) For purposes of this rule, the terms "certified beds," "dually participating," "facility," and "religious non-medical health care institution" (RNHCI) are defined in rule 5160-3-02.3 of the Administrative Code.

(2) For purposes of this rule, the term "reasonable assurance period" is defined in rule 5160-3-02.1 of the Administrative Code.

(3) "Fully participating" means participation of an institution in its entirety, either in the medicare or medicaid program, or both. A fully participating skilled nursing facility (SNF) is one in which every bed is certified for participation in medicare. A fully participating nursing facility (NF) is one in which every bed is certified for participation in medicaid. A fully participating SNF/NF is one in which every bed is certified for participation in both medicare and medicaid.

(B) Mandatory medicare participation and exceptions.

(1) Operators of Ohio NFs ~~shall~~ should have all medicaid-certified beds as counted in the medicaid provider agreement also certified under medicare as SNF beds, in accordance with section 5165.082 of the Revised Code and the provisions of this rule.

(2) Exceptions to mandatory medicare participation are:

(a) RNHCIs.

~~(b) Veteran's homes operated under Chapter 5907. of the Revised Code.~~

~~(c)~~(b) Out-of-state providers of long term care institutional services in accordance with the criteria specified in paragraph (G) of rule 5160-3-02.3 of the Administrative Code.

~~(d)~~(c) Hospital beds re-categorized as skilled nursing beds after August 5, 1989 in accordance with section 3702.521 of the Revised Code. These beds are not permitted to be covered by a medicaid provider agreement.

(C) Dual and full participation.

(1) Operators of Ohio NFs currently holding a medicaid provider agreement under which all medicaid-certified beds are also medicare-certified are in compliance with the ~~requirement~~provision ~~for~~that NFs ~~to~~ be both dually and fully participating SNF/NFs.

(2) Pursuant to rule 5160-3-02.2 of the Administrative Code, the Ohio department of medicaid (ODM) ~~shall~~ should terminate or not revalidate an operator's provider agreement if the provider fails to ensure a nursing facility's full participation in the medicare program as a SNF.

(D) Enrollment of new facilities.

(1) Operators of Ohio facilities requesting participation in the medicaid NF program ~~must~~ should provide documentation that they have requested full participation in the medicare SNF program.

(2) Operators of Ohio facilities requesting participation in the medicaid NF program that have been recommended for medicaid certification by the Ohio department of health (ODH) and that have provided documentation that they have requested full participation in the medicare SNF program, may be issued a fully participating NF medicaid provider agreement with an effective date determined in accordance with rule 5160-3-02.1 of the Administrative Code.

(3) After ODM is notified by the ~~centers for medicare and medicaid services (CMS) that a facility operator's request for medicare certification has been approved~~state survey agency that a facility has passed their survey and is certified for participation in the medicare program, a SNF/NF provider agreement may be issued by ODM using the medicare SNF's effective date of certification in accordance with rule 5160-3-02.1 of the Administrative Code.

(4) If ODM is notified by CMS that a facility operator's request for medicare participation has been denied and all appeals have been exhausted, ODM ~~shall~~ should terminate the NF's provider agreement in accordance with rule 5160-3-02.2 of the Administrative Code.

(E) Readmission to the medicaid program.

(1) A facility operator requesting readmission to the medicaid program ~~must~~ should provide documentation of the request for admission or readmission, and of full participation in the medicare SNF program.

(2) If a facility's participation in the medicaid program ends due to voluntary withdrawal from participation by the operator, and the operator requests

readmission to the medicaid NF program, enrollment will be processed in the same manner as for a new facility as set forth in paragraph (D) of this rule.

(3) If a facility's participation in the medicaid program ends due to involuntary termination, cancellation, or non-revalidation by ODM, and ODH recommends that the facility receive certification, ODM may issue a provider agreement that begins on or after the effective date of medicare certification or recertification. If CMS has imposed a reasonable assurance period prior to re-entry to the medicare program, the reasonable assurance period also ~~shall be~~ is imposed for medicaid enrollment purposes.

(F) Change of operator.

If a SNF/NF undergoes a change of operator that results in a change of provider agreement, the entering operator ~~must~~ should either accept assignment of the exiting operator's provider agreement and survey results, or refuse assignment and undergo a new certification survey. An operator may accept or refuse assignment of the medicare provider agreement and/or the medicaid provider agreement.

(1) If an entering operator of a SNF/NF accepts assignment of both the medicare and medicaid provider agreements of the exiting operator, ODM ~~shall~~ should issue a SNF/NF provider agreement to the entering operator. The entering operator ~~must~~ should continue to operate a dually participating facility that fully participates in both the medicare and medicaid programs.

(2) If an entering operator of a SNF/NF refuses to accept assignment of the exiting operator's medicare provider agreement, but does accept assignment of the exiting operator's medicaid provider agreement, the entering operator ~~must~~ should meet requirements for medicare participation in the same manner as for a new facility as set forth in paragraph (D) of this rule.

(3) If an entering operator of a SNF/NF refuses to accept assignment of the exiting operator's medicaid provider agreement, ODM ~~shall~~ should terminate the agreement of the exiting operator. To enter the medicaid program, the entering operator ~~must~~ should apply for medicaid participation as a new facility. Upon notice of certification approval from ODH, ODM may issue a medicaid provider agreement to the entering operator in the same manner as for new facilities as set forth in paragraph (D) of this rule.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5165.02
Rule Amplifies:	5165.082
Prior Effective Dates:	09/29/2005, 02/15/2011, 06/24/2016

TO BE RESCINDED

5160-3-39 **Payment and adjustment process for nursing facilities (NFs).**

(A) Forms.

For dates of services preceding July 1, 2005, NFs shall submit the form "Nursing Facility Payment and Adjustment Authorization" (JFS 09400, rev. 10/2012) directly to the Ohio department of job and family services (ODJFS) for the reimbursement of services.

The county department of job and family services (CDJFS) and NFs shall use the "Facility/CDJFS Transmittal" (JFS 09401, rev. 4/2011) form to exchange information necessary to complete the billing process for payment.

(B) Notification of admission.

The facility shall notify the CDJFS using the JFS 09401 form within five business days of admission of a new resident who is medicaid eligible or who has an application for medicaid that is pending even if care may initially be covered under a medicare benefit.

(C) Notification of death.

The NF shall notify the CDJFS of the death of a medicaid resident by completing the JFS 09401 and forwarding it to the CDJFS within five business days following the death of the resident. The CDJFS shall terminate medicaid eligibility within ten days after the receipt of the JFS 09401.

For dates of service preceding July 1, 2005, the CDJFS shall stop vendor payment within ten days after the receipt of the JFS 09401.

(1) The CDJFS shall complete and return the JFS 09401, when appropriate, to the NF within ten days of the receipt of the JFS 09401 for any required payment adjustment.

(2) The NF shall complete the JFS 09400, when appropriate (e.g., final payment adjustment), within thirty days of the receipt of the JFS 09401 and submit it to the address listed on the bottom of form JFS 09400.

(D) Notification of discharge.

Discharge has the same meaning as defined in rule 5101:3-3-16.4 of the Administrative Code. The NF shall notify the CDJFS within five business days of the discharge of a medicaid eligible resident by completing the JFS 09401 identifying the type of discharge, and forwarding the JFS 09401 to the CDJFS. The CDJFS shall adjust medicaid eligibility within ten days after the receipt of the JFS 09401.

For dates of service preceding July 1, 2005, the CDJFS shall stop vendor payment within ten days after the receipt of the JFS 09401.

(1) The CDJFS shall complete and return the JFS 09401, when appropriate, to the NF within ten days after the receipt of the JFS 09401 for any required payment adjustment.

(2) The NF shall complete the JFS 09400, when appropriate (e.g., final payment adjustment), within thirty days of the receipt of the JFS 09401 and submit to the address listed on the bottom of form JFS 09400.

(E) Notification of hospice enrollment.

If a NF resident on medicaid vendor payment elects to receive medicaid hospice services in accordance with rule 5101:3-56-03 of the Administrative Code, the NF shall notify the CDJFS by completing the JFS 09401 and forwarding it to the CDJFS within five business days of receiving notice from the hospice agency that a resident elected hospice services. The CDJFS shall adjust medicaid eligibility within ten days after receipt of the JFS 09401 for the resident enrolled in hospice.

For dates of service preceding July 1, 2005, the CDJFS shall stop vendor payment within ten days after the receipt of the JFS 09401.

(1) The CDJFS shall complete and return the JFS 09401, when appropriate (e.g., final payment adjustment), to the NF within ten days of the receipt of the JFS 09401 for any required payment adjustment.

(2) The NF shall complete the JFS 09400, when appropriate, within thirty days of the receipt of the JFS 09401 and submit it to the address on the bottom of form JFS 09400.

Effective:

Five Year Review (FYR) Dates:

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Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03
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