Ohio Administrative Code

Rule 5160-3-50 Nursing facilities (NFs): use of additional dollars as a result of rebasing of rates.

Effective: July 10, 2022

(A) Definitions.

For purposes of this rule:

(1) "Ancillary and support costs," "cost center," "direct care costs," "rebasing" and "tax costs" have the same meaning as in section 5165.01 of the Revised Code.

(2) "Cost center report" means a report submitted to the Ohio department of medicaid (ODM) by a nursing facility provider that identifies the amount spent on each cost center included in rebasing.

(B) Direct care spending.

(1) In accordance with section 5165.36 of the Revised Code, nursing facilities should increase direct care spending by at least seventy percent of any additional dollars received as a result of rebasing.

(2) For purposes of determining compliance with section 5165.36 of the Revised Code, the increased spending in direct care will be evaluated using calendar year 2019 medicaid nursing facility cost report data for direct care.

(C) Submission of cost center reports.

(1) In accordance with Section 333.240 of Amended Substitute House Bill 110 of the 134th General Assembly, for state fiscal years 2022 and 2023, cost center reports are to be submitted as follows:

(a) The first cost center report is to be submitted not later than ninety days after the end of calendar year 2021 and should cover the period of July 1, 2021 through December 31, 2021.

(b) Subsequent cost center reports should cover one calendar year each and should be submitted not

later than ninety days after the end of the applicable calendar year.

(2) Reports should include only direct care, ancillary and support, and tax costs as well as inpatient days.

(3) Reports should be submitted on an electronic form prescribed by ODM.

(D) Extensions.

For good cause shown, cost center reports may be submitted within fourteen days after the original due date if written approval is received from ODM prior to the original due date of the report. Requests for extensions should be sent via email to LTCAudits@medicaid.ohio.gov and explain the circumstances resulting in the need for an extension.

(E) Late reporting penalties.

(1) If a report is not received by the original due date, or by an approved extension due date if applicable, the provider may be assessed a late reporting penalty for each day a complete and adequate report is not received

(2) The late reporting penalty period begins on the day after the original due date or on the day after the extension due date, whichever is applicable, and continues until the complete and adequate report is received by ODM.

(3) The late reporting penalty will be one hundred dollars per calendar day for each day after the original due date or the extension due date, whichever is applicable, that a nursing facility does not submit a cost center report.

(4) The late reporting penalty is assessed annually and will be a reduction in payments to providers that submit claims directly to ODM or by payment submitted to ODM outside the claims process for providers that do not submit claims directly to ODM. No penalty is imposed during a fourteen-day extension granted by ODM.

(F) Change of operator (CHOP).

In cases of a change of operator, the exiting operator's 2019 cost reports and the additional dollars received as a result of rebasing will be used for the purposes of determining the entering operator's compliance with section 5165.36 of the Revised Code and Section 333.240 of Amended Substitute House Bill 110 of the 134th General Assembly.

(G) New providers.

For state fiscal years 2022 and 2023, nursing facilities with an initial medicaid certification date on or after January 1, 2020 are excluded from the requirements set forth in paragraphs (B) and (C) of this rule.

(H) Reviews.

For purposes of determining compliance with this rule, Section 333.240 of Amended Substitute House Bill 110 of the 134th General Assembly, and section 5165.36 of the Revised Code, ODM may conduct reviews of cost center report data beginning with calendar year 2022 data.

(I) Reimbursement of funds to ODM.

(1) Any amounts spent on cost centers other than as permitted by this rule, Section 333.240 of Amended Substitute House Bill 110 of the 134th General Assembly, and section 5165.36 of the Revised Code will be reimbursed to ODM with interest.

(a) The interest will be no greater than two times the current average bank prime rate determined at the mid-point of the reporting quarter.

(b) Interest will accrue from the mid-point of the reporting quarter until the date funds are recouped from medicaid payments or until payment is submitted to ODM outside the claims process for providers who do not submit claims directly to ODM.

(2) Reimbursement of funds pursuant to a review as set forth in paragraphs (H) and (I) of this rule is

not subject to appeal under Chapter 119. of the Revised Code.