Rule Summary and Fiscal Analysis (Part A)

Ohio Department of Medicaid
Agency Name

Tommi Potter
Division | Contact

50 West Town Street Suite 400 Columbus OH 43218-2709 | **614-752-3877** | **614-995-1301**
Agency Mailing Address (Plus Zip) | Phone | Fax

Tommi.Potter@medicaid.ohio.gov
Email

5160-26-03 **AMENDMENT**
Rule Number | TYPE of rule filing

Rule Title/Tag Line **Managed health care programs: covered services.**

RULE SUMMARY

1. Is the rule being filed for five year review (FYR)? **No**

2. Are you proposing this rule as a result of recent legislation? **No**

3. Statute prescribing the procedure in accordance with the agency is required to adopt the rule: **119.03**

4. Statute(s) authorizing agency to adopt the rule: **5167.02**

5. Statute(s) the rule, as filed, amplifies or implements: **5164.34, 5167.201, 5167.20, 5167.10, 5167.03**

6. State the reason(s) for proposing (i.e., why are you filing,) this rule:

This rule is being amended to clarify policy relating to the administration of the Medicaid Managed Care program.

7. If the rule is an AMENDMENT, then summarize the changes and the content of the proposed rule; If the rule type is RESCISSION, NEW or NO CHANGE, then summarize the content of the rule:

This rule sets forth the services Medicaid managed care plans are required to cover. Changes to the rule include: in paragraph (A) clarified that plans must cover Ohio Medicaid state plan services; updated the prior authorization language in (A)(3) to prevent plans from imposing hard limits on services, updated medical necessity

language in (B)(1) to be member specific; in paragraph (E)(7) added a requirement that the MCP must reimburse for emergency services until the member is stabilized and can safely be discharged or transferred; in paragraph (H)(12) added language related to payment for IMD stays; updated language in paragraph (I)(2) to allow plans to prior authorize additional services after the 100 hour limit has been reached; updated Healthchek language to remove notification requirements because notification is covered thoroughly in the provider agreement; removed respite payment language; and other grammatical/technical edits.

8. If the rule incorporates a text or other material by reference and the agency claims the incorporation by reference is exempt from compliance with sections 121.71 to 121.74 of the Revised Code because the text or other material is **generally available** to persons who reasonably can be expected to be affected by the rule, provide an explanation of how the text or other material is generally available to those persons:

This rule incorporates one or more references to another rule or rules of the Ohio Administrative Code (OAC). This question is not applicable to any incorporation by reference to another OAC rule because such reference is exempt from compliance with RC 121.71 to 121.74 pursuant to RC 121.76(A)(3). OAC Medicaid rules may be found online at: http://codes.ohio.gov/oac/5160.

This rule incorporates one or more references to the Ohio Revised Code. This question is not applicable to any incorporation by reference to the Ohio Revised Code because such reference is exempt from compliance with RC 121.71 to 121.74 pursuant to RC 121.76(A)(1). The Ohio Revised Code references may be found online at: http://codes.ohio.gov/orc/51.

9. If the rule incorporates a text or other material by reference, and it was **infeasible** for the agency to file the text or other material electronically, provide an explanation of why filing the text or other material electronically was infeasible:

Not applicable.

10. If the rule is being **rescinded** and incorporates a text or other material by reference, and it was **infeasible** for the agency to file the text or other material, provide an explanation of why filing the text or other material was infeasible:

Not Applicable.

11. If **revising** or **refiling** this rule, identify changes made from the previously filed version of this rule; if none, please state so. If applicable, indicate each specific paragraph of the rule that has been modified:

Not Applicable.

12. Five Year Review (FYR) Date: **2/1/2022**

(If the rule is not exempt and you answered NO to question No. 1, provide the scheduled review date. If you answered YES to No. 1, the review date for this rule is the filing date.)

NOTE: If the rule is not exempt at the time of final filing, two dates are required: the current review date plus a date not to exceed 5 years from the effective date for Amended rules or a date not to exceed 5 years from the review date for No Change rules.

FISCAL ANALYSIS

13. Estimate the total amount by which *this proposed rule* would **increase / decrease** either **revenues / expenditures** for the agency during the current biennium (in dollars): Explain the net impact of the proposed changes to the budget of your agency/department.

This will have no impact on revenues or expenditures.

0.00

No impact on current budget.

14. Identify the appropriation (by line item etc.) that authorizes each expenditure necessitated by the proposed rule:

Not applicable.

15.
Provide a summary of the estimated cost of compliance with the rule to all directly affected persons. When appropriate, please include the source for your information/estimated costs, e.g. industry, CFR, internal/agency:

There are no new costs of compliance with the changes to this rule. OAC rule 5160-26-03 holds MCPs financially responsible for payment of certain services. Requirements in addition to the payment for covered services as outlined in this rule include: Establishing, in writing, a process for the submission of claims for services delivered by non-contracting providers; Designating a telephone line to receive provider requests for coverage of certain services; and Submitting written requests or notifications to ODM, contracting providers and members. Managed care plans (MCPs) are paid per member per month and receive funds to cover required services. ODM must pay MCPs rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.4 and CMS's 2016 Managed Care Rate Setting Consultation Guide. All rates and actuarial methods can be found on the ODM website in Appendix E of the Medicaid Managed Care provider agreement.

Provider agencies are required to: Be accredited by at least one of several national accreditation entities; Hold a Medicaid provider agreement; Comply with applicable background check requirements; and Behavioral health provider agencies must be OhioMHAS certified.

Agency employees: Long-term care providers must obtain a certificate of completion from the Ohio Department of Health or a Medicare competency evaluation program; All providers must obtain first aid certification; and Long-term care providers must obtain evidence of completion of twelve hours of in-services continuing education each year.

16. Does this rule have a fiscal effect on school districts, counties, townships, or municipal corporations? **No**

17. Does this rule deal with environmental protection or contain a component dealing with environmental protection as defined in R. C. 121.39? **No**

S.B. 2 (129th General Assembly) Questions

18. Has this rule been filed with the Common Sense Initiative Office pursuant to R.C. 121.82? **Yes**

19. Specific to this rule, answer the following:

A.) Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business? **No**

B.) Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms? **No**

C.) Does this rule require specific expenditures or the report of information as a condition of compliance? **Yes**

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Consultation Guide. All rates and actuarial methods can be found on the ODM website in Appendix E of the Medicaid Managed Care provider agreement.

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