CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Job and Family Services

Regulation/Package Title: Medicaid: Determining Patient Liability

Rule Number(s): 5101:1-39-24

Date: 6/27/13

Rule Type:

- ☐ New
- X Amended
- X 5-Year Review
- ☐ Rescinded

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

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Regulatory Intent

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

   This regulation sets forth the policies for determining Medicaid patient liability. The regulation was opened in order to make changes to comply with a Federal Court Order in Ledford v. Colbert, Case No. 1:10-cv-706, which required a disregard of certain pension income for veterans. The actual amendments to this regulation have no impact on business. However, the requirements in paragraphs (E), (F) and (G), which are unchanged from previous versions, require Medicaid Providers to participate in the processing of patient liability payments. These requirements result in a minimal business impact to the Medicaid Provider.

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

   Ohio Revised Code sections 5111.01, 5111.011

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

   This regulation implements Federal requirements for Medicaid eligibility standards and post-eligibility treatment of income. The regulation is necessary for participation, administration and enforcement of the Medicaid Program. The following regulations are implicated: 42 USC 1396a (state plans for medical assistance), 42 USC 1396b (payment to states of federal match), 42 USC 1396k (assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State), 42 CFR 435.733 (post-eligibility treatment of income of institutionalized individuals in States using more restrictive requirements than SSI: Application of patient income to the cost of care), 42 CFR 435.735 (post-eligibility treatment of income and resources of individual receiving home and community-based services furnished under a waiver: application of patient income of the cost of care) and 42 CFR 484.10(e) (condition of participation, patient rights: patient liability for payment).

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

   None. The parts of the regulation triggering this analysis are required and in-line with federal regulations and authority.

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

   This regulation describes how the agency determines the amount of income a Medicaid recipient must contribute towards the cost of his/her long-term care services as required by Federal Medicaid law.

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

   The successful output/outcome is determined by the compliance of the State of Ohio with Federal Medicaid requirements and making the correct determination of the patient liability for Medicaid recipients. The accuracy of those determinations is ascertainable by periodic Medicaid Eligibility Qualify Control (MEQC) audits.

Development of the Regulation

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

   The draft regulation went through internal pre-clearance review and was posted on the state clearance website on February 1, 2013 for a period of 14 days. Comments were received from Ohio Department of Job and Family Services & OMA (Legal, Policy and Bureau of State Hearings), County Department of Job and Family Services staff, and ProSeniors attorneys.

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

The parts of the regulation triggering this analysis generated no comments from stakeholders. There were, however, general comments about clarification of definitions and terms used in the regulation, for example the terms "administrative agency," "institutionalization" and "separated spouses" found in part B. Additionally, one stakeholder expressed concern about whether an individual had to pay both a spenddown and a patient liability in the same month. As a result of the latter comment, that section of the regulation was rewritten for clarity.

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

   The use of scientific data is not applicable to the requirements of this rule.

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

    This rule is required by Federal law 42 USC 1396a, 42 USC 1396b, 42 USC 1396k, 42 CFR 435.733, 42 CFR 435.735 and 42 CFR 484.10(e). As such, the Agency does not consider alternative regulations appropriate.

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

    No. There are no specific regulations governing the process for Medicaid Providers, other than the provider is required to receive, process, or refund the payments. Performance-based regulation would be inapplicable because Medicaid Providers are given flexibility to develop and use methods to best fit their business models to accomplish the regulation.

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

    The Agency performed a review of the Ohio Administrative Code. Regulations defining the calculation of patient liability for Ohio Medicaid recipients of long-term care services exist in only two regulations, this rule and in OAC 5101:1-39-24.1 (describes a variation of the patient liability calculation for recipients of the Assisted Living Waiver). Further, under Ohio Revised Code Section 5101.01(B), the Ohio Department of Medicaid is the single state

agency to supervise the administration of the Medicaid program, and its regulations governing Medicaid are binding on other agencies that administer components of the Medicaid program. No agency may establish, by rule or otherwise, a policy governing Medicaid that is inconsistent with a Medicaid policy established, in rule or otherwise, by the medical assistance director.

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

    The parts of the regulation triggering this analysis do not require the Medicaid Provider to implement anything, as it is already part of the standard business practice of the Medicaid Provider. However, implementation of the amended parts of this regulation will be performed on behalf of the Agency by the 88 county departments of job and family services (CDJFS). County eligibility workers will determine the Medicaid recipients' or applicants' patient liability amount in the course of normal business. The CDJFS will then communicate this amount to the Medicaid Provider, as is the standard course of business today.

Adverse Impact to Business

14. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**

    a. **Identify the scope of the impacted business community;**
    The target of this regulation is not primarily the business community, but does have a minimal business impact on Medicaid Providers. The Agency, and by extension, the CDsJFS will use this regulation to determine patient liability amounts for Medicaid recipients of long-term care services. It is a long-standing standard business practice that Medicaid providers incur the cost of compliance with this regulation, as it receives, processes, and refunds patient liability payments for the individuals it serves.

    b. **Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and**
    Medicaid providers will expend the same amount of employee time in receiving, processing, and refunding patient liability payments as they currently do. In addition, PACE providers will expend the same amount of employer time informing recipients

where to send patient liability payments. The implementation of the amended regulation will also cause a slight increase in administrative effort at CDJFS; county eligibility workers will have to take a few extra steps to ensure the correct patient liability amount is entered into the electronic eligibility system, as it is not programmed to perform calculations in accordance with the change presented in this regulation.

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.

This is a minor change to an established business practice; as such, for Medicaid providers, these practices are not new and are a standard part of business. Based on interviews with two providers, the estimated amount of time to receive and process patient liability and to process over-payments is a few hours per month. Similarly, per a discussion with a PACE provider, the estimated amount of time to receive and process patient liability payments range from a few moments for patients who consent to automatic ACH withdrawals of the patient liability, to a few hours for patients who pay patient liability by check.

The regulations should also have minimal impact to the CDJFS. The extra steps required of the county eligibility workers should take no more than a few minutes per affected applicant.

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

The parts of the regulation triggering this analysis were not changed from previous versions. Those sections that create a minimal impact on business are long-standing standard business practices for Medicaid providers, which includes the cost of compliance to process, receive, or refund payments from the individuals served. The intent of the regulation, as a whole, is to comply with Federal regulation and to ensure continuation of the Medicaid program.

Regulatory Flexibility

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

No. When Medicaid recipients are required to pay patient liability (their share of the cost of care) the Medicaid Provider has to have the ability to receive, process, and refund those payments. PACE Providers also have to inform recipients where to make patient liability payments. If these practices are not done appropriately, and the recipient is found to have paid more than required, a violation of State and Federal law has occurred. For example, see, Ohio Administrative Codes 5101:1-39-24 and 5101:1-39-24.1, 42 CFR 435.733 and 42 CFR 435.735.

There are no specific regulations governing this process, other than the provider is required to receive, process, or refund the payments. As such, Medicaid Providers are given flexibility to develop and use methods to best fit their business models to accomplish the regulation.

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

This is not applicable since there are no fines or penalties associated with non-compliance.

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

Medicaid providers in need of technical assistance can contact Medicaid Provider Assistance at 1-800-686-1516.