CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: BMC Respite Care and Third Party Rule Revisions

Rule Number(s): 5101:3-26-03 and 5101:3-26-09.1

Date: 9/16/2013

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- ☐ Rescinded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.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   OAC rule 5101:3-26-03 sets forth the covered services that Medicaid managed care plans (MCPs) are required to provide to Medicaid managed care members. The rule is being

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amended to add respite services for Medicaid children enrolled in Medicaid managed care plans who are under the age of 21 years and eligible for Supplemental Security Income (SSI). "Respite services" are services that provide short-term, temporary relief to an informal unpaid caregiver of an individual under the age of 21 in order to support and preserve the primary caregiving relationship. Other amendments clarify language describing the obligations of MCPs regarding payment for emergency conditions and update cross-references and legal citations.

The amendments to OAC rule 5101:3-26-09.1 address an MCP's obligation to report all cases of suspected fraud and abuse by providers subcontracting with the MCP, and specify the circumstances under which an MCP may keep the funds recovered as the result of the identification of fraud and abuse. Other amendments clarify the coordination of benefits for prenatal and preventive pediatric services, update cross-references and legal citations, and change the agency's name from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).

A BIA is being completed due to the language that requires that plans establish procedures and report information. Specifically, OAC rule 5101:3-26-03 requires MCPs to establish, in writing, the process and procedures for claims submissions from non-contracting providers. OAC rule 5101:3-26-09.1 requires MCPs to report to ODM suspected cases of fraud and abuse and identified resources for tort recoveries.

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

   Sections 5111.01, 5111.02, 5111.021, 5111.16, 5111.162, 5111.163, 5111.17, 5111.172 and Chapter 119. of the Ohio Revised Code (ORC).

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?**

   Yes. OAC rule 5101:3-26-03 specifies the covered services that MCPs must cover. 42 CFR 438.6(l) requires all subcontracts to fulfill the requirements of 42 CFR 438.6 that are appropriate to the service or activity delegated under the subcontract. Further 42 CFR 438.114(c) requires MCPs to cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCP. Since MCPs must pay for emergency services to non-contracting providers, they must also establish the submission processes for the claims for services.

   Additionally, OAC rule 5101:3-26-09.1 specifies the federal managed care requirements for third party recovery. Pursuant to 42 CFR Parts 455 and 438, States are required to conduct

appropriate program integrity processes and methods to ensure the efficient operation of the MCPs. This includes mechanisms to safeguard against fraud and abuse.

ODM must comply with these and other federal Medicaid regulations as a condition for receiving federal funding to operate Ohio's Medicaid program.

This proposed regulations allow the State to monitor the performance of MCPs.

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

   Although the federal regulations do not impose requirements directly on MCPs, they do require state Medicaid agencies to ensure MCP compliance with federal standards.

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)?**

   The public purpose of this regulation is to comply with federal regulations that require the State Medicaid agency to ensure that MCPs provide information about emergency services and reporting of fraud and abuse, so that the information is readily available for the State, and if requested, for the Centers for Medicare and Medicaid Services (CMS).

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

   Through the review of reports, the Agency verifies that MCPs are complying with federal standards. With five MCPs in the state, all will be expected to provide similar information, making missing information more obvious, measuring the success of the regulation.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**

   The Ohio Council for Home Care and Hospice, Midwest Care Alliance, Voices for Ohio's Children, Arc of Ohio and Medicaid managed care plans have been involved in the development of the draft amendments to rule 5101:3-26-03 that will add respite services. Medicaid managed care plans were involved in the review of both regulations when they were initially drafted in 2006. The rules were made available for public comment to stakeholders and the general public during the ODM policy clearance process in 2006.

   In 2012, Ohio Medicaid issued a request for applications (RFA) for MCPs to contract with the State Medicaid agency beginning July 1, 2013. The applying MCPs were aware of the expectations and requirements they would be held to if they were to become a Medicaid MCP for the state of Ohio. Since the regulations were in place prior to the RFA process last year,

these plans were already aware of the reporting requirements. The MCPs under contract with the state in 2006 were Amerigroup, Anthem, Buckeye, CareSource, Molina, Paramount, Unison and WellCare. The MCPs selected for the current procurement are Buckeye, CareSource, Molina, Paramount and UnitedHealthCare.

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

   The stakeholders provided comments when the regulations were initially drafted in 2006 and the Agency responded during the public comment period. Stakeholders have provided informal input that has been the basis for the draft regulations. Additionally, stakeholders provided formal input when the rule was distributed to stakeholders during the department's clearance process from August 29 to September 12, 2013. Comments received during clearance included requests to broaden the weekly respite limit and the rules have been revised to change the weekly respite limit to a monthly limit. All comments received to date have been considered in developing the draft regulations.

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?**

   No scientific data was used; however, the requirements in these rules are based on federal regulations as mentioned above.

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?**

    The Agency considered performing periodic audits; however, reports provide more real-time feedback to assure timely access to needed services for Medicaid beneficiaries.

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.***

    A performance-based regulation would not comply with the federal regulations. However, through the submission of the requested data, the Agency is able to determine whether the MCPs are meeting the standards specified in federal regulations.

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

    All Medicaid regulations governing MCPs are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid program.

Furthermore, this regulation was reviewed by ODM's legal and legislative staff to ensure that there is no duplication within ODM rules.

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.**

    All five MCPs are required to publish claims submission requirements and submit reports for instances of fraud and abuse.

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;**
       This rule only impacts MCPs in the State. The MCPs that will be impacted are Buckeye, CareSource, Molina, Paramount and UnitedHealthCare.
    b. **Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and**
       Administrators of MCPs will be required to establish claims submission processes for non-contracting providers and maintain and submit required reports for instances of fraud and abuse.
    c. **Quantify the expected adverse impact from the regulation.**
       Through the administrative component of the capitation rate paid to the MCPs by the Department of Medicaid, MCPs will be compensated for the cost of the time required in maintaining and submitting required reports. Furthermore, the MCPs were aware of the need to maintain and submit various reports prior to deciding to do business with the State.

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

    The MCPs were aware of the federal requirements for the reporting of information prior to seeking contracts with the state, as well as before signing their contracts with the state. More importantly, without the requested reports the State would be out of compliance with federal regulations.

Regulatory Flexibility

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

    No, as none of the five MCPs qualifies as a small business.

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?**

The Agency will not apply this section of the ORC as the waiving of penalties would render Ohio's Medicaid agency out of compliance with federal regulations.

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

None, as none of the five MCPs qualifies as a small business.