CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Medicaid Consumer Liability

Rule Number(s): 5160-1-13.1

Date: 2/24/14

Rule Type:

- ☐ New
- ✓ Amended
- ✓ 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- ☐ Rescinded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.

Rule 5160-1-13.1 defines conditions under which Medicaid consumers may or may not be billed for medical services. The rule also states that any Medicaid provider accepts as payment in full the amount paid by the agency.

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

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Ohio Revised Code 5164.02

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. 5160-1-13.1 assists ODM in complying with Section 1902 (a)(19) of the Social Security Act, which requires states to provide necessary safeguards to assure that services delivered through the Medicaid program are in the best interests of the recipients. ODM must meet the requirements under this section of the Act in order to participate in the federal/state run Medicaid program.

Section (A) of 5160-1-13.1 also complies with CMS regulations, 42 CFR 447.15, that requires any provider enrolled in Medicaid accept, as payment in full, the amounts paid by the agency.

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

To ensure both member choice and market transparency, ODM may require the provider to do 3 things before billing the member: 1) notify the member prior to rendering the medical service that the provider will not bill ODM for the covered service; 2) the member signs an agreement to become liable for the rendered medical service; and 3) the provider explains to the member that he or she may receive the medical service from another provider at no cost to the member.

Furthermore, to ensure program integrity and patient safety, providers cannot bill Medicaid members if submitted claims were denied because of failure to comply with timely filing requirements or lack of medical necessity.

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 rule serves as a safeguard for Medicaid consumers. The provisions ensure that all Medicaid beneficiaries have an informed choice in whether or not to pay out-of-pocket for medical services or receive services from a provider who will bill the Department. The provisions also ensure patient safety by prohibiting providers from billing consumers for claims that were denied for lack of medical necessity.

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

The Department will start tracking the percentage of Medicaid enrolled individuals, 19-64, who have had difficulty paying medical bills in the last 12 months. The source of this data comes from the Ohio Medicaid Assessment Survey. The latest Survey, completed in 2012, showed that over 30% of Medicaid enrolled individuals, 19-64, had trouble paying medical bills in the last 12 months compared to over 33% for those individuals not enrolled in Medicaid.

Development of the Regulation

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

All providers and the public had opportunities to review and comment on the rule during ODM's 2-week clearance process. ODM policy staff has met with internal and external stakeholders during the review of this rule. Policy staff meets with provider relations and ombudsman staff on a regular basis and frequently discusses and reviews this rule. Staff have also met with representatives from the Ohio Hospital Association during ODM's large provider group meeting to discuss this rule and clarify the Medicaid consumers to whom this rule applies.

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

Stakeholders wanted to know whether or not certain Medicaid eligibility groups fall under the definition of Medicaid consumers for purposes of sections (C) and (D) of this rule. While no change was made to the rule, a clarification was made for consumers who are enrolled with ODM as Qualified Medicare Beneficiaries-only: providers should follow Medicare consumer liability and advanced beneficiary notice policies, and also refer to rule 5160-1-05 (B)(4). Furthermore, policy staff provided stakeholders with a contact list for Medicare Administrative Contractors (MACs), so interested parties may seek further information from Medicare.

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?

Not applicable.

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 did not consider regulatory alternatives because the provisions implement federal regulations and protect Medicaid beneficiaries from further financial hardships.

11. Did the Agency specifically consider a performance-based regulation? Please explain.

No, because the rule is meant to educate the member to make a choice about the payment of his/her medical services. ODM requires the provider disclose certain information to the member before billing, so the member may make an informed decision about where to receive his/her medical services.

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

The rule was reviewed by policy and legal staff for ODM. There are no other regulations in the Medicaid program that define under which conditions a provider may bill a member for medical services.

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.

As with all Medicaid OAC rules requiring compliance, ODM plans on training for the Surveillance, Utilization, and Review System to ensure that staff incorporate consumer liability requirements into their provider audits.

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;

All businesses enrolled as Medicaid providers are subject to this rule.

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

Affected businesses are required to report information to the Medicaid member prior to billing for rendered services.

c. Quantify the expected adverse impact from the regulation.

Health care providers are already required to disclose information to consumers, such as HIPAA and HITECH Act-related information. Any additional time will depend on if the provider creates a standard Medicaid disclosure document or if the provider complies on a case-by-case basis. The former tactic would reduce the marginal cost of compliance.

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

The benefits that come from increased individual choice are hard to quantify. However, the financial benefit to the Medicaid member of potentially avoiding a catastrophic medical bill outweighs the cost of compliance to the provider. Considering Medicaid members have little to no income, the benefits of avoiding high medical-related debt, compounding interest from collections, and potential bankruptcies also outweigh the provider's opportunity costs of compliance.

Regulatory Flexibility

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

No, there are no small business exceptions. There is no reason why small business should be treated differently in this instance as this is a rule meant to protect Medicaid consumers. All impacted businesses can decide how they come into compliance, so long as the required disclosure and choice are afforded the Medicaid member.

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 rule imposes no sanctions on providers.

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

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.

5160-1-13.1 **Medicaid consumer liability~~[except for services provided through a medicaid managed health care program]~~.**

(A) The medicaid payment for a covered service constitutes payment-in-full and may not be construed as a partial payment even when the reimbursement amount is less than the provider's charge. The provider may not collect and/or bill the consumer for any difference between the medicaid payment and the provider's charge or request the consumer to share in the cost through a deductible, coinsurance, co-payment or other similar charge, other then medicaid co-payments as defined in rule ~~5101:3-1-09~~5160-1-09 of the Administrative Code. The provider may not charge the consumer a down payment, refundable or otherwise.

(B) A medicaid consumer cannot be billed when a medicaid claim has been denied due to:

(1) Unacceptable or untimely submissions of claims;

(2) Failure to request a prior authorization; or

(3) A peer review organization (PRO) retroactively denying services for lack of medical necessity.

(C) Providers are not required to bill the Ohio department of ~~job and family services (ODJFS)~~medicaid (ODM) for medicaid-covered services rendered to eligible consumers. However, providers may not bill consumers in lieu of ~~ODJFS~~ODM unless:

(1) The consumer is notified in writing prior to the service being rendered that the provider will not bill ~~ODJFS~~ODM for the covered service; and

(2) The consumer agrees to be liable for payment of the service and signs a written statement to that effect prior to the service being rendered; and

(3) The provider explains to the consumer that the service is a covered medicaid service and other medicaid providers may render the service at no cost to the consumer.

(D) Services that are not covered by the medicaid program, including services requiring prior authorization that have been denied by ~~ODJFS~~ODM, may be billed to the consumer when the provisions in paragraphs (C)(1) and (C)(2) of this rule are met.