CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Managed Care 2014 Five Year Rule Review

Rule Number(s): 5160-26-02.1 (Rescind/New), 5160-26-03, 5160-26-05, 5160-26-05.1, 5160-26-10 (Rescind/New)

Date: November 19, 2014

Rule Type:

X New
X Amended
X 5 Year Review
X Rescinded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.**
   Please include the key provisions of the regulation as well as any proposed amendments.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIOhio@governor.ohio.gov

Rule 5160-26-02.1, entitled Managed health care programs: termination of membership is being proposed for rescission and adoption due to five year rule review. The rule sets forth reasons for membership termination from a Medicaid managed care plan (MCP) and the processes to be used when a member is terminated from a plan. The rule is being rescinded and adopted as a new rule 5160-26-02.1, which reorganizes the text of the rescinded rule to achieve greater clarity. Other amendments to this rule clarify that this rule does not apply to MyCare Ohio plans, and update legal citations and cross-references. The substance of the rescinded and adopted rules remains the same.

Rule 5160-26-03 entitled Managed health care programs: covered services, is being proposed for amendment to update policy relating to the administration of the Medicaid program. The rule sets forth the covered services that Medicaid MCPs are required to provide to their members. Changes to the rule clarify language describing the obligations of MCPs regarding the payment of emergency services provided by hospitals pursuant to state law in ORC 5167.10. Another amendment clarifies that the department's approval is required for any disenrollment requests for nursing facility admissions beyond a stay of two consecutive months. Additional amendments for this rule indicate that the specific coverage provisions for MyCare Ohio plans are described in Chapter 5160-58 of the Administrative Code, remove the exclusion of habilitation pursuant to Ohio's January 1, 2014 approved Medicaid State Plan, and update cross-references and legal citations.

Rule 5160-26-05, entitled Managed health care programs: provider panel and subcontracting requirements is being proposed for amendment due to five year rule review. The rule sets forth Medicaid MCP provider panel and subcontracting requirements. Changes to the rule clarify and update subcontracting requirements for MCP subcontractors. Other amendments update the obligations of MCPs regarding provider qualifications and the notification of providers. Additional amendments to the rule update legal citations and cross-references.

Rule 5160-26-05.1, entitled Managed health care programs: provider services, is being proposed for amendment due to five year rule review. The rule sets forth the requirements for information that MCPs must make available to providers and interested parties. Changes to the rule update a cross-reference and clarify that Medicaid MCPs must disseminate their practice guidelines to all affected providers and upon request to members and pending members.

Rule 5160-26-10, entitled Managed health care programs: sanctions and provider agreement actions, is being proposed for rescission and adoption due to five year rule review. The rule sets forth the sanctions and provider agreement actions for Medicaid MCPs. The rule is being rescinded and adopted as a new rule 5160-26-10. Changes to the rule add fines and sanctions to the list of sanctions that may be imposed on MCPs by ODM. Other amendments clarify the circumstances when MCPs can appeal actions under Chapter 119. of the Revised Code. Additionally, legal citations and cross-references are updated.

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

   Ohio Revised Code Section 5167.02.

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? If yes, please briefly explain the source and substance of the federal requirement.**

   Yes. 42 C.F.R. Part 438 imposes comprehensive requirements on Medicaid managed care plans. Subpart C of the regulations imposes requirements for enrollee protections and marketing activities. Subpart D of the regulations sets forth requirements regarding quality and adequate access to services by Medicaid recipients. Subparts H and I address program integrity and authorize states to impose sanctions on MCPs that do not comply with legal requirements or the conditions of their contracts.

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 managed care plans, they do require state Medicaid agencies to ensure managed care plan 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)?**

   These rules perform several functions. They ensure compliance with federal regulations governing Medicaid managed care. They ensure that information maintained by managed care plans is readily available for the State, and if requested, for the Centers for Medicare and Medicaid Services (CMS). Additionally, they provide authority for the Ohio Department of Medicaid to sanction MCPs that do not comply with applicable law and provider agreements.

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 plans are complying with federal standards. With five plans in the state, all will be expected to provide similar information, making missing information more obvious, measuring the success of the regulation.

The managed care plans must demonstrate compliance with several performance measures that gauge the performance of plans. Successful health outcomes are measured through a finding of compliance with these standards. Sanctions may be used to correct MCPs that are not compliant with the applicable sanctions.

Development of the Regulation

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

   Medicaid managed care plans and stakeholders such as the Ohio Hospital Association and Voices for Ohio's Children have been involved in the initial review of the draft regulations.

   The MCPs that applied for a request for applications (RFA) in 2012 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, these plans were already aware of the reporting requirements. The MCPs selected 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 Department received comments from Paramount, a managed care plan stakeholder. The comments from Paramount requested clarifications pertaining to the agency 5160 designation in proposed rule 5160-26-02.1, the inpatient capital costs reference for providers as described in proposed rule 5160-26-03 and the proposed revisions to the managed care plan subcontracting requirements in proposed rule 5160-26-05. The Department provided the necessary clarifications to Paramount. The clarifications were satisfactory to Paramount and the Department did not make any additional rule changes.

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 the required reports consistently. A robust effort will be employed by the department to notify the MCPs and stakeholders of the rules. A variety of communication methods will be used, including, but not limited to e-mail notification and posting of the rules on the ODM website.

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 maintain and submit required reports and documentation of information as a result of these rules. The required reports include documents that address the use of medical providers as subcontractors and

notifications to members concerning appeals, grievances, state fair hearing procedures, and services for children.

Proposed rule 5160-26-10 describes sanctions that may be imposed on an MCP for failure to comply with its duties and obligations under law and contract. The types of sanctions include but are not limited to corrective action, the imposition of temporary management, suspension of the MCP's enrollment of members, disenrollment of the MCP's members, the prohibition or reduction of enrollees assigned to the MCP, the termination of the MCP's members without cause, the retention of premium payments by ODM and the imposition of fines or other financial sanctions. Additionally, ODM may terminate, nonrenew or deny the MCP's entire provider agreement or terminate the provider agreement in one or more service areas.

c. Quantify the expected adverse impact from the regulation.

The Ohio Department of Medicaid (ODM) estimates that 1- 2 full time employees are necessary for an MCP to meet the requirements within these regulations. This is based on input from CareSource, one of the managed care plans. CareSource has an enrollment of approximately 1 million Medicaid members and is paid approximately $4 billion dollars per year in capitation payments on behalf of Medicaid members.

All MCPs were aware of the need to maintain and submit various reports prior to deciding to do business with the State. Through the administrative component of the capitation rate paid to the MCPs by ODM, MCPs will be compensated for the cost of the time required in maintaining and submitting required reports. For CY 2014, the administrative component of the capitation rate varies by population/program and ranges from $2.05 to $5.52 per person per month.

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 and the possible sanctions prior to seeking contracts with the state, as well as before signing their contracts with the state. More importantly, without the requested reports and sanctions 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 plans 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 plans qualifies as a small business.