CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Managed Care rule amendments, 2016 5-year Review and 1/1/2017 New Policy and Population Rollout

Rule Number(s):

SUBJECT TO BUSINESS IMPACT ANALYSIS: 5160-26-02 (Rescind/New), 5160-26-02.1, 5160-26-03, 5160-26-05, 5160-26-08.4, 5160-26-09.1, 5160-26-12, 5160-58-02, 5160-58-02.1, 5160-58-05.3, 5160-58-08.4

NOT SUBJECT TO BUSINESS IMPACT ANALYSIS, INCLUDED FOR INFORMATION ONLY:

5160-58-02.2

Date: Original File Friday, April 15, 2016 with effective date of Friday, July 1, 2016

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X Rescinded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.

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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.

OAC Rule 5160-26-02, entitled Managed health care programs: eligibility, membership, and automatic renewal of membership is being proposed for rescission and will be replaced by a new rule of the same number to update policy relating to the administration of the Medicaid program. The rule describes the managed care enrollment process, enrollment exclusions, and the categories of individuals who are eligible for mandatory and voluntary enrollment in Medicaid managed care plans (MCPs). New rule 5160-26-02 has the simplified title, Managed health care programs: eligibility and enrollment. In the new rule, the text of the rescinded rule is reorganized to achieve greater clarity and legal citations and cross-references are updated. The new rule also updates managed care mandatory and voluntary enrollment criteria and adds the following groups to Medicaid recipients who must receive services through managed care:

- Children receiving services from the Ohio Department of Health Bureau of Children with Medical handicaps, or any other family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V of the Social Security Act,
- Children receiving Title IV-E federal foster care maintenance or Title IV-E federal adoption assistance, and
- Children in foster care or other out of home placement.

OAC Rule 5160-26-02.1, entitled Managed health care programs: termination of membership is being proposed for amendment to update policy relating to the administration of the Medicaid program. The rule sets forth reasons for membership termination from an MCP and the processes to be used when a member is terminated from a plan. Changes to the rule reduce circumstances in which a MCP member can be terminated. The rule also clarifies when member placement in a nursing facility authorizes disenrollment. Another amendment updates the requirements for any disenrollment requests from nursing facility admissions beyond a stay of two consecutive months. Changes to the rule also update cross-references.

OAC 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. MCP obligations around home and community based waiver services (HCBS) are clarified. Language authorizing termination of membership for members placed in nursing facilities has been moved to 5160-26-02.1 in order to consolidate termination requirements. Changes to the rule also update cross-references.

OAC Rule 5160-26-05, entitled Managed health care programs: provider panel and subcontracting requirements is being proposed for amendment to update policy relating to the administration of the

Medicaid program. 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 member materials and quarterly reports, allowing the MCPs more administrative flexibility.

OAC Rule 5160-26-08.4, entitled Managed health care programs: MCP grievance system is being proposed for amendment to update policy relating to the administration of the Medicaid program. The rule sets forth Medicaid MCP member appeal and grievance rights. One minor change to the rule clarifies and updates a requirement allowing the MCPs more administrative flexibility.

OAC Rule 5160-26-09.1, entitled Managed health care programs: third party liability and recovery is being proposed for amendment due to five year rule review. The rule sets forth Medicaid MCP third party recovery requirements. Minor changes to the rule clarify and update requirements. Additional amendments to the rule update legal citations and cross-references.

OAC Rule 5160-26-12, entitled Managed health care programs: member co-payments, is being proposed for amendment due to five year rule review. The rule sets forth requirements for MCPs when they elect to implement a co-payment program. Changes to the rule update legal citations and cross-references.

OAC Rule 5160-58-02, entitled MyCare Ohio plans: eligibility, membership and automatic renewal of membership, is being proposed for amendment to update policy relating to the administration of the Medicaid program. This rule sets forth the MyCare Ohio enrollment process and the categories of individuals who are eligible for enrollment in MyCare Ohio plans (MCOPs). The title of the rule is simplified to MyCare Ohio plans: eligibility and enrollment. Other amendments to this rule clarify the new managed care mandatory and voluntary enrollment criteria, reorganize the text to achieve greater clarity, and update legal citations and cross-references.

OAC Rule 5160-58-02.1, entitled MyCare Ohio plans: termination of membership, is being proposed for amendment to update policy relating to the administration of the Medicaid program. This rule sets forth reasons for enrollment termination from a MCOP and the processes to be used when a member is terminated from a plan. Changes to the rule update rule references and reduce circumstances in which a MCOP member can be terminated.

OAC Rule 5160-58-02.2, entitled MyCare Ohio plans: eligibility and enrollments, is being proposed for amendment to update policy relating to the administration of the Medicaid program. This rule sets forth the MyCare Ohio enrollment process. The changes to the rule comply with federal requirements relating to settings and person centered care in 42 CFR 441.301.

OAC Rule 5160-58-05.3, entitled MyCare Ohio plans: incident management system, is being proposed for amendment to update policy relating to the administration of the Medicaid program. This rule sets forth the MyCare Ohio incident requirements. The changes to the rule accommodate the inclusion of requirements specific to Specialized Recovery Service Program (SRSP) enacted pursuant to 1915(i) of the Social Security Act, including the population enrolled in SRSP and specific types of incidents.

OAC Rule 5160-58-08.4, entitled Appeals and Grievances for MyCare Ohio is being proposed for amendment to update policy relating to the administration of the Medicaid program. The rule sets forth Medicaid MCOP member appeal and grievance rights. One minor change to the rule clarifies and updates a requirement allowing the MCOPs more administrative flexibility.

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 the state around Medicaid managed care plans. Subpart B of the regulations imposes requirements for managed care enrollments and disenrollments. Subpart C of the regulations imposes requirements for cost-sharing. Subpart D of the regulations sets forth requirements regarding quality and availability of services for Medicaid recipients. Additionally, Section 1902(a)(25)(A) of the Social Security Act requires State Medicaid programs to identify and seek payment from liable third parties before billing Medicaid.

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).

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 and MCOPs are complying with federal standards. All plans in the state will be expected to provide similar information, making missing information more obvious.

MCPs and MCOPs must demonstrate compliance with several performance measures contained in their provider agreements that gauge the performance of plans. Successful health outcomes are measured through a finding of compliance with these standards.

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.

These rules primarily impact Ohio's six Medicaid managed care plans; however other stakeholders have also provided informal input that has been the basis for the draft regulations. Changes have been discussed with the MCPs and MCOPs during regular monthly meetings, and will continue to be a topic as we approach implementation.

Stakeholders such as Public Children Services Association of Ohio, Cleveland Clinic, Ohio Children's Hospitals Association, Initiative Ohio advocates, Ohio Department of Developmental Disabilities (DoDD), Ohio Department of Health, Bureau of Children with Medical Handicaps (BCMH), Ohio Department of Job and Family Services (ODJFS), and representatives of county departments of job and family services, have been involved in the initial review of the 5160-26 draft regulations. Regular meetings are being held with public children services agencies (PCSAs), MCPs, and other stakeholders involved with foster and adoption children to review changes and work through the processes to make sure transition is as seamless as possible for the consumers involved. Statewide Automated Child Welfare Information System (SACWIS) representatives from ODJFS are involved in the meetings to discuss current systems processes and changes that will possibly need to be made in the future to accommodate the new populations. The discussions relate to children who are already enrolled in an MCP for 'regular' Medicaid with their family and then are removed from the home, but need to remain enrolled in the same MCP for continuity of care and better care management.

Meetings are being held with BCMH staff and stakeholders and DoDD staff and stakeholders to review population changes and work through the processes to make sure transition is as seamless as possible for the consumers involved. Significant stakeholder and MCP/MCOP face-to face meetings about these rules took place on the following dates: 9/25/15, 10/28/15, 12/3/15, 12/7/15, 12/8/15, and 12/18/15.

The MyCare Ohio rules in O.A.C. Chapter 5160-58 were reviewed and commented on by the MCOPs (AETNA, Buckeye, CareSource, Molina, United Health Care) and stakeholders, such as Public Consulting Group (the State vendor to investigate MyCare Ohio waiver Incidents), and members of the HCBS Rules Workgroup that is comprised of a wide variety of Medicaid waiver stakeholder representation, including Ohio Hospice, Disability Rights Ohio, Ohio Department of Aging, Area Agencies on Aging, NAMI Ohio, Assisted Living Association, Nursing Facilities, Ohio Department of

Development Disabilities, and others. Stakeholders have provided informal input that has been the basis for the draft regulations. Additionally, stakeholders provided further input when the rule was distributed and reviewed with during meetings as follows: on 10/13/15 and 12/18/15 with all five MCOPs to review rules; on 10/14/15 with Public Consulting Group to review 5160-58-05.3; and on 10/28/15 with the HCBS Rules Workgroup to review rules.

Subsequent revisions based on their input were circulated via email for further reviews.

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

Minor changes to the proposed rules were made based on the input of stakeholders. 5160-26-05, and 5160-26-8.4 were amended to ease obligations for Ohio's MCPs at their suggestion. 5160-26-9.1 and 5160-26-12, up for 5 year review, remained essentially unchanged and no comments were received.

As for 5160-58-05.3, the department received comments from the MyCare Ohio Plans and stakeholders, resulting in the following modifications: extending the required timeframe for the incident management system, adding clarifying language regarding oversight of medications or misuse of medications, replacing a nursing code plus modifier, and adding a separate service code for Home Delivered Meals to accommodate differing rates for different meals.

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 federal regulations. However, through the submission of the requested service codes and data, the Agency will be able to determine whether the MCPs and MCOPs 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 and MCOPs 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 MCPs and MCOPs 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, MCOPs, 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;

These rules only impacts MCPs and MCOPs in the State. The MCPs and MCOPs that will be impacted are Aetna, Buckeye, CareSource, Molina, Paramount and UnitedHealthCare.

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

The rules in this packet contain requirements for the MCPs and MCOPs to maintain records and other documentation, and to submit reports. The required reports, include, but are not limited, to the following:

- Reports about members' third party coverage,
- Information regarding subcontractors and information that must be included in the subcontracts,
- Newborn notifications to ODM's designee,
- Notifications to members concerning providers, grievance and appeal rights, state fair hearings rights, and services for children,
- Reports regarding care management, false claims, suspected fraud or abuse, and quality assurance, and

- Incident reports, notifications to appropriate agencies, and incident data.

Many of these reports are federally mandated.

In addition, rule 5160-58-05.3 authorizes ODM to impose sanctions, remediation, or corrective action upon a provider for failure to comply with the incident management requirements or failure to assure the health or welfare of a member of a MCOP plan.

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.

Managed care plans are paid per member per month. ODM must pay MCPs and MCOPs rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.6(c) and CMS's "2016 Managed Care Rate Setting Consultation Guide." Ohio Medicaid capitation rates are "actuarially sound" for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. Costs include but are not limited to expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital and government mandated assessments, fees, and taxes.

All rates and actuarial methods can be found on the ODM website in Appendix E of both the Medicaid Managed Care and MyCare Ohio provider agreements. Through the administrative component of the capitation rate paid to the MCPs and MCOPs by ODM, MCPs and MCOPs will be compensated for the cost of the time required in maintaining and submitting required documents and reports. For CY 2016, the administrative component of capitation rate varies by program/population and ranges from 3.5% to 6.85% for MCPs and from 2% to 8% for MCOPs.

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

The MCPs and MCOPs 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 six 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 six plans qualifies as a small business.