CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Managed Care – Subcontracting

Rule Number(s): 5160-26-05

Date: December 14, 2016

Rule Type:

- ☐ New
- X 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- ☐ Rescinded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.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   In Ohio, approximately 86% of Medicaid recipients receive their Medicaid services through a Managed Care Plan (MCP) or MyCare Ohio Plan (MCOP). MCPs/MCOPs are health insurance companies that are licensed by the Ohio Department of Insurance and have a provider agreement

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with the Ohio Department of Medicaid (ODM) to provide coordinated health care to Medicaid beneficiaries. There are six MCPs/MCOPs in Ohio each with a network of health care professionals.

OAC rule 5160-26-05, entitled Managed health care programs: provider panel and subcontracting requirements, sets forth MCP provider panel and subcontracting requirements. The rule is being amended to align managed care policy language with the terminology found in 42 C.F.R. 438.2. The regulation delineates the difference between a "subcontractor" and a health care "provider." Language related to subcontractors (administrative service providers) has been removed from rule and incorporated into the managed care provider agreements to allow for flexibility to adapt to MCP business needs. The term "subcontractor" has been replaced with the term "provider" or "contracted provider" to clarify that this rule pertains to healthcare providers only.

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

   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 regarding Medicaid managed care programs. Subpart A of the regulation sets forth general provisions regarding managed care. OAC rule 5160-26-05 is being proposed for amendment to align Ohio Medicaid managed care terminology with the federal regulation.

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

   Federal regulations do not impose requirements directly on MCPs, instead they require state Medicaid agencies to ensure MCP compliance with federal standards. This rule is consistent with federal managed care requirements outlined in 42 C.F.R Part 438.

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 help ODM ensure the health and welfare of individuals enrolled in Medicaid managed care through the provision of medically necessary services by qualified providers.

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

   Through reporting requirements established within the rule and within the managed care provider agreements, ODM is able to monitor compliance with the regulation. Successful outcomes are measured through a finding of compliance with these standards as determined by monitoring and oversight.

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 Medicaid Managed Care and MyCare Ohio Plans listed below were provided with a draft of OAC rule 5160-26-05 on October 24th. The plans participated in a meeting with ODM on October 25th to discuss the rule changes and related provider agreement changes. Copies of the draft rule were provided and plans were given approximately a week to comment.

   - Aetna
   - Buckeye Health Plan
   - CareSource
   - Molina Healthcare of Ohio
   - Paramount Advantage
   - UnitedHealthcare Community Plan of Ohio

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

   MCPs and MCOPs agreed that the language should be updated to align managed care policy language with the terminology found in 42 C.F.R. 438.2. The changes to the rule will benefit the plans by removing subcontractor language from rule and incorporating it into the managed care provider agreements. This will result in greater rule clarity, and will allow for flexibility to adapt to managed care business needs. No concerns were expressed by the MCPs or MCOPs with regard to the rule changes after having been given the draft to review.

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 to develop these rules or the measureable outcomes of the rules.

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 changes to this rule represent the alternative language considered by the agency and stakeholders. The rule language meets federal guidelines while providing flexibility to the MCPs.

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 documentation, ODM will be able to determine whether the MCPs/MCOPs are meeting the standards specified in the federal guidelines.

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. There are no redundancies within this chapter of the OAC. No other state agencies impose requirements that are specific to the Medicaid program.

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.**

    ODM will notify MCPs and MCOPs of the final rule changes via email notification and by posting the amended rules on the ODM website http://medicaid.ohio.gov/. The changes to the rule will not impact the plans' current business processes.

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 will impact MCPs and MCOPs in the State including: 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**

This rule requires the plans to evaluate the delegated entities (subcontracted providers of administrative services) and provide a copy of the evaluation summary to ODM. It also requires the plans to provide the delegated entity with information, materials and documentation to meet program requirements. These requirements are being removed from the rule and will no longer be requirements outlined in the OAC.

Additionally, MCPs are required to notify ODM, providers and/or members of the addition or removal of health care providers from their provider panel including the expiration, non-renewal or termination of any provider subcontract.

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 covered services prior to seeking and signing their contracts with the state. More importantly, without the requirement of certain covered health care services, 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.

Not applicable for this program.

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?

Not applicable for this program.

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

While there are no small businesses impacted by this rule, the managed care plans may contact ODM directly through their assigned Contract Administrator.

5160-26-05 **Managed health care programs: provider panel and subcontracting requirements.**

(A) Subcontracts.

~~(1) For the purposes of this rule, delegated entity means a subcontractor that has been provided the authority by the managed care plan (MCP) to conduct any of the following functions or related services or both: claims processing, network development, care coordination, quality management and improvement, care management, interpreter services, reinsurance, fraud and abuse identification, benefit management, utilization management, credentialing and recredentialing, or any other program function that may affect a member's safety, welfare or access to medicaid covered services. In the event of inconsistency or ambiguity and upon the MCP's request of a determination from the Ohio department of medicaid (ODM), ODM will make the final determination of program functions or related services that may affect a member's safety, welfare or access to medicaid covered services.~~

~~(2)~~(1) ~~An~~ A managed care plan (MCP) must provide or arrange for the delivery of covered health care services described in rule 5160-26-03 of the Administrative Code either through the use of employees or through subcontracts with network providers of health care services ("providers"). ~~Subcontractors include the MCP's parent company or its subsidiaries.~~ All subcontracts must be in writing and in accordance with paragraph (D) of this rule and 42 C.F.R. 434.6 and 438.6 (October 1, ~~2015~~2016). The MCP's execution of a subcontract with a ~~subcontractor~~provider does not terminate the MCP's legal responsibility to the Ohio department of medicaid (ODM) to ~~assure~~ensure ~~that~~ all of the MCP's activities and obligations are performed in accordance with Chapter 5160-26 or Chapter 5160-58 of the Administrative Code, as applicable, or both, the MCP provider agreement, and all applicable federal, state, and local regulations.

~~(3) The MCP must do all of the following for any delegated entity:~~

~~(a) Evaluate the entity prior to executing a subcontract to assure that the entity is capable of performing the delegated activity in accordance with all applicable program requirements and provide a copy of the evaluation summary to ODM upon request.~~

~~(b) Provide the delegated entity with all information, materials, and documentation the entity will need to meet the delegated program requirement(s).~~

~~(c) Require the delegated entity to submit a report to the MCP, at least~~

~~quarterly, summarizing the status of the delegated activity, and including at a minimum:~~

~~(i) A copy of any required reports or logs maintained by the delegated entity; and~~

~~(ii) Identification of any problems, concerns or potential compliance issues that may exist.~~

~~(d) Monitor the entity's performance on an ongoing basis, including a review of the report referenced in paragraph (A)(3)(c) of this rule, all relevant member grievances and appeals as specified in rule 5160-26-08.4 of the Administrative Code, and all member complaints reported to the Ohio department of medicaid (ODM) and forwarded to the MCP, to identify any deficiencies or areas for improvement. If requested to do so, the MCP must also provide documentation of the MCP's monitoring efforts and its findings to ODM.~~

~~(e) Submit an annual assessment of the delegated entity's performance with meeting the delegated program requirements throughout the year to ODM as directed by ODM.~~

~~(f) Include in the subcontract between the MCP and the delegated entity the sanctions that will be imposed for inadequate performance. The sanctions must specify the MCP's authority to require corrective action for any deficiencies or areas for improvement identified and provide for the revocation of the delegation if the MCP or ODM determines that the delegation is not in the best interest of the enrollees.~~

~~(g) Include in the subcontract between the MCP and the delegated entity the sanctions that will be imposed for unauthorized uses or disclosures of protected health information (PHI).~~

~~(h) Include in the subcontract between the MCP and the delegated entity that, unless otherwise specified by ODM, all information required to be submitted to ODM must be submitted directly by the MCP.~~

~~(4) For subcontracts that the MCP believes to be short-term, one-time, or for infrequent activities, the MCP may request that ODM exempt them from the reporting, monitoring and assessment requirements specified in paragraphs (A)(3)(c) and (A)(3)(e) of this rule.~~

~~(5)~~(2) Subcontracts may not include language that conflicts with the specifications identified in paragraphs (C) and (D) of this rule.

~~(6)~~(3) ~~For a provider that does not have an executed subcontract with the~~

When utilizing an out of panel provider, the MCP must establish a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of paragraph (D) of this rule. For medicaid-covered non-emergency hospital services outlined in rule 5160-26-03 of the Administrative Code, the compensation amount is identified in rule 5160-26-11 of the Administrative Code.

(B) Notification.

(1) Notwithstanding paragraph (D)(13) of this rule, an MCP must notify ODM of ~~the~~any addition to or deletion from ~~of subcontractors~~ its provider panel on an ongoing basis, and must follow the time restrictions contained in this paragraph unless the explanation of extenuating circumstances is accepted by ODM.

(2) At the direction of ODM, the MCP must submit evidence of the following:

(a) A copy of the ~~subcontractor's~~provider's current licensure;

(b) Copies of written agreements with the ~~subcontractor~~provider, including but not limited to subcontracts, amendments and the medicaid addendum as specified in paragraph (D) of this rule;

(c) Notification to ODM of any hospital subcontract for which a date of termination is specified; and

(d) The ~~subcontractor's~~provider's medicaid provider number or provider reporting number, as applicable.

~~(3) When any program function is to be delegated as specified in paragraph (A)(1) of this rule, the MCP must submit a copy of the dated and fully executed medicaid addendum or amendment as applicable thirty calendar days prior to the effective date of the subcontract or subcontract amendment. ODM may request additional information prior to the effective date of the subcontract or subcontract amendment. Delegation of the program function or related services may not take effect without acceptance in writing by ODM.~~

~~(4)~~(3) The MCP shall ~~inform~~notify ODM of the expiration, nonrenewal, or termination of any ~~subcontractor~~provider subcontract at least fifty-five calendar days prior to the expiration, nonrenewal or termination of the subcontract in a manner and format directed by ODM. If the MCP receives less than fifty-five calendar days' notice from the ~~subcontractor~~provider, the MCP must inform ODM within one working day of ~~its awareness~~ becoming

aware of this information. The MCP must also comply with the following:

(a) If the ~~subcontractor~~ subcontract is for a hospital:

(i) Forty-five calendar days prior to the effective date of the expiration, nonrenewal or termination of the hospital's subcontract, the MCP shall notify in writing all providers who have admitting privileges at the hospital of the impending expiration, nonrenewal, or termination of the subcontract and the last date the hospital will provide services to members under the MCP subcontract. If the MCP receives less than forty-five calendar days' notice from the hospital, the MCP shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the subcontract.

(ii) Forty-five calendar days prior to the effective date of the expiration, nonrenewal, or termination of the hospital's subcontract, the MCP shall notify in writing all members in the service area, or in an area authorized by ODM, of the impending expiration, nonrenewal, or termination of the hospital's subcontract. If the MCP receives less than forty-five calendar days' notice from the ~~subcontractor~~hospital provider, the MCP shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the subcontract.

(iii) The MCP shall submit a template for member and provider notifications to ODM along with the MCP's notification to ODM of the impending expiration, nonrenewal, or termination of the hospital's subcontract. The notifications shall comply with the following:

(a) The form and content of the member notice must be prior-approved by ODM and contain an ODM designated toll-free telephone number ~~that~~ members can call for information and assistance.

(b) The form and content of the provider notice must be prior-approved by ODM.

(iv) ODM may require the MCP to notify additional members or providers if the impending expiration, nonrenewal, or termination of the hospital's subcontract adversely impacts additional members or providers.

(b) If the ~~subcontractor~~ subcontract is for a primary care provider (PCP):

(i) The MCP shall include the number of members that will be affected by the change in the notice to ODM; and

(ii) The MCP shall notify in writing all ~~the~~ members who use or are assigned to the ~~subcontractor~~provider as a PCP at least forty-five calendar days prior to the effective date of the change. If the MCP receives less than forty-five calendar days prior notice from the PCP, the MCP shall issue the notification within one working day of the MCP becoming aware of the expiration, nonrenewal, or termination of PCP's subcontract. The form of the notice and its content must be prior-approved by ODM and must contain, at a minimum, all of the following information:

(a) The PCP's name and last date the PCP is available to provide care to the MCP's members;

(b) Information regarding how members can select a different PCP; and

(c) An MCP telephone number members can call for further information or assistance.

~~(5)~~(4) ODM may require the MCP to notify members or providers for the expiration, nonrenewal, or termination of certain other provider subcontracts that may adversely impact the MCP's members.

~~(6)~~(5) In order to assure availability of services and qualifications of providers, ODM may require submission of documentation in accordance with paragraph (B) of this rule regardless of whether the MCP subcontracts directly for services or does so through another entity.

~~(7)~~(6) In the event that an MCP's medicaid managed care program participation in a service area is terminated, the MCP must provide written notification to its affected ~~subcontractors~~subcontracted providers at least forty-five calendar days prior to the termination date, unless otherwise specified by ODM.

(C) Provider qualifications.

(1) The MCP must ensure that none of its employees or

subcontracted providers are sanctioned or excluded from providing medicaid or medicare services. At a minimum, monthly, the MCP shall utilize available resources for identifying sanctioned providers, including, but not limited to, the following:

(a) The federal office of inspector general provider exclusion list;

(b) The ODM excluded provider web page; and

(c) The discipline pages of the applicable state boards that license providers or an alternative data resource, such as the national practitioner databank, that is as complete and accurate as the discipline pages of the applicable state boards.

(2) An MCP may not discriminate ~~in~~ with regard to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. If an MCP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reasons for its decision. This paragraph may not be construed to:

(a) Require the MCP to contract with providers beyond the number necessary to meet the needs of its members;

(b) Preclude the MCP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(c) Preclude the MCP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

(3) The MCP must have written policies and procedures for the selection and retention of providers that prohibit discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

~~(4) When initially credentialing and recredentialing providers in connection with policies, contracts, and agreements providing basic health care services, the MCP must utilize the standardized credentialing form and process as prescribed by the Ohio department of insurance under sections 3963.05 and 3963.06 of the Revised Code. Upon ODM's request, the MCP must~~

~~demonstrate to ODM the record keeping associated with maintaining this documentation.~~

~~(5) If any MCP delegates the credentialing or recredentialing of subcontractors to another entity, the MCP must retain the authority to approve, suspend, or terminate any subcontractors.~~

(D) Subcontracts.

All subcontracts must include a medicaid addendum that has been approved by ODM. The medicaid addendum must include the following elements, appropriate to the service being rendered ~~or delegated function(s)~~, as specified by ODM:

(1) An agreement by the ~~subcontractor~~provider to comply with the applicable provisions for record keeping and auditing in accordance with Chapter 5160-26 of the Administrative Code.

(2) Specification of the medicaid population and service area~~s(s) to be served~~, pursuant to the MCP's provider agreement with ODM.

(3) Specification of the health care services to be provided.

(4) Specification that the subcontract is governed by, and construed in accordance with all applicable laws, regulations, and contractual obligations of the MCP and:

(a) ODM shall notify the MCP and the MCP shall notify the ~~subcontractor~~provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCP;

(b) The subcontract shall be automatically amended to conform to such changes without the necessity for written execution; and

(c) The MCP shall notify the ~~subcontractor~~provider of all applicable contractual obligations.

(5) Specification of the beginning date and expiration date of the subcontract, or an automatic renewal clause, as well as the applicable methods of extension, renegotiation, and termination.

(6) Specification of the procedures to be employed upon the ending, nonrenewal, or termination of the subcontract, including an agreement by the

provider to promptly supply all records necessary for the settlement of outstanding medical claims.

(7) Full disclosure of the method and amount of compensation or other consideration to be received by the ~~subcontractor~~provider from the MCP.

(8) An agreement not to discriminate in the delivery of services based on the member's race, color, religion, gender, genetic information, sexual orientation, age, disability, national origin, military status, ancestry, health status, or need for health services.

(9) An agreement by the ~~subcontractor~~provider to not hold liable ODM or members in the event that the MCP cannot or will not pay for services performed by the ~~subcontractor~~provider pursuant to the subcontract with the exception that:

(a) Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be reimbursed by ODM in the event of MCP insolvency.

(b) The ~~subcontractor~~provider may bill the member when the MCP has denied prior authorization or referral for services and the following conditions are met:

(i) The member was notified by the ~~subcontractor~~provider of the financial liability in advance of service delivery.

(ii) The notification by the ~~subcontractor~~provider was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose.

(iii) The notification is dated and signed by the member.

(10) An agreement by the ~~subcontractor~~provider that with the exception of any member co-payments the MCP has elected to implement in accordance with rule 5160-26-12 of the Administrative Code, the MCP's payment constitutes payment in full for any covered service and that the ~~subcontractor~~provider will not charge the member or ODM any co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise. This agreement does not prohibit nursing facilities ~~(NFs)~~ or home and community-based services waiver providers from collecting patient liability payments from members as specified in ~~rule 5160:1-3-04.3~~rules 5160:1-6-05.1 and

5160:1-6-05.2 of the Administrative Code or FQHCs and RHCs from submitting claims for supplemental payments to ODM as specified in Chapter 5160-28 of the Administrative Code. Additionally, the MCP and ~~subcontractor~~provider agree to the following:

(a) MCP shall notify the ~~subcontractor~~provider whether the MCP has elected to implement any member co-payments and if, applicable, the circumstances in which member co-payment amounts will be imposed in accordance with rule 5160-26-12 of the Administrative Code; and

(b) ~~Subcontractor~~Provider agrees that member notifications regarding any applicable co-payment amounts must be carried out in accordance with rule 5160-26-12 of the Administrative Code.

(11) A specification that the ~~subcontractor~~provider and all employees of the ~~subcontractor~~provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the subcontract, and that ~~subcontractor~~provider and all employees of the ~~subcontractor~~provider have not been excluded from participating in federally funded health care programs.

(12) An agreement that ~~subcontractors~~providers who are currently medicaid providers meet the qualifications specified in paragraph (C) of this rule.

(13) A stipulation that the MCP will give the ~~subcontractor~~provider at least sixty-days' prior notice for the nonrenewal or termination of the subcontract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the subcontract be terminated sooner.

(14) A stipulation that the ~~subcontractor~~provider may nonrenew or terminate the subcontract if one of the following occurs:

(a) The ~~subcontractor~~provider gives the MCP at least sixty days prior notice for the nonrenewal or termination of the subcontract. The effective date for any nonrenewal or termination of the subcontract must be the last day of the month.

(b) ODM has proposed action to terminate, nonrenew, deny or amend the MCP's provider agreement in accordance with rule 5160-26-10 of the Administrative Code, regardless of whether this action is appealed. The ~~subcontractor's~~provider's termination or nonrenewal notice must be received by the MCP within fifteen working days prior to the end of the

month in which the ~~subcontractor~~provider is proposing termination or nonrenewal. If the notice is not received by this date, the ~~subcontractor~~provider must agree to extend the termination or nonrenewal date to the last day of the subsequent month.

(15) The ~~subcontractor's~~provider's agreement to serve members through the last day the subcontract is in effect.

(16) The ~~subcontractor's~~provider's agreement to make the medical records for medicaid eligible individuals available for transfer to new providers at no cost to the individual.

(17) A specification that all laboratory testing sites providing services to members must have either a current clinical laboratory improvement amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or certificate of registration along with a CLIA identification number.

(18) A requirement securing cooperation with the MCP's quality assessment and performance improvement (QAPI) program in all its provider subcontracts and employment agreements for physician and nonphysician providers.

(19) An agreement by the ~~subcontractor~~provider and MCP that:

(a) The MCP shall disseminate written policies in accordance with the requirements of 42 U.S.C. 1396a(a)(68) (as in effect July 1, 2016) and section 5162.15 of the Revised Code, regarding the reporting of false claims and whistleblower protections for employees who make such a report, and including the MCP's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(b) The ~~subcontractor~~provider agrees to abide by the MCP's written policies related to the requirements of 42 U.S.C. 1396a(a)(68) (as in effect July 1, 2016) and section 5162.15 of the Revised Code, including the MCP's policies and procedures for detecting and preventing fraud, waste, and abuse.

(20) A specification that hospitals and other ~~subcontractors~~providers must allow the MCP access to all member medical records for a period of not less than eight-years from the date of service or until any audit initiated within the eight year period is completed and allow access to all record-keeping, audits, financial records, and medical records to ODM or its designee or other

entities as specified in rule 5160-26-06 of the Administrative Code.

(21) A specification, appearing above the signature(s) on the signature page in all PCP subcontracts, stating the maximum number of MCP members that each PCP can serve at each practice site for that MCP.

(22) A specification that the ~~subcontractor~~provider must cooperate with the ODM external quality reviews required by 42 C.F.R. 438.358 (October 1, ~~2015~~2016) and on-site audits as deemed necessary based on ODM's periodic analysis of financial, utilization, provider panel and other information.

(23) A specification that the ~~subcontractor~~provider must be bound by the same standards of confidentiality that apply to ODM and the state of Ohio as described in rule ~~5160:1-1-51.1~~5160-1-32 of the Administrative Code, including standards for unauthorized uses of or disclosures of protected health information (PHI).

(24) A specification that any third party administrator (TPA) must include the elements of paragraph (D) of this rule in its subcontracts and ensure that its ~~subcontractors~~subcontracted providers will forward information to ODM as requested.

(25) A specification that home health ~~subcontractors~~providers must meet the eligible provider requirements specified in Chapter 5160-12 of the Administrative Code and comply with the requirements for home care dependent adults as specified in section 121.36 of the Revised Code.

(26) A specification that PCPs must participate in the care coordination requirements outlined in rule 5160-26-03.1 of the Administrative Code.

(27) A specification that the ~~subcontractor~~provider in providing health care services to members must identify and where necessary arrange, pursuant to the mutually agreed upon policies and procedures between the MCP and ~~subcontractor~~provider, for the following at no cost to the member;

(a) Sign language services; and

(b) Oral interpretation and oral translation services.

(28) A specification that the MCP agrees to fulfill the ~~subcontractor's~~provider's responsibility to mail or personally deliver notice of the member's right to request a state hearing whenever the ~~subcontractor~~provider bills a member

due to the MCP's denial of payment of a service, as specified in rules 5160-26-08.4 and 5160-58-08.4 of the Administrative Code, utilizing the procedures and forms as specified in rule 5101:6-2-35 of the Administrative Code.

(29) The ~~subcontractor's~~provider's agreement to contact the twenty-four-hour post-stabilization services phone line designated by the MCP to request authorization to provide post-stabilization services in accordance with rule 5160-26-03 of the Administrative Code.

(30) A specification that the MCP may not prohibit or otherwise restrict a ~~subcontractor~~provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

(a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the member needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment versus non-treatment; and

(d) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(31) A stipulation that the ~~subcontractor~~provider must not identify the addressee as a medicaid consumer on the outside of the envelope when contacting members by mail.

(32) An agreement by the ~~subcontractor~~provider that members will not be billed for missed appointments.

(33) An agreement that in the performance of the subcontract or in the hiring of any employees for the performance of services under the subcontract, the ~~subcontractor~~provider shall not by reason of race, color, religion, gender, genetic information, sexual orientation, age, disability, national origin, military status, health status, or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

(34) An agreement by the ~~subcontractor~~provider that it shall not in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the subcontract on account of race, color, religion, gender, genetic information, sexual orientation, age, disability, national origin, military status, health status, or ancestry.

(35) Notwithstanding paragraphs (D)(13) and (D)(14) of this rule, in the event of a hospital's proposed nonrenewal or termination of a hospital subcontract, an agreement by the subcontracted hospital ~~subcontractor~~ to notify in writing all providers who have admitting privileges at the hospital of the impending nonrenewal or termination of the subcontract and the last date the hospital will provide services to members under the MCP contract. The ~~subcontracting~~subcontracted hospital must send this notice to the providers with admitting privileges at least forty-five calendar days prior to the effective date of the nonrenewal or termination of the hospital subcontract. If the ~~subcontractor~~ contracted hospital issues less than forty-five days prior notice to the MCP, the notice to providers with admitting privileges must be sent within one working day of the ~~subcontractor~~subcontracted hospital issuing notice of nonrenewal or termination of the subcontract.

(36) An agreement by the ~~subcontractor~~provider to supply, upon request, the business transaction information required under 42 C.F.R. 455.105 (October 1, ~~2015~~2016).

(37) An agreement by the ~~subcontractor~~provider to release to the MCP, ODM or ODM designee any information necessary for the MCP to perform any of its obligations under the ODM provider agreement, including but not limited to compliance with reporting and quality assurance requirements.

(38) An agreement by the ~~subcontractor~~provider that its applicable facilities and records will be open to inspection by the MCP, ODM or its designee, or other entities as specified in rule 5160-26-06 of the Administrative Code.

~~(39) An agreement by the subcontractor that if the base contract with the MCP provides for assignment to another entity, no assignment, in whole or in part, shall take effect without sixty days prior notice to the MCP.~~

~~(40) An agreement by the subcontractor to immediately forward any information regarding a member appeal or grievance as defined in rule 5160-26-08.4 or 5160-58-08.4 of the Administrative Code to the MCP for processing.~~

~~(41) A specification that if the subcontractor has been delegated decision-making authority to reduce, suspend, deny or terminate services to a member, the~~

~~MCP must ensure compliance with the state hearing notification requirements specified in rule 5101:6-2-35 of the Administrative Code.~~

~~(42) A specification that the subcontractor not providing direct health care services agrees to provide a report to the MCP, on at least a monthly basis, summarizing the status of the work in support of the program requirement, including a copy of any required reports or logs maintained by the subcontractor, the submission dates for any required documentation sent to MCP, and indicating any problems, concerns or potential compliance issues that may exist.~~

(E) In lieu of including a medicaid addendum as required by paragraph (D) of this rule, an MCP may permit a benefit manager that assists in the administration of health care services including pharmaceutical, dental, vision and behavioral health services on behalf of the MCP's members, to include elements (D)(1) to (D)(38) in subcontracts with entities that provide for the direct provision of health care services to ~~the~~ MCP members. The MCP must receive written evidence that the benefit manager complied with this paragraph and has informed the entities of the obligation to provide health care services to the MCP's members.

Effective:

Five Year Review (FYR) Dates: 05/01/2022

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5167.02
Rule Amplifies:	5162.20, 5164.02, 5167.02, 5167.03, 5167.10
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