CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Medicaid Managed Care Program

Rule Number(s): 5160-26-02, 5160-26-02.1, 5160-26-3.1, 5160-26-06 and 5160-26-09.1

Rule 5160-26-01 is not subject to CSIO review, but is included for reference.

Date: March 21, 2017

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X Rescinded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.

   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 (contract) with the Ohio Department of Medicaid (ODM) to provide coordinated health care to Medicaid beneficiaries. There are six MCPs/MCOPs (referred to as plans) in Ohio each with a network of health care professionals. The rules outlined in Chapter 5160-26 of the Administrative Code set forth the requirements of MCPs and the Ohio Medicaid managed care program.

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OAC rule 5160-26-02, entitled "Managed health care program: eligibility and enrollment," sets forth the eligibility criteria for individuals who are then enrolled in the managed care program and the enrollment process. It is being proposed for amendment to update policy related to the administration of the Medicaid managed care program. In Paragraph (C)(1)(e), the "and" is being replaced with "or" to clarify when the MCP is responsible for member coverage. Gender identity is being added as a prohibited basis for discrimination in paragraph (C)(1)(a), in order to comply with 42 C.F.R. 438.3(d). Ohio Administrative Code (OAC), United States Code (U.S.C) and Code of Federal Regulations (C.F.R) references are being updated. General edits are being made to terminology, grammar and formatting.

OAC rule 5160-26-02.1, entitled "Managed health care program: termination of enrollment," sets forth the criteria for termination of enrollment and the process used for terminating a Medicaid recipient from enrollment in an MCP. It is being proposed for amendment to update policy related to the administration of the Medicaid managed care program. In paragraph (E)(3) ODM is clarifying that when a termination of enrollment is initiated by the MCP, ODM will provide a "written" approval of the termination request. Gender identity is being added as a prohibited basis for discrimination in paragraphs (D)(3)(b) and (E)(2), in order to comply with 42 C.F.R. 438.3(d). U.S.C and Code of C.F.R references are being updated. ODM is also updating terms to reflect current OAC terminology and making general edits for grammar and formatting.

OAC rule 5160-26-03.1, entitled "Managed health care program: care coordination," sets forth the requirements for MCPs related to members' primary care providers (PCPs) and of utilization management. It also sets forth the utilization management program requirements intended to maximize the effectiveness of care provided to a Medicaid beneficiary, including prior authorization and a coordinated services program. It is being proposed for rescission and will be made new to update policy related to the administration of the Medicaid managed care program. The rule title is being changed to "Managed health care programs: primary care and utilization management," to reflect the changes. Paragraph (A)(3) of the rescission rule is being removed as it is duplicative to language in OAC rule 5160-26-03. Paragraph (A)(6) of the rescission rule is being removed as it is described in Appendix C of the Medicaid managed care and MyCare Ohio provider agreements. Paragraph (A)(8) of the rescission rule is being removed to streamline the rule because the same care management language is located in Appendix K of the provider agreements. Under primary care provider (PCP) care coordination responsibilities, a requirement is being added to the new rule for PCPs to provide medically necessary services in line with OAC rule 5160-1-01. ODM is also updating terms to reflect current OAC terminology, and making general edits for grammar and formatting.

OAC Rule 5160-26-06, entitled "Managed health care programs: program integrity – fraud and abuse, audits, reporting, and record retention," sets forth the MCP requirements related to fraud and abuse prevention, program integrity, audits, reporting and record retention. It is being proposed for amendment to update policy related to the administration of the Medicaid managed care program and to comply with five year rule review requirements. In paragraph (A)(1)(j)

language is being updated to correspond with the suspected fraud reporting requirements outlined in the Medicaid managed care and MyCare Ohio provider agreements. In paragraph (F) language is being added requiring plans to retain records for ten years beginning January 1, 2018, in accordance with 42 C.F.R. 438.3. Other changes include updates to C.F.R references, current OAC terminology and general edits for grammar and formatting.

OAC rule 5160-26-09.1 entitled "Managed health care programs: third party liability and recovery," sets forth the MCPs' rights to recover third party payer liability in certain instances and establishes the requirement for MCPs to provide coordination of benefits when a Medicaid beneficiary has third party resources. It is being proposed for amendment to update policy related to the administration of the Medicaid managed care program and to comply with five year rule review requirements. Language is being added in paragraph (C) allowing ODM to identify, pursue and retain any recovery of third party resources assigned to the MCPs when not collected by the MCP one year after the date of claim payment. Language is being removed in paragraph (B) related to "fraud and abuse recovery" and existing language was reformatted. The removed language is thoroughly covered in the managed care provider agreements including more specific requirements. Changes include updates to U.S.C and C.F.R references.

The MCP provider agreement may be found online at:
http://www.medicaid.ohio.gov/PROVIDERS/ManagedCare/ProgramResourceLibrary/CombinedProviderAgreement.aspx

The MCOP provider agreement may be found online at:
http://medicaid.ohio.gov/PROVIDERS/ManagedCare/IntegratingMedicareandMedicaidBenefits.aspx

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. Several changes are being made to align with changes implemented in 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. The rules and the provider agreements are 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 ensure MCP members' rights and protections, to ensure MCPs follow third party liability policy and to ensure MCPs are implementing protections against fraud and abuse, by requiring MCPs to follow established guidelines.

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

   Through reporting requirements established within the rules and 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 the draft rules on February 9, 2017. The plans were given until February 17, 2017 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?**

   As a result of stakeholder outreach, changes were made to rule 5160-26-03.1. UnitedHealthcare requested the addition of "Providing services which are medically necessary as described in rule 5160-1-01 of the Administrative Code" in paragraph (A)(2), the listing of primary care provider (PCP) care coordination activities. Although the obligation to follow medical necessity is in every contract, having the reference tied to PCPs in the OAC would assist MCPs in upholding PCP compliance with this obligation. Additional changes were made to the formatting of the rule to clarify MCP and PCP care coordination responsibilities.

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 the rules include general updates to keep the rules current, changes to correspond with the C.F.R., clarifications and to streamline managed care plan requirements. No alternative regulations were discussed during the rule process for this reason.

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 be appropriate because ODM is required to comply with detailed federal requirements set forth in 42 C.F.R. Part 438.

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.

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.

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;**

       Changes to these rules 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

Rule 5160-26-02 requires MCPs to notify ODM or its designee of the birth of any newborn whose mother is enrolled in an MCP.

Rule 5160-26-02.1 requires MCPs to submit requests to ODM for member termination in MCP enrollment, and the MCPs may be asked to provide additional documentation around the reason for termination of enrollment.

Rule 5160-26-03.1 requires MCPs to share specific information with ODM and certain providers, to maintain a log, and to implement written policies and procedures.

- This report of information includes: MCP contact information, prior authorization procedures, a listing of panel labs and pharmacies, documentation of non-contracting providers upon ODM request and provider referral approvals/denials.
- The MCPs are also required to provide a toll-free 24/7 call-in system for MCP member access and must maintain a log of calls to that call-in system.
- MCPs are required to implement written policies and procedures with regard to their required utilization management (UM) program. The policies must be made available to ODM and providers upon request.
- The MCP's UM program must document: an annual review and update of the UM program, the use of certain health professionals and consultants including compensation information for these activities, the reason for each service denial, and that UM decisions are consistent with clinical practice guidelines (medical necessity).
- MCPs must send written notice to a member and provider of any decision to reduce, suspend, terminate, or deny a service authorization request, or to authorize a service in scope, duration or amount that is less than requested. Service authorization decisions for covered outpatient drugs must be made by telephone or other telecommunication device.
- MCPs must maintain and submit to ODM a record of all authorization requests.
- Regarding the mandatory coordinated services program (CSP), MCPs must notify members of their hearing rights when enrolled in this program.

Rule 5160-26-06 requires MCPs to maintain written policies and procedures that articulate the MCPs' commitment to comply with federal and state standards including the prevention, identification, investigation, correction and reporting of fraud and abuse.

- MCPs must promptly report all instances of fraud and abuse to ODM.
- MCP policies and procedures, reports and additional information must be made available to ODM upon request.

- The MCP must submit to ODM, an annual report that summarizes the MCP's fraud and abuse prevention activities for the year.
- The MCP and its subcontractors must retain and safeguard all records as required by the record retention schedule set forth in this rule and the MCP Provider Agreement.

Rule 5160-26-09.1 requires MCPs to report information to ODM and to members.

- MCPs must notify ODM of requests related to tort action using specific ODM forms.
- MCPs must report to ODM all cases of suspected fraud or abuse.
- MCPs are required to submit information regarding members with third party coverage as directed by ODM.
- In order to comply with coordination of benefits requirements outlined in this rule, the MCP is required to share information regarding third party resources with the service provider.

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 (MCPs) 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 "2017 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 requirements found in these rules. For CY 2017, the administrative component of the capitation rate varies by program/population and ranges from 3.5% to 8.48% for MCPs and from 2.0% to 8.5% 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.

The requirements of these rules must be applied uniformly and no exception is made based on a plan's size.

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?

These rules impose no sanctions.

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.