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 and 5160-26-03

Date: March 19, 2018

Rule Type:

New	5-Year Review
X Amended	Rescinded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 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. This rule is being proposed for amendment to clarify policy related to the administration of the Medicaid managed care program. In paragraph (B)(4), (B)(4)(c) was moved to paragraph (B)(5). A new paragraph (B)(5) was added to clearly define which individuals are excluded from managed care enrollment. Other technical edits were made throughout.

OAC rule 5160-26-03, entitled "Managed health care programs: covered services," describes the services which must be covered by MCPs and addresses any exclusions or limitations for those services. This rule is being proposed for amendment to update policy related to the administration of the managed care program. The change is related to implementation of "Behavioral Health Carve-in" beginning July 1, 2018. This is when MCPs become responsible for coverage of behavioral health services provided to managed care members by community behavioral health centers certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS). Paragraph (H)(3) related to the community behavioral health center requirements was removed to align with behavioral health services being "carved-in" to managed care.

Other technical edits were made throughout.

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

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 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 the provision of medically necessary services, preventative care, emergency services, post stabilization services and respite to promote the best outcomes for individuals enrolled in the Medicaid managed care program by requiring MCPs to follow established guidelines and to ensure providers are paid appropriately for services delivered. In addition, the rules ensure compliance with federal regulations governing Medicaid managed care.

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 have been very involved in the stakeholder process related to the "Behavioral Health Carve-in" initiative prompting these rule changes. The plans were provided the draft rules on March 5, 2018. The plans were given until March 9, 2018 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 MCP/MCOP outreach, no comments were received, and therefore, no changes were made to the rules.

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, clarification related to managed care enrollment and to implement the "Behavioral Health Carve-in" initiative. 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;

These rules impact MCPs and MCOPs in the State including: Aetna, Buckeye, CareSource, Molina, Paramount and UnitedHealthcare. Certain MCP and MCOP providers are also impacted.

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.

OAC rule 5160-26-03 holds MCPs financially responsible for payment of certain services including respite for children. Requirements in addition to the payment for covered services as outlined in this rule include:

- Establishing, in writing, a process for the submission of claims for services delivered by non-contracting providers;
- Designating a telephone line to receive provider requests for coverage of certain services; and
- Submitting written requests or notifications to ODM, contracting providers and members.

Respite provider agencies are required to:

- Be accredited by at least one of several national accreditation entities;
- Hold a Medicaid provider agreement;
- Comply with applicable background check requirements; and
- Behavioral health provider agencies must be OhioMHAS certified.

Agency employees:

- Long-term care providers must obtain a certificate of completion from the Ohio Department of Health or a Medicare competency evaluation program;
- All providers must obtain first aid certification; and
- Long-term care providers must obtain evidence of completion of twelve hours of in-services continuing education each year.

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 2018, the administrative component of the capitation rate varies by program/population and ranges from 3.50% to 8.48% for MCPs and from 2.25% to 10.00% for MCOPs.

Respite providers must hold a Medicaid provider agreement. The cost associated with obtaining a Medicaid provider agreement is currently $554. This fee may be paid to Ohio Medicaid, their designated agency or to Medicare. It is paid at initial application and then at revalidation every five years.

Fees for the BCII criminal records check for all applicants considered for employment may vary depending on the location or agency providing the service, but on average cost approximately $22.00. The fee for criminal records check from the FBI for each applicant considered for employment, who has not resided in Ohio for five years is currently $24.00 which may vary depending on the location or agency providing the service. BCII accepts and processes FBI background checks. Fees associated with criminal records checks are passed to the applicant/employee resulting in no impact to the agency.

Respite provider agencies must be certified through OhioMHAS. The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. A provider already certified by OhioMHAS, requesting to add an additional service(s) pays a fee based only upon their budget for the new service(s), not their entire budget. When the agency has appropriate accreditation from The Joint Commission, CARF, or COA there is no certification fee owed to OhioMHAS.

Respite provider agencies are required to be accredited by at least one of several accreditation entities. The average cost of accreditation is between $1,295 and $2,300 annually. Costs vary depending on the size of the facility, the number of employees, facility type, the average daily population being served and whether there are satellite offices.

Individual respite providers working for an agency must be first aid certified. The City of Columbus Division of Fire offers a certification course for $30.00 per person. Individual providers also must obtain a certificate of completion of a competency evaluation program approved by the Ohio Department of Health (ODH) or a Medicare competency evaluation program for home health aides. Per ODH, the cost of this certification can range from approximately $200 to $500 depending on where they take the course and who is presenting the materials. Additionally, individual providers must maintain evidence of completion of twelve hours of in-service continuing education per year. On average, the cost for continuing education courses can range from free of charge to $12 per course.

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.