CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: **Ohio Department of Medicaid**

Regulation/Package Title: **Medicaid Consumer Liability Rule**

Rule Number(s): **5160-1-13.1 Medicaid Consumer Liability (Rescind); 5160-1-13.1 Medicaid Recipient Liability (New)**

Date: **6/3/2019**

Rule Type:

X New

☐ 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X Rescinded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.

Ohio Administrative Code rule 5160-1-13.1, entitled "Medicaid consumer liability", has been reviewed as part of the five-year review process and is being proposed for rescission. This rule establishes what constitutes payment in full to a provider for Medicaid services rendered to a Medicaid recipient. This rules also explains under which conditions a provider can or cannot bill the Medicaid recipient for medical services.

Ohio Administrative Code rule 5160-1-13.1, entitled "Medicaid recipient liability", is being proposed for adoption to replace the existing rule which is being proposed for rescission. This rule establishes what constitutes payment in full to a provider for Medicaid services rendered to a Medicaid recipient. This rule also explains under which conditions a provider can or cannot bill the Medicaid recipient for medical services.

All references to a 'consumer' were updated to a 'Medicaid recipient' to reflect current terminology. This rule is being amended to cite 42 CFR 447.15 to clarify the federal authority under which Medicaid payment constituting payment in full resides. Patient liability was added to instances where a Medicaid recipient may be asked to share in the cost of care. Based on a Center for Medicare and Medicaid Services (CMS) clarification, the requirement that providers cannot bill for missed appointment fees was added. The first paragraph was also reordered for clarity and the word 'may' was replaced with 'shall' since these requirements are federally mandated for Medicaid providers.

A clarification for providers was added regarding an individual being financially responsible for payment of services if the individual is not covered by Medicaid or eligible for the hospital care assurance program (HCAP) on the date of service. The rule was further clarified that for the situation where Medicaid eligibility is provided retroactively the individual may not be held financial responsible if the eligibility span includes the date of service. An exception was added to the rule to not allow a pharmacy to accept payment from a Medicaid recipient for a prescription for a controlled substance instead of submitting a claim. This exception was added to aid in preventing opioids and other controlled substances from being paid for with cash to bypass the protections built into the Medicaid claim payment system. Instances of incorrect grammar were corrected. The provision when providers may bill a Medicaid recipient was reworded and reorganized for clarity.

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

   5164.02

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, the rules implement a federal requirement and do not exceed federal authority. For both the rescinded and new rule, these regulations implement 42 CFR 447.15, that requires any provider enrolled in Medicaid to accept, as payment in full, the amounts paid by the agency.

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

   For both the rescinded and new rule, these regulations do not exceed the federal requirement.

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)?**

   Both the rescinded and new rule explain to providers the federal requirement that the Medicaid payment constitutes payment in full for Medicaid covered services. The rules also provide guidance to providers regarding the limited circumstances a provider can bill a Medicaid recipient for covered or non-covered services. These regulations need to be in administrative rule to remove ambiguity by providing clear guidance to providers.

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

   ODM provides a Consumer Hotline for Medicaid recipients where these individuals can report complaints or issues. The hotline reported 186 Medicaid recipient complaints for 2018 regarding the issue of providers billing Medicaid recipients. The success of this regulation will be measured by fewer complaints.

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 draft of the new rule was sent to the Pharmacy Board and Ohio Pharmacy Association for comment prior to posting for clearance. The drafts of these rules were posted for all stakeholders to review for seven calendar days on the ODM rules webpage and notification was sent to the ODM stakeholder list to seek public comment.

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

   No concerns were raised in response to the draft 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?**

   Scientific data is not applicable to the development of the proposed 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?**

    No other alternative regulations were considered. These regulations need to be in administrative rule to remove ambiguity by providing clear guidance to providers.

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.***

    No, because the rules set forth the federal requirement for providers to accept the Medicaid payment for a covered service as payment-in-full and outlines the specific exceptions to this requirement. For this reason, ODM does not have the flexibility to implement a performance-based regulation.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    The rules were reviewed by policy staff for ODM. There are no other regulations in the Medicaid program that define under which conditions a provider may bill a Medicaid recipient for medical services.

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.**

To implement these regulations, ODM will provide a notice of changes to providers and other interested parties. ODM will post this information on the agency website to ensure thorough communication with the regulated community.

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;

The scope of the business community impacted by 5160-1-13.1 is limited to Ohio Medicaid providers.

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

The nature of the adverse impact is a provider's employee time to explain the requirements and obtain consent from the Medicaid recipient. If a provider chooses to not submit a claim to Medicaid, the provider cannot bill the Medicaid recipient unless the following exceptions are met. Ohio Medicaid providers are required to explain to the Medicaid recipient that the individual can receive the Medicaid covered service if applicable at no cost from another Ohio Medicaid provider prior to the service being rendered. A written explanation must also be provided prior to each date of service for the specific service rendered. The Ohio Medicaid provider must also obtain written consent from the individual of their liability for payment before the service can be rendered. The provider must complete the last two requirements (i.e. Give a written explanation and obtain written consent) even if the service is not covered by Medicaid or prior authorization is denied before being able to bill a Medicaid recipient.

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.

The cost to providers would be provider staff time necessary to revise or create the written form and explain the liability multiplied by the staff's hourly rate. Health care providers routinely obtain written consent from individuals as a daily practice. Many providers already have similar disclosure forms for private insurance companies for the individual to attest to their liability for payment for uncovered services. These forms can be revised by administrative staff in about thirty minutes to create a

standard reusable form. The explanation prior to the date of service that the covered medical service could be obtained by another provider at no cost to the recipient along with the provider's staff's time to have the Medicaid recipient sign the form should take no longer than five minutes. ODM does not expect this to be a common occurrence for most providers.

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

ODM determined that the regulatory intent justifies the adverse impact to the regulated business community because the rule sets forth the federal requirement for Medicaid providers to accept the Medicaid payment for a covered service as payment-in-full and outlines the specific exceptions to this requirement. This rule ensures providers are not unduly billing for services these Medicaid recipients could otherwise receive at no cost to themselves.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

No, there are no exceptions. This policy is applied uniformly among all providers. No exceptions are made based on a provider'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?

This rule imposes no sanctions for first-time paperwork violations.

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

The Provider Hotline, (800) 686-1516, can serve as a resource to render technical assistance to providers. The Consumer Hotline, (800) 324-8680, will continue to monitor Medicaid recipient complaints in regards to these requirements.