Ohio | Common Sense Initiative

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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

Rule Contact Name and Contact Information:

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Regulation/Package Title (a general description of the rules' substantive content):

MyCare Ohio CARA Amendment

Rule Number(s): 5160-58-02.1

Date of Submission for CSI Review: 10/3/2019

Public Comment Period End Date: 10/10/2019

Rule Type/Number of Rules:

New/___ rules

No Change/____ rules (FYR? ___)

Amended/_1_ rules (FYR? ___)

Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☐ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☐ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **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 90% of Medicaid recipients receive their Medicaid services through a Managed Care Plan (MCP) or a MyCare Ohio Plan (MCOP). MCPs/MCOPs are health insuring corporations 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. MyCare Ohio is a managed care program aimed at providing integrated care for individuals who are dual eligible (both Medicaid and Medicare recipients.)

   5160-58-02.1 "MyCare Ohio plans: termination of enrollment" sets forth the reasons why a MyCare Ohio plan member may be terminated from enrollment in the plan, and the process for termination. This rule is being proposed for amendment in compliance with federal regulations. Updates include: in paragraph (C)(4), new language is added to allow CMS to prevent MyCare Ohio enrollees from switching plans when they are enrolled in a Medicare Part D drug management

program and identified as “potentially at-risk” or “at-risk” as defined in 42 CFR 423.100. Other grammatical and technical edits are also being made.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   Revised Code Sections 5160.02, 5164.02, 5167.02

4. **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. Additionally, ODM has entered into a three-way contract with the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services and each MCOP to implement the MyCare Ohio demonstration program.

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

   No provisions exceed federal requirements.

6. **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 MCOP members’ rights, protections, and health and safety by requiring plans to follow established guidelines. The addition of the CARA act requirements are intended to aid in the fight against the opioid crisis by restricting individuals who are identified as at risk for opioid misuse to a single MyCare Ohio plan.

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

   Through reporting requirements established 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 established standards as determined by monitoring and oversight.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

No

Development of the Regulation

9. 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 MyCare Ohio Plans listed below were provided a guidance memo from CMS in November 2018 and CMS held a meeting in December 2018 to review the federal regulations. The MyCare Ohio Plans were provided a copy of the draft rule on 9/10/2019 and given until 9/16/2019 to provide feedback.

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

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

No concerns or comments were received as the changes were federally mandated updates.

11. 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 the rules or the measurable outcomes of the rules.

12. 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 MCOP requirements. No alternative regulations were discussed during the rule process for this reason.

13. 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 and the three-way contract with CMS.

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

All Medicaid regulations governing MCOPs are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid managed care program.

15. 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 MCOPs of the final rule changes via email notification. The changes to the rule will have minimal impact on the plans' current business processes.

Adverse Impact to Business

16. 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; and

This rule impacts MCOPs in the State including: Aetna, Buckeye, CareSource, Molina, and UnitedHealthcare.

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

Rule 5160-58-02.1 requires the MCOP to provide documentation when a member requests termination of plan enrollment for just cause. It also requires the MCOP to submit a request for termination for a member when the member is uncooperative, disruptive or acts fraudulently.

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.

Plans are paid per member per month. ODM must pay MCOPs rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.6(c) and CMS's "2018-2019 Medicaid Managed Care Rate Development Guide" (May 2018). 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 the MyCare Ohio provider agreements. Through the administrative component of the capitation rate paid to the MCOPs by ODM, MCOPs will be compensated for the cost of the reporting and notice requirements found in these rules. For CY 2019, the administrative component of the capitation rate varies by program/population and ranges from 2.00% to 9.75% of the effective rate for MCOPs. Note that these amounts exclude care management and risk margin included in the capitation rates.

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

The 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

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

The requirements of this rule must be applied uniformly and no exception is made based on an MCOP's size.

19. 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.

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

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

DRAFT - NOT FOR FILING

5160-58-02.1 MyCare Ohio plans: termination of enrollment.

(A) A member will be terminated from enrollment in a MyCare Ohio plan ("plan") for any of the following reasons:

(1) The member becomes ineligible for full medicaid or medicare parts A or B or D. Termination of plan enrollment is effective the end of the last day of the month in which the member became ineligible.

(2) The member's permanent place of residence is moved outside the plan's service area. Termination of plan enrollment is effective the end of the last day of the month in which the member moved from the service area.

(3) The member dies, in which case plan enrollment ends on the date of death.

(4) The member is found by the Ohio department of medicaid (ODM), or their designee, to meet the criteria for the developmental disabilities (DD) level of care and has a stay in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) or is enrolled in a DD waiver. After the plan notifies ODM this has occurred, termination of plan enrollment takes effect on the last day of the month preceding the ICF-IID facility stay or enrollment on the DD waiver.

(5) The member has third party coverage, excepting medicare coverage, and ODM determines it is not in the best interest of the member to continue in the plan. The effective date of termination shall be determined by ODM but in no event shall the termination date be later than the last day of the month in which ODM approves the termination.

(6) The provider agreement between ODM and the plan is terminated or not renewed. The effective date of termination shall be the last day of the month of the provider agreement termination or nonrenewal.

(7) The member is not eligible for enrollment in a plan for one of the reasons set forth in rule 5160-58-02 of the Administrative Code.

(B) All of the following apply when enrollment in a MyCare Ohio plan is terminated for any of the reasons set forth in paragraph (A) of this rule:

(1) Such terminations may occur either in a mandatory or voluntary service area;

(2) All such terminations occur at the individual level;

(3) Such terminations do not require completion of a consumer contact record (CCR);

(4) If ODM fails to notify the plan of a member's termination from the plan, ODM shall continue to pay the plan the applicable monthly premium rate for the member. The plan shall remain liable for the provision of covered services as set forth in rule 5160-58-03 of the Administrative Code, until ODM provides the plan with documentation of the member's termination.; and

(5) ODM shall recover from the plan any premium paid for retroactive enrollment termination occurring as a result of paragraph (A) of this rule.

(C) Member-initiated terminations.

(1) A dual-benefits member may request disenrollment from the plan and transfer between plans on a month-to-month basis any time during the year. Plan coverage continues until the end of the month of

disenrollment.

(2) A medicaid-only member may request a different plan in a mandatory service area as follows:

(a) From the date of initial enrollment through the first three months of plan enrollment, whether the first three months of enrollment are dual-benefits or medicaid-only enrollment periods;

(b) During an open enrollment month for the member's service area as described in paragraph (E) of this rule; or

(c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph (C)(4)(e) of this rule.

(3) A medicaid-only member may request a different plan if available or be returned to medicaid fee-for-service in a voluntary service area as follows:

(a) From the date of enrollment through the initial three months of plan enrollment;

(b) During an open enrollment month for the member's service area as described in paragraph (E) of this rule; or

(c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph (C)(4)(e) of this rule.

(4) The following provisions apply when a member ~~either~~ requests a different plan in a mandatory service area~~, requests disenrollment in a voluntary service area, or qualifies as voluntary population as set forth in rule 5160-58-02 of the Administrative Code~~:

(a) The request may be made by the member, or by the member's authorized representative.

(b) All member-initiated changes or terminations must be voluntary. Plans are not permitted to encourage members to change or terminate enrollment due to a member’s race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services. Plans may not use a policy or practice that has the effect of discrimination on the basis of the above criteria.

(c) If a member requests disenrollment because he or she meets any of the requirements in rule 5160-58-02 of the Administrative Code, the member will be disenrolled after the member notifies the consumer hotline.

(d) Disenrollment will take effect on the last day of the calendar month as specified by an ODM-produced HIPAA compliant 834 daily or monthly file sent to the plan.

(e) In accordance with 42 C.F.R. 438.56 (October 1, ~~2017~~2019), a change or termination of plan enrollment may be permitted for any of the following just cause reasons:

(i) The member moves out of the plan's service area and a non-emergency service must be provided out of the service area before the effective date of a termination that occurs for one of the reasons set forth in paragraph (A) of this rule;

(ii) The plan does not, for moral or religious objections, cover the service the member seeks;

(iii) The member needs related services to be performed at the same time in a coordinated manner; however, not all related services are available within the plan network, and the member's primary care provider (PCP) or another provider determines that receiving services separately would subject the member to unnecessary risk;

(iv) The member has experienced poor quality of care and the services are not available from another provider within the plan's network;

(v) The member receiving long-term services and supports would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to and out-of-network provider with the plan and, as a result, would experience a disruption in their residence or employment;

(vi) The member cannot access medically necessary medicaid-covered services or cannot access the type of providers experienced in dealing with the member's health care needs;

(vii) ODM determines that continued enrollment in the plan would be harmful to the interests of the member.

(f) The following provisions apply when a member seeks a change or termination in plan enrollment for just cause:

(i) The member or an authorized representative must contact the plan to identify providers of services before seeking a determination of just cause from ODM.

(ii) The member may make the request for just cause directly to ODM or an ODM-approved entity, either orally or in writing.

(iii) ODM shall review all requests for just cause within seven working days of receipt. ODM may request documentation as necessary from both the member and the plan. ODM shall make a decision within ten working days of receipt of all necessary documentation, or forty-five days from the date ODM receives the just cause request. If ODM fails to make the determination within this timeframe, the just cause request is considered approved.

(iv) ODM may establish retroactive termination dates and/or recover premium payments as determined necessary and appropriate.

(v) Regardless of the procedures followed, the effective date of an approved just cause request must be no later than the first day of the second month following the month in which the member requests change or termination.

(vi) If the just cause request is not approved, ODM shall notify the member or the authorized representative of the member's right to a state hearing.

(vii) Requests for just cause may be processed at the individual level or case level as ODM determines necessary and appropriate.

(viii) If a member submits a request to change or terminate enrollment for just cause, and the member loses medicaid eligibility prior to action by ODM on the request, ODM shall assure that the

member's plan enrollment is not automatically renewed if eligibility for medicaid is reauthorized.

(g) A member who is in a Medicare Part D drug managment program and is in a potentially at-risk or at-risk status as defined in 42 C.F.R. 423.100 (October 1, 2019) is precluded from changing plans.

(D) The following provisions apply when a termination in plan enrollment is initiated by a plan for a medicaid-only member:

(1) A plan may submit a request to ODM for the termination of a member for the following reasons:

(a) Fraudulent behavior by the member; or

(b) Uncooperative or disruptive behavior by the member or someone acting on the member's behalf to the extent that such behavior seriously impairs the plan's ability to provide services to either the member or other plan members.

(2) The plan may not request termination due to a member's race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services.

(3) The plan must provide covered services to a terminated member through the last day of the month in which the plan enrollment is terminated.

(4) If ODM approves the plan's request for termination, ODM shall notify in writing the member, the authorized representative, the medicaid consumer hotline and the plan.

(E) Open enrollment

Open enrollment months will occur at least annually. At least sixty days prior to the designated open enrollment month, ODM will notify eligible individuals by mail of the opportunity to change or terminate enrollment in a plan and will explain how the individual can obtain further information.