Ohio | Common Sense Initiative

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Business Impact Analysis

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

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

Rule Number(s): 5160-26-02.1, 5160-26-05, 5160-26-05.1, 5160-26-09, 5160-26-10, and 5160-26-12; 5160-26-01 is included for information purposes only.

Date of Submission for CSI Review: March 3, 2020

Public Comment Period End Date: _____

Rule Type/Number of Rules:

New/___ rules

Amended/ 5 **rules (FYR?** Yes**)**

No Change/____ rules (FYR? ___)

Rescinded/ 1 **rules (FYR?** Yes**)**

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.

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, including prescribed drugs, through a Managed Care Organization (MCO) or MyCare Ohio Plan (MCOP). MCOs/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 MCOs/MCOPs 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 MCOs and the Ohio Medicaid managed care program.

   Ohio Administrative Code (OAC) rule 5160-26-01, entitled "Managed health care programs: definitions," sets forth the definitions used throughout Chapter 5160-26 of the Administrative Code regarding the Medicaid managed care program. This rule is being updated to add the definition of "federally qualified health center" and "managed care organization". Other grammatical and technical edits were made throughout.

   OAC rule 5160-26-02.1, entitled "Managed health care programs: termination of enrollment", sets forth the reasons why an individual enrolled in the Medicaid managed care program may be terminated from the program and the process for termination. Changes to the rule changing references from "managed care plans" to "managed care organizations" in accordance with OAC rule 5160-26-01, and updated references to United States Code and the Code of Federal Regulations.

   OAC rule 5160-26-05, entitled "Managed health care programs: provider panel and subcontracting requirements", sets forth managed care organization (MCO) provider panel and subcontracting

requirements. Changes to the rule include: revising paragraph (D) to include single case agreements MCOs hold with providers; clarifying that requirements listed in paragraph (D)(14) regarding provider notification to the MCO of nonrenewal or termination also applies to the termination of any service for which the provider is contracted; changing references from "managed care plan" to "managed care organization" in accordance with OAC rule 5160-26-01; and updating references to United States Code and the Code of Federal Regulations.

OAC rule 5160-26-05.1, entitled "Managed health care programs: provider services", sets forth the requirements for information that MCOs must make available to providers and interested parties. Changes to the rule changing references from "managed care plans" to "managed care organizations" in accordance with OAC rule 5160-26-01, and updated references to United States Code and the Code of Federal Regulations.

OAC rule 5160-26-09, entitled "Managed health care programs: payment and financial responsibility", sets forth the Ohio Medicaid managed care organization payment and financial responsibility guidelines, including reinsurance requirements. This rule is being rescinded to streamline managed care organization requirements. The rule language has been incorporated into the MCO provider agreements.

OAC rule 5160-26-10, entitled "Managed health care programs: sanctions and provider agreement actions", sets forth the sanctions and provider agreement actions for Medicaid MCOs. Changes to the rule changing references from "managed care plans" to "managed care organizations" in accordance with OAC rule 5160-26-01, and updated references to United States Code and the Code of Federal Regulations.

OAC rule 5160-26-12, entitled "Managed health care programs: member co-payments", sets forth requirements for MCOs when they elect to implement a co-payment program. Changes to the rule changing references from "managed care plans" to "managed care organizations" in accordance with OAC rule 5160-26-01, and updated references to United States Code and the Code of Federal Regulations.

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 Section 5167.02 authorizes ODM to adopt the rule, and 5162.02, 5162.03, 5164.02, 5167.02, 5167.03, 5167.10, and 5167.12 amplify that authority.

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, however the proposed changes to the rule are not related to changes to federal regulation.

5. **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 MCOs; instead they require state Medicaid agencies to ensure MCO compliance with federal standards. The rules are consistent with federal managed care requirements outlined in 42 C.F.R Part 438 that require the state to implement policies and regulations as the state deems necessary and appropriate.

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 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 MCOs 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.

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

   ODM monitors compliance with the regulation through reporting requirements established within the managed care provider agreements. Successful outcomes are measured through a finding of compliance with these 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 Medicaid Managed Care Plans listed below were provided the draft rules electronically on February 10, 2020. The plans were given until February 14, 2020 to comment.

   - Buckeye Health Plan
   - CareSource
   - Molina Healthcare of Ohio
   - Paramount Advantage
   - 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?**

    As a result of MCO outreach, no concerns were expressed. Therefore, no changes were made to the rules.

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 this rule 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 amendments to the rules include general updates to keep the rules current and to implement minor changes to the managed care program. 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 CFR Part 438. MCO performance requirements are outlined in the Medicaid Managed Care Plan Contracts available online at: https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans

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

    All Medicaid regulations governing MCOs are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid program, and the rules in Chapter 5160-26 are not duplicated elsewhere in Agency 5160.

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 the MCOs of the final rule changes via email notification. Additionally, per the provider agreement, managed care plans are required to subscribe to the appropriate distribution lists for notification of all OAC rule clearances and final published rules including RuleWatch Ohio and the Regulatory Reform eNotification System.

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 MCOs in the State of Ohio including: Buckeye Health Plan, CareSource, Molina Healthcare of Ohio, Paramount Advantage, and UnitedHealthcare Community Plan of Ohio.

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

- OAC rule 5160-26-02.1 requires MCOs to provide notice and potentially documentation to ODM upon member disenrollment from the MCO.
- OAC rule 5160-26-05 requires the MCOs to report certain information related to their subcontracts to ODM upon request including making subcontracts themselves available. MCOs are also 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.
- OAC rule 5160-26-05.1 requires MCOs to provide written information to their contracting providers, and disseminate practice guidelines to providers and, upon request, to members. This rules also requires the MCOs to have staff specifically responsible for resolving provider issues.
- OAC rule 5160-26-09 requires MCOs to report certain information to ODM including a copy of current licensure or certificate of authority, copies of annual or quarterly financial statements, audited financial statements, cost reports, financial disclosure statements, physician incentive plans disclosure statements, and certain reinsurance requirement documents.
- OAC rule 5160-26-10 describes sanctions that may be imposed on an MCO for failure to comply with its duties and obligations under law and contract.
    - The types of sanctions include but are not limited to corrective action, the imposition of temporary management, suspension of the MCO's enrollment of members, disenrollment of the MCO's members, the prohibition or reduction of enrollees assigned to the MCO, the termination of the MCO's members without cause, the retention of premium payments by ODM, and the imposition of fines or other financial sanctions.
    - The rule also allows ODM to terminate, non-renew, or deny the MCO's entire provider agreement or terminate the provider agreement in one or more service areas.
    - This rule requires MCOs to submit corrective action plans (CAPs) to ODM upon request.
- OAC rule 5160-26-12 may adversely affect the MCOs due to them potentially incurring administrative costs if the MCO elects to implement and impose co-payment(s) on their members. The costs would vary based on the MCO's business practices.

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 (MCOs) are paid per member per month. ODM must pay MCOs rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.6(c) and CMS's "2019/2020 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 the Medicaid Managed Care provider agreement. Through the administrative component of the capitation rate paid to the MCOs by ODM, MCOs will be compensated for the cost of the requirements found in this rule. For CY 2020, the administrative component of the capitation rate varies by program/population and ranges from 3.00% to 6.50% of the effective rate for MCOs. 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 MCOs were aware of federal requirements for covered services prior to seeking and signing contracts with the state. More importantly, without the requirement, 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 MCO'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 negatively impacted by this rule, the managed care plans may contact ODM directly through their assigned Contract Administrator.